

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/29/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200726, Complaint IN00204111, Complaint IN00206175, Complaint IN00206300 and Complaint IN00207361 .</p> <p>Complaint number IN00200726- -Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F356.</p> <p>Complaint IN00204111--Substantiated. Federal/state deficiency related to the allegations is cited at F425.</p> <p>Complaint number IN00206175- -Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint number IN00206300- -Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309 and F356.</p> <p>Complaint number IN00207361-Substantiated. Federal/state deficiency related to the allegations is cited at F425.</p> <p>Unrelated deficiencies are cited.</p>	F 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p>	

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

TITLE

(X6) DATE

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

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F 0241 SS=D Bldg. 00	<p>Survey dates: August 22, 23, 24, 25, 26 and 29, 2016</p> <p>Facility number: 000009 Provider number: 155022 Aim number: 100274760</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 1 Medicaid: 46 Other: 13 Total: 60</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on September 2, 2016</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</p>						

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	<p>in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure a resident's request for the use of an electric shaver to be used for facial shaving was disregarded by a staff member for 1 of 4 residents reviewed for bathing and hygiene services. (Resident #F)</p> <p>Findings include:</p> <p>In an interview with Resident #F on 8-23-16 at 10:16 a.m., he indicated, "Last week, had a girl named [name of CNA #1], who is very pushy. She gave me a shave with a razor and I told her I wanted an electric razor. She did it anyway. No, I wasn ' t harmed in any way. If I thought she did, I probably would have hurt her back. I just didn ' t appreciate the way she did things."</p> <p>In a review of unusual events and/or abuse allegations provided by the Administrator on 8-22-16, it included an abuse allegation, dated 8-16-16 at 8:40 a.m., which had been submitted to the Indiana State Department of Health (ISDH) on 8-16-16 at 2:22 p.m. This report indicated, "It was reported to [name of DON] [by name of CNA #2] that another [name of CNA #2] was rude</p>	F 0241	<p><b>F241 Dignity and Respect of Individuality</b></p> <p>Community will continue to enhance each resident's dignity and respect by recognizing his or her individuality when they are receiving care. Communities Policy and Procedure on Resident Rights and Abuse was reviewed.</p> <p>All residents have the potential to be effected; there was no actual harm to any resident.</p>	09/28/2016

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	<p>and abrupt with [name of Resident #F]. [Name of DON] immediately called [name of CNA #1] into Administrator's office and was sent home pending investigation...[Resident #F without injury and without signs or symptoms of mental anguish."</p> <p>In a timeline of events, dated 8-16-16, with Resident #F provided by the Administrator on 8-23-16 at 8:45 a.m., it indicated on 8-16-16 at 8:40 a.m., CNA #2 heard Resident #F say to CNA #1 he wanted CNA #1 to shave him "with the electric razor that he brought to use." She continued that CNA #1 responded with, "I'm old military style, men need to be shaved twice a day with a razor," to which Resident #F responded with, "I'm not in the military, I'm in an old folk's home and I don't want shaved like this." CNA #2 indicated CNA #1 continued and "shaved him with the regular razor," and Resident #F also requested CNA #1 to assist him with changing the television channel and donning a jacket to which she added, "she told him 'no,' and left the room."</p> <p>The timeline indicated CNA #2 notified the DON of the events on 8-16-16 at 8:40 a.m. The DON had CNA #1 come into the Administrator's office and informed her of an abuse allegation had been made</p>		<p>Staff were educated on Resident Rights and will continue with education on Resident Rights, Abuse and Elder Justice Act upon hire and annually.</p> <p>All interview able residents were asked the following question: Does staff allow you to make your own choices on when you get up, when/what you eat and personal grooming choices (attachment A)</p> <p>DON or designee will observe staff rendering care to ensure resident choices are being honored (attachment B). Staff will be observed 5 times weekly for 3 months</p>	

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	<p>against her and she would be suspended immediately while it was investigated.</p> <p>The timeline continued, at 8:55 a.m., the Social Services Designee (SSD) interviewed Resident #F. The SSD asked how Resident #D was doing. Resident #F indicated, "Fine, except for one b---h this morning...wanted shaved with electric razor and she wouldn't."</p> <p>The timeline concluded, "Summary. It was decided that incident did occur, therefore employee was terminated."</p> <p>In review of CNA #1's employee personnel file, a document entitled, "Employee Counseling Record " indicated, " There has been an allegation of abuse against employee. Employee being suspended until investigation completed," which was signed 8-16-16, by Administrator and DON. This form continued, " After completion of investigation it was determined that the allegation of abuse was true. According to state regulations any employee who is guilty of abuse is to be terminated. Per telephone conversation-employee termed. " This form was signed 8-19-16 by the Administrator and DON.</p> <p>In interview with the Administrator on 8-23-16 at 10:50 a.m., she indicated,</p>		<p>than 2 times weekly for 3 months. Results of audit will be reviewed by the QA committee and any recommendations will be followed.</p> <p>Social Services or designee will interview 5 residents weekly for 3 months than 2 residents weekly for 3 months. Any concerns will be handled immediately Results of audits (attachment C) will be reviewed by the QA committee and any recommendations will be followed.</p>		

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F 0272 SS=D Bldg. 00	<p>"[Name of CNA #1] only had one other write up and that was actually more of a verbal counseling or teaching moment. She has had several times where we have had to talk to her to be careful about her voice tone because she had a kind of loud, boomy voice that really carried. She worked here about a year... When we interviewed [name of Resident #F], he told us almost the exact same words the aide who reported it said."</p> <p>In review of Resident #F's most recent Minimum Data Set assessment, dated 8-7-16, it indicated he was cognitively intact, required extensive assistance of one person with bathing, hygiene and dressing.</p> <p>3.1-3(t)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;</p>			

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	<p>Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure an assessment was conducted in a timely manner, prior to the placement and use of side rails for 1 of 2 residents reviewed for side rail use. (Resident #D)</p> <p>Findings include:</p> <p>In review of Resident #D's clinical record on 8-26-16 at 2:15 p.m., it indicated her diagnoses included, but were not limited to, hypertensive heart disease with heart failure, colon cancer, osteoarthritis, legally blind, impulse disorder and dementia, as well as, receiving hospice services for 11 months. Her most recent</p>	F 0272	<p><b>F272 Comprehensive Assessments</b></p> <p>It is the practice of this community to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>	09/28/2016

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	<p>Minimum Data Set assessment, dated 6-24-16, showed she is moderately cognitively impaired.</p> <p>In review of Resident #D's care plan, dated as initiated on 4-16-16 and revised on 4-23-16, indicated, "Requires use of half rails to assist with bed mobility," with the goal of "Bed mobility will be enhanced as evidenced by assisting with bed mobility using half rails thru [sic] next review." Interventions for this care plan included, but were not limited to, "Half rails as ordered," with an initiation date of 4-16-16, and "Staff to complete side rail assessment per facility policy and PRN [as needed] changes in condition to ensure rails are still appropriate," with an initiation date of 4-16-16 and revision date of 5-2-16.</p> <p>In review of the most recent quarterly side rail assessments, the 3-18-16, assessment indicated she was not indicated for side rails at that time. The next and most recent side rail assessment, dated 6-24-16, indicated top half side rails were indicated as enablers to assist with positioning and to promote independence. In review of the clinical record, there was not a side rail assessment conducted on or around the date of the initiation of the use of the side rails on 4-16-16, on the care plan.</p>		<p>All residents have the potential to be effected; there was no actual harm to any resident.</p> <p>All residents were audited for side rail, side rail assessment, side rail order, side rail care plan accuracy by DON or designee.</p> <p>Licensed nurses were educated on side rail orders, assessment, and care plan.</p> <p>MDS Coordinator or designee will audit (attachment D) all residents' side rail orders, assessment and care plan with quarterly MDS, and/or with each side rail order</p>				

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F 0282 SS=D Bldg. 00	<p>In an interview with the Director of Nursing (DON) on 8-29-16 at 4:05 p.m., she indicated, she could not locate a side rail assessment immediately prior to the placement of the side rails for Resident #D. In an interview on 8-29-16 at 4:50 p.m., with the DON, she continued, "We have a side rail assessment form that is used to determine if someone would need side rails. I'm not aware of any particular policy on this."</p> <p>3.1-31(a) 3.1-31(d)(3)</p> <p>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 interview and record review, the facility failed to ensure physician orders were followed for the monitoring of blood pressure after a fall for 1 of 3 residents reviewed for falls. (Resident #D)</p>	F 0282	<p>written for 6 months, results will be taken to QA committee and any recommendations will be followed.</p> <p><b>F282 Services by Qualified Persons/Per Care Plan</b></p>	09/28/2016			

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	<p>Findings include:</p> <p>In review of Resident #D's clinical record on 8-26-16 at 2:15 p.m., it indicated her diagnoses included, but were not limited to, hypertensive heart disease with heart failure, colon cancer, osteoarthritis, legally blind, impulse disorder and dementia, as well as, receiving hospice services for 11 months. Her most recent Minimum Data Set assessment, dated 6-24-16, showed she is moderately cognitively impaired, is a fall risk with one fall without injury since the previous assessment was conducted, required supervision with ambulation and used a walker to assist with ambulation in her room and in the halls.</p> <p>In review of the clinical record, notes, dated 7-7-16 at 8:15 a.m., it indicated the resident was witnessed by a staff member to attempt to bend over to pick up a towel on the floor and slid to the floor, as the staff member could not reach the resident in time to prevent the fall. A new order was issued by the physician to obtain orthostatic blood pressures [BP] [blood pressures taken in multiple positions to determine rise or fall in blood pressure in various positions] daily for 7 days and report any abnormal findings.</p> <p>In review of the Medication</p>		<p>Community will continue to use qualified persons to provide services for the residents in accordance with each resident's written plan of care.</p> <p>All residents have the potential to be effected; there was no actual harm to any resident.</p> <p>Licensed Nurses were educated on documentation in MARS and TARS. Licensed nurses educated on writing of and physician's order and to place green carbon copy of order in DON's mailbox.</p> <p>DON or designee will</p>		

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	<p>Administration Record (MAR) for July, 2016, the entries for "orthostatic BP daily x7, report to hospice or NP [nurse practitioner] if changes noted" indicated the BP checks were not initiated until 7-9-16. Of the 7 days identified on the MAR for checking the BP, one day indicated no orthostatic BP was documented, as well as 2 days the orthostatic BP was documented for one position only with had no pulse (heart rate) documented.</p> <p>In interview with the Director of Nursing (DON) on 8-29-16 at 1:40 p.m., she indicated, "For the orthostatic vital signs, we want the staff to use 2 different positions and check the BP a few minutes apart."</p> <p>In an interview on 8-29-16 at 2:15 p.m., with the Administrator, she clarified, "We do not have a policy or procedure for orthostatic blood pressure. I will have to check with [name of the DON] to see if we have a reference book for procedures."</p> <p>In interview with the DON on 8-29-16 at 4:05 p.m., she indicated, "We don't have a reference book for procedures. At [name of a sister facility], we used [name of a nursing manual.] A lot of times, I will go to the internet to find procedures</p>		<p>audit (attachment E) MARS and TARS for accuracy twice weekly times 3 months then weekly times 3 months. DON or designee will audit Physician orders 5 times weekly for 2 months than 3 times weekly for 2 months than 1 times weekly for 2 months (attachment F). Results of audits will be reviewed by the QA committee and any recommendations will be followed.</p>	

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	<p>or to look up how to do something. The only trouble with that is that sometimes, like on [these web-based] sites, there is almost too much information to go through."</p> <p>On 8-29-16 at 4:50 p.m., in an interview with the DON, she indicated, "Blood pressures that are ordered [as in orthostatic blood pressures] would be documented on the MAR, so the policy and procedure for medication administration would apply."</p> <p>On 8-30-16, an instructional flowsheet was retrieved from the "Stopping Elderly Accidents, Deaths and Injuries" site at <a href="http://www.cdc.gov/injury/STEADI">www.cdc.gov/injury/STEADI</a>, regarding "Measuring Orthostatic Blood Pressure." This flow sheet indicated, "1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing [at] 1 and 3 minutes. A drop in [systolic or top number of] blood pressure [sign for greater than or equal to] 20 [points], or in diastolic [bottom number of] bp of [sign for greater than or equal to] 10 [points], or experiencing lightheadedness or dizziness is considered abnormal."</p> <p>On 8-29-16 at 4:35 p.m., the</p>			

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	<p>Administrator provided a copy of policy entitled, "Drug Administration-General Guidelines." This policy was updated on 12-3-14 and was indicated to be the policy currently used by the facility. It indicated, "Medications are administered as prescribed, in accordance with good nursing principles and practices...the licensed nurse is aware of an indication for the resident receiving medication...If an unusual dose is ordered, considering the resident's age and condition, or a medication order seems unrelated to the resident's current diagnosis or condition; the physician is contacted for clarification prior to administration of the medication. The pharmacist is also available for consultation for drug therapy concerns or questions...At the end of each medication pass, the person administering medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications..."</p> <p>This Federal tag relates to Complaint IN00206300.</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=E Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure adequate staffing and/or call lights were responded to in a timely manner to provide the care and services needed for 2 of 5 residents reviewed for staffing adequacy and timely call light response. This deficient practice has the potential to adversely affect the care and well being of all the residents of the facility. (Residents #A and #D)</p> <p>Findings include:</p> <p>1. In an interview with Resident #A on 8-23-16 at 2:50 p.m., she indicated, "When I use my call light, it seems like it takes a long time to get somebody to help</p>	F 0309	<p>F309 Provide Care/Services for Highest Well Being</p> <p>It is the practice of this facility to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the</p>	09/28/2016

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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	<p>me. When the aides come in, they apologize to me for taking so long. That kind of tells me that I'm right that it takes longer than it should."</p> <p>Resident #A's clinical record was reviewed on 8-23-16 at 4:00 p.m. Her diagnoses included, but were not limited to, a central nervous system disorder and chronic pain. Her most recent Minimum Data Set (MDS) assessment, dated 6-14-16, indicated she is cognitively intact, is dependent of 2 or more persons for transfers, bed mobility, toileting and bathing, is dependent of one person for dressing and hygiene, is unable to ambulate and uses a wheelchair for mobility.</p> <p>2. In an interview with a family member of Resident #B on 8-23-16 at 1:40 p.m., she indicated, "Several weeks ago, I noticed an aide walk past a room with the call light on. This went on several times until I said something. I have no idea who it was or what they needed."</p> <p>3. In an interview with Resident #D on 8-24-16 4:23 p.m., she indicated, " I think they could probably use some more people working here. Sometimes, when I use my call light, it can take them better than 20 minutes to come and see what I need. Sometimes, I feel a little weak and</p>		<p>comprehensive assessment and plan of care.</p> <p>All residents have the potential to be effected; there was no actual harm to any resident.</p> <p>Interview able residents were asked the following: In the past week has staff been answering your call light in a timely manner?</p> <p>Staff was educated on answering of call lights; continue to run employment ads in local newspapers, and on line. One more CNA hired, and continue to interview.</p> <p>Social Services or designee will interview 5 residents weekly</p>	

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	<p>need somebody to help me to the bathroom to make sure I don't fall."</p> <p>In review of Resident #D's clinical record on 8-26-16 at 2:15 p.m., it indicated her diagnoses included, but were not limited to, hypertensive heart disease with heart failure, colon cancer, osteoarthritis, legally blind, impulse disorder and dementia, as well as, receiving hospice services for 11 months. Her most recent Minimum Data Set assessment, dated 6-24-16, showed she is moderately cognitively impaired, is a fall risk with one fall without injury since the previous assessment was conducted, required supervision with ambulation and used a walker to assist with ambulation in her room and in the halls. A review of the clinical record indicated a witnessed fall on 7-7-16 at 8:15 a.m., resulting in no apparent injury and an unwitnessed fall on 7-25-16 at 5:10 p.m., resulting in a small skin tear to the right elbow. Both falls were related to unassisting rising by the resident.</p> <p>4. In an interview with a Confidential Staff Member #4 on 8-29-16, she indicated. "Don't feel we have enough staff because of continued call-ins..[This shift on the non-dementia unit there are] just 3 people. It works better with 4 aides. [This makes it hard for] getting</p>		<p>times 3 months than 2 residents weekly times 3 months (attachments A &amp; C), any concerns will be addressed immediately. Social Services or designee will interview 3 staff members weekly for 2 months, then 2 staff members weekly for 2 months than 1 staff member weekly for 2 months (attachments Gand H) Results from audits will be reviewed by QA committee any recommendations will be followed</p>	

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F 0356	<p>people up, ice and linens don't get passed, call lights don't get answered as quickly as they should, sometimes don't have time to get showers done like we should."</p> <p>5. In an interview with a Confidential Staff Member #5 on 8-29-16, she indicated, "Don't feel we have enough staff. At times, ice doesn't get passed; showers aren't getting done, call lights don't get answered as quick as I would like. This is when we are short-handed, that we just don't have the time to get things done the way that I would prefer."</p> <p>4. In an interview with a Confidential Staff Member #6 on 8-29-16, she indicated, "Don't feel we have enough staff to get the things that need done. Like, not getting ice passed, getting showers done, taking them out to smoke on time, call lights not getting answered in a timely manner. Kind of feels like we are neglecting their needs. We are kind of in a jam with people quitting and some going back to school."</p> <p>This Federal tag relates to Complaint IN00200726 and Complaint IN00206300.</p> <p>3-1-37(a)</p>			
	483.30(e)			

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SS=E Bldg. 00	<p><b>POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure the daily nurse staffing data was posted in a timely manner at the beginning of each shift for 3 consecutive days. This deficient practice has the potential to adversely affect the health care needs</p>	F 0356	<p><b>F356 Posted Nurse Staffing Information</b> It is the practice of this community to post the nurse staffing data on a daily basis and in a clear and readable format. All residents have the potential to be effected; there was no actual harm to any resident. Daily</p>	09/28/2016
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	<p>and well-being of each resident in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility with the Director of Nursing on 8-22-16 at 4:50 p.m., the daily nurse staffing data posting was observed at the nurse's station, located near the visitor's entrance of the facility and dated for 8-22-16. In observation on 8-23-16 at 8:45 a.m., 8-24-16 at 8:40 a.m., and 8-25-16 at 9:05 a.m., the daily nurse staffing data posting remained unchanged since 8-22-16. On 8-26-16 at 9:25 a.m., the daily nurse staffing data posting was observed to be updated to 8-26-16.</p> <p>In an interview with the Director of Nursing on 8-29-16 at 1:40 p.m., she indicated, "I do the staff hours for posting as I'm putting the staff's schedule together. So I know they were in the [picture] frame to be put out [ for public display by the nursing staff]. I guess they just forgot to pull the ones that needed pulled [for each day]."</p> <p>This Federal tag relates to Complaint IN00200726 and Complaint IN00206300.</p> <p>3-1-17(b)</p>		<p>nurse staffing information will be put out with daily staffing sheet. This information will be changed by the nightshift nurse. Licensed nurses were educated on this. DON or designee will monitor 5 times weekly for 2 months, 3 times weekly for 2 months than 1 time weekly for 2months. Results of audit will be taken to the QA committee any recommendations will be followed.</p>	

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F 0425 SS=D Bldg. 00	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure the correct medications were administered in a timely manner and a narcotic medication patch was closely monitored to 1 of 4 residents reviewed for medication errors and timeliness of medication of administration. (Resident #H)</p> <p>Findings include:</p> <p>Resident #H's clinical record was reviewed on 8-29-16 at 9:57 a.m. Her diagnoses included, but were not limited</p>	F 0425	<p><b>F425 Pharmaceutical Services – Accurate Procedures, RPH</b></p> <p>Community will continue to provide pharmaceutical services that include procedures that assure the accurate acquiring, receiving and dispensing, and administering of all drugs and biologicals to ensure the needs of each resident are met. All residents have the potential to be effected; there was no actual harm to any resident. Patch placement will be monitored every shift by licensed nurse or QMA. Licensed nurses and QMAs were educated on the</p>	09/28/2016

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	<p>to, left hip fracture in June, 2016, chronic pain, anxiety and Parkinson's disease. Her most recent Minimum Data Set (MDS) assessment, dated 6-13-16, showed she was moderately cognitively impaired, did not ambulate in her room, had impairment of one side of the lower extremities, required the use of a wheelchair for mobility and experienced pain as noted by staff, as well as experiencing a fall with major injury since the previous MDS assessment. It indicated she has been on hospice services since admission to the facility 3 months ago.</p> <p>On 8-26-16, the Director of Nursing (DON) provided a copy of a "Medication Error Report" for Resident #H, dated 7-2-16. It indicated on 7-2-16 at 4:20 p.m., LPN #3 "pulled out Ativan [an anti-anxiety medication] 1 mg [milligram] and gave 3 tabs, instead of Dilaudid [a narcotic pain medication] 2 mg 3 tabs. Res [resident] in DR [dining room] 1.5 hr [hours] [sign for after] receiving meds. Alert and eating sandwich." It specified the family and attending physician were notified of the error with no new orders received. It indicated precautionary measures to prevent further medication errors included, "Check label on narc [narcotic medication] card," and "take time."</p>		<p>monitoring of patch placement. DON or designee will audit monitoring of patches 3 times weekly for 2 months; 2 times weekly for 2 months than weekly for 2 months. Monitoring of medication administration by DON or designee will be done 3 x weekly for 2months; 2 times weekly times 2 months than 1 time a week for 2 months. Results of audits will be reviewed by the QA committee any recommendations will be followed.</p>	

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	<p>Associated nursing notes added Resident #H's vital signs were within normal range after the error.</p> <p>Review of the nursing notes for 6-24-16 at 6:09 p.m., indicated an ordered fentanyl patch had been omitted on 6-23-16 with no adverse effect. An order was received to place the omitted patch at that time and this was done.</p> <p>Additionally, the nursing notes for 6-29-16 at 12:00 a.m., documented a fentanyl patch was "missing" when the nurse assessed the resident for the patch's presence. In interview with the DON on 8-29-16 at 11:15 a.m., she indicated, "I can't remember if there was any investigation done for the missing fentanyl patch. We would sometimes put it on her back and the back brace would rub it off. I will have to check on that and get back with you." The DON failed to provide additional information prior to the end of the survey regarding the missing medication.</p> <p>Resident #H's August, 2016 recapitulation orders included, but were not limited to, an order with an original date of 7-1-16, for Dilaudid 2 mg, take 3 tablets (6 mg total) by mouth every 4 hours around the clock for pain. It also included an order, dated 6-17-16, for Ativan 1 mg 1 tablet by mouth every 4</p>			

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	<p>hours as needed for anxiety. It indicated no current order for the fentanyl patch.</p> <p>On 8-29-16 at 4:35 p.m., the Administrator provided a copy of a policy entitled, "Medication Errors." This policy was identified as the current policy utilized by the facility. It indicated, "Purpose: To safeguard the resident from future errors. Policy: Medication errors are to be reported to the physician. A Medication Error Report is to be completed by the individual noting the error...Procedure: Medication errors must be reported to the physician. The licensed nurse is responsible for generating a report describing the incident and action taken. The resident is kept under observation per physician's orders. Any change in condition must be reported to the physician."</p> <p>On 8-29-16 at 4:35 p.m., the Administrator provided a copy of policy entitled, "Drug Administration-General Guidelines." This policy was updated on 12-3-14 and was indicated to be the policy currently used by the facility. It indicated, "Medications are administered as prescribed, in accordance with good nursing principles and practices...the licensed nurse is aware of an indication for the resident receiving medication...If an unusual dose is ordered, considering</p>			

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	<p>the resident's age and condition, or a medication order seems unrelated to the resident's current diagnosis or condition; the physician is contacted for clarification prior to administration of the medication. The pharmacist is also available for consultation for drug therapy concerns or questions...At the end of each medication pass, the person administering medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications..."</p> <p>This Federal tag relates to Complaint IN00204111 and IN00207361.</p> <p>3.1-25(b) 3.1-25(b)(2) 3.1-25(b)(9) 3.1-25(e)(2)</p>			