

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: February 4, 5, 6, 9, 10, 11, 2015</p> <p>Facility number: 001138 Provider number: 155632 AIM number: 200157070</p> <p>Survey Team: Dorothy Watts, RN, TC Terri Walters, RN Amy Wininger, RN (2/4, 2/5, 2/9, 2/10, 2/11/2015) Sylvia Scales, RN (2/5, 2/6, 2/9, 2/10, 2/11/2015)</p> <p>Census bed type: SNF: 0 SNF/NF: 40 Residential: 14 Total: 54</p> <p>Census payor type: Medicare: 9 Medicaid: 28 Other: 3 Total: 40</p> <p>Residential sample: 7</p>	F000000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the facility 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 law. Submission of the 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 against interest of the facility, the HFA or any employees, agents or other individuals who draft or may be discussed in the response and Plan of Correction. This Plan of Correction shall constitute this facility's credible allegation of compliance on or before March 6, 2015.</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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F000157 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC16.2-3.1</p> <p>Quality review completed on February 18, 2015 by Jodi Meyer, RN</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal</p>			

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	<p>representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to inform physicians of falls and/or medication errors for 2 of 3 residents reviewed for falls and 1 of 4 residents reviewed for unnecessary medication, in that, a resident had a fall from bed and another resident had 2 consecutive days in which sliding scale insulin was not administered. (Resident #19, Resident #42)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #19 was reviewed on 2/6/15 at 1:21 P.M. The record indicated the diagnoses of Resident #19 included, but were not limited to, cerebral vascular accident, fall - hematoma, and degenerative osteoarthritis.</p> <p>A Nurses Note dated 1/21/15 at 12:05 P.M., read as follows: "...INCIDENT TYPE:...while trying to get into her wheelchair resident slide (sic) off of</p>	F000157	<p>It is the practice of the facility to notify a physician and legal representative of incidents, change of condition or change in roommates. The licensed nursing staff was retrained on February 23, 2015 on facility policy for physician and family notification parameters and nurse charting guidelines. To monitor for compliance, the Director of Nursing and/or designee will review incident reports, medication errors and nursing documentation daily. Any concerns will be addressed with the nursing staff and reviewed with the HFA. To monitor for continued compliance, the HFA will receive reports of any adverse findings and review through the monthly QAPI meeting for three months. If no concerns noted, the QAPI committee will monitor quarterly.</p>	03/06/2015			

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	<p>bed...DATE OF INCIDENT: 1/20/15...TIME OF INCIDENT: 11:58 AM...LOCATION: Resident's room...PHYSICIAN NOTIFICATION: No need to notify: resident stated she was not in any pain or had any injury, she had just slide (sic) down onto the floor from bed while transferring herself into her wheelchair...FAMILY NOTIFICATION: N/A (not applicable)..."</p> <p>During an interview on 2/11/15 on 10:26 A.M., LPN #10 indicated the physician and family would be notified of any fall, including sliding off the bed without any injuries occurring. LPN #10 further indicated an incident report would be filled out, a fall assessment would be completed and a follow up assessment of the resident would be conducted for 72 hours following the incident.</p> <p>The Policy and Procedure for "Physician Notification/Consultation Parameters" provided by Medical Records #1 on 2/11/15 at 11:08 A.M., read as follows: "...Condition...Falls...Non-immediate (Physician notification required, consultation consideration given)...Any occurrence of a fall..."</p> <p>2. The clinical record of Resident #42 was reviewed on 2/6/15 at 1:21 P.M. The record indicated the diagnoses of</p>						

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	<p>Resident #42 included, but were not limited to, IDDM (insulin dependent diabetic mellitus), and dementia.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/18/15 indicated Resident #42 experienced severe cognitive impairment and received insulin injections daily.</p> <p>The Medication Administration Record (MAR) for February 2015 documented Resident #42 had a blood sugar level of 173 on 2/7/15 and a blood sugar level of 151 on 2/8/15. Documentation was lacking in the MAR that Resident #42 had received the 2 units of Humalin R insulin prescribed by the physician for sliding coverage for both 2/7/15 and 2/8/15.</p> <p>The clinical record was reviewed for the following days, 2/7/15 through 2/9/15 and documentation was lacking a medication error had occurred or that the physician had been notified of the medication error.</p> <p>The Physician's Order dated 9/16/14 read as follows: "...HUMALIN R S/S (sliding scale) AS FOLLOWS: 151- 200 = 2 U (units); 201 -250 =4 U..."</p> <p>During an interview on 2/9/15 at 2:30</p>			

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	<p>P.M., LPN #10 was made aware of a medication error for Resident #42 concerning Resident #42's sliding scale coverage for Humalin R insulin. LPN #10 indicated Resident #42 should have received insulin per sliding scale and the MAR indicated no insulin had been administered, LPN#10 further indicated an insulin error had occurred.</p> <p>The clinical record was reviewed for the following days, 2/9/15, 2/10/15, 2/11/15, and documentation was lacking that an insulin medication administration error had occurred on 2/7 and/or 2/8/15 or that the physician had been notified concerning the medication error.</p> <p>A Care Plan for fluctuating blood sugars dated 1/21/15 read as follows: "...APPROACH...Follow physicians (sic) orders related to diabetes..."</p> <p>During an interview on 2/10/15 at 2:30 P.M., the Director of Nursing (DON) indicated medication errors, physician's notification of medication errors, family notification of medication errors and follow up assessment concerning the medication errors were not documented in the resident's clinical record. The DON further indicated the information was part of their Quality Assurance Program (QA) and that the information</p>						

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F000225 SS=D	<p>concerning the medication error was for QA and personal management only and therefore could not be provided to the survey team.</p> <p>The Policy and Procedure for "Physician Notification/Consultation Parameters" provided by Wendy on 2/11/15 at 11:08 A.M., read as follows: "...Condition...Medication Errors...Non-immediate (Physician notification required, consultation consideration given)...Wrong...Dose of drug administered and resident is asymptomatic..."</p> <p>3.1-5(a)(1)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>						

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	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse had been immediately reported to the administrator and to the State Department of Health for 1 of 2 resident allegations of abuse reviewed. (Resident # 22)</p> <p>Findings include:</p> <p>On 2/9/15 at 11:30 A.M., Resident #22 was observed sitting in his wheelchair in his room.</p>	F000225	The facility does not employ individuals who have been found guilty of any form of mistreatment, nor does the facility employ any person with negative findings on the nurse aide registry. An all staff inservice was held on February 23, 2015 to review the facility abuse policy and protocol for reporting. The unusual occurrence reporting to State was reviewed by the HFA and Director of Nursing on February 12, 2015. The facility abuse policy and reporting will be provided to staff through inservicing for six months and	03/06/2015

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	<p>On 2/9/15 at 11:30 A.M., during an interview, Resident #22 indicated CNA #10 had crawled in to bed with him and gave him hugs and kisses. Resident #22 indicated CNA #10 had quit working at the facility 2 or 3 months ago. He also indicated another CNA, CNA #11 had been friends with CNA #10. Resident #22 indicated CNA #10 told CNA #11 "Look at this" and Resident #22 indicated CNA #10 had then gotten in to bed with him. Resident #22 indicated CNA #11 told CNA #10 to apologize to him for her actions. He indicated CNA #11 currently did not work at the facility. Resident #22 indicated he had not told staff about the allegation.</p> <p>On 2/9/15 at 11:58 A.M., the Administrator was made aware of the above allegation. She indicated she had been unaware of the allegation and she would now begin the investigation. She indicated she would not have to suspend any employees due to CNA #10 and CNA #11 were no longer employed at the facility.</p> <p>On 2/10/15 at 1:08 P.M., a facility faxed report to the State Board of Health dated 2/9/15 at 12:45 P.M., was reviewed. The faxed report included but was not limited to, "... Resident [Resident #22] States that CNA [CNA #10's first name] would at</p>		<p>then quarterly thereafter. The resident right regarding abuse will be reviewed monthly during the facility resident council meeting. To monitor for compliance, the HFA and/or designee will interview a minimum of two residents and two staff members weekly to ensure understanding of reporting allegations of abuse. Any adverse findings will be reviewed monthly by the HFA during the QAPI meeting ongoing. IDR for F225The facility respectfully requests that this deficiency be deleted. We do follow State guidelines for reporting allegations of abuse. The facility completes orientation for employees on hire and at least quarterly each year. Nurse aide #10 started employment on June 25, 2013 and terminated employment in April, 2014. She received orientation on facility abuse policy and reporting on June 25, 2013, January 8, 2014 and February 7, 2014. She signed papers acknowledging understanding of the policy. Nurse aide #11 started employment on January 10, 2014 and terminated employment in June, 2014. She received orientation on facility abuse policy and reporting on January 10, 2014, February 7, 2014, and May 8, 2014. She signed papers acknowledging understanding of the policy. The facility should not be held liable for these employees who terminated their employment over</p>				

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	<p>times get into his bed and hug. Resident [Resident #22] states No sexual acts occurred. He further reports a second CNA [CNA #11] witnessed this act and requested CNA [CNA #10] apologize for her actions. At said time this action occurred the Facility Administrator and Director of Nursing was not made aware of this action..." "... This employee [CNA#10] has not been employed with the facility since 4-30-2014..."</p> <p>On 2/10/15 at 3:30 P.M., the Administrator was made aware that the allegation of abuse witnessed by CNA #11 had not been reported immediately to Administrator or to the State Department of Health. The Administrator indicated an allegation of abuse had not been reported to her by CNA #11.</p> <p>The facility's abuse policy entitled, "Resident Safety Abuse Statement [Date Revised 12/13] " included but was not limited to, "Purpose ...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, or legal guardians, friends, or other individuals..."</p> <p>"...12. NEW EMPLOYEE ORIENTATION: ...c. Each new employee will be informed of their</p>		<p>six months before the incident was reported by the surveyors to the HFA. The facility followed policy when the surveyor reported. Several attempts were made to contact these two individuals with no success.</p>				

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	responsibility to immediately report any violation or alleged violations..." "...16. REPORTING SUSPECTED VIOLATIONS: a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property to the facility Administrator. The Administrator will notify the DON and/or others as appropriate..." "... c. The Administrator shall also report all alleged violations to appropriate regulatory agencies per state statute and federal regulations..." 3.1-28(c)						
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to implement the facility abuse policy in	F000226	The facility has developed and implemented written policies and procedures that prohibit	03/06/2015			

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	<p>regard to reporting an allegation of abuse immediately to the administrator and the state agency for 1 of 2 allegations of abuse reviewed. (Resident #22)</p> <p>Findings include:</p> <p>On 2/9/15 at 11:30 A.M., Resident #22 was observed sitting in his wheelchair in his room.</p> <p>On 2/9/15 at 11:30 A.M., during an interview, Resident #22 indicated CNA #10 had crawled in to bed with him and gave him hugs and kisses. Resident #22 indicated CNA #10 had quit working at the facility 2 or 3 months ago. He also indicated another CNA, CNA #11 had been friends with CNA #10. Resident #22 indicated CNA #10 told CNA #11 "Look at this" and Resident #22 indicated CNA #10 had then gotten in to bed with him. Resident #22 indicated CNA #11 told CNA #10 to apologize to him for her actions. He indicated CNA #11 currently did not work at the facility. Resident #22 indicated he had not told staff about the allegation.</p> <p>On 2/9/15 at 11:58 A.M., the Administrator was made aware of the above allegation. She indicated she had been unaware of the allegation and she would now begin the investigation.</p>		<p>mistreatment, neglect and abuse of residents. The facility does not employ individuals who have been found guilty of any form of mistreatment, nor does the facility employ any person with negative findings on the nurse aide registry. Orientation on abuse is provided to all employees at the time of hire and at least quarterly each year. The employees in question did receive orientation on allegations of abuse and reporting to the HFA. Neither of the employees are currently employed at the facility. An all staff inservice was held on February 23, 2015 to review facility policy on abuse and reporting procedure. To monitor for compliance, the HFA and/or designee will interview a minimum of two residents and two staff members weekly to ensure understanding of reporting allegations of abuse. Any adverse findings will be reviewed monthly by the HFA during the facility QAPI meetings ongoing.IDR F226The facility respectfully requests that this deficiency be deleted. We do follow State guidelines for reporting allegations of abuse. The facility completed orientation for employees on hire and at least quarterly each year.Nurse aide #10 started employment on June 24, 2013 and terminated employment in April, 2014. She received orientation on facility abuse policy and reporting on</p>				

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	<p>On 2/10/15 at 1:08 P.M., a facility faxed report to the State Board of Health dated 2/9/15 at 12:45 P.M., was reviewed. The faxed report included but was not limited to, "... Resident [Resident #22] States that CNA [CNA's first name] would at times get into his bed and hug. Resident [Resident #22] states No sexual acts occurred. He further reports a second CNA witnessed this act and requested CNA [CNA #10] apologize for her actions. At said time this action occurred the Facility Administrator and Director of Nursing was not made aware of this action..." "... This employee [CNA#10] has not been employed with the facility since 4-30-2014..."</p> <p>On 2/10/15 at 3:30 P.M., the Administrator was made aware the facility had not followed the facility's abuse policy, in that, an allegation of abuse had not been reported immediately to Administrator or to the State Department of Health. The Administrator indicated an allegation of abuse had not been reported to her by CNA #11.</p> <p>The facility's abuse policy entitled, "Resident Safety Abuse Statement [Date Revised 12/13] " included but was not limited to, "...16. REPORTING SUSPECTED VIOLATIONS: a. The</p>		<p>June 25, 2013, January 8, 2014 and February 7, 2014. She signed papers acknowledging understanding of the policy. Nurse aide #11 started employment January 10, 2014 and terminated employment in June, 2014. She received orientation on facility abuse policy on January 10, 2014, February 7, 2014 and May 8, 2014. She signed papers acknowledging understanding of the policy. The facility should not be held liable for these employees who terminated their employment over six months before the incident was reported by the surveyors to the HFA.</p>	

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F000272 SS=D	<p>supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property to the facility Administrator. The Administrator will notify the DON and/or others as appropriate... " "... c. The Administrator shall also report all alleged violations to appropriate regulatory agencies per state statute and federal regulations..."</p> <p>3.1-28(c)</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; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;</p>						

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	<p>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 observation, interview, and record review, the facility failed to ensure the comprehensive assessment was accurate, in that, the comprehensive assessment indicated a resident with history of pressure ulcer did not have a history of pressure ulcer, and/or a resident with a pressure wound had a surgical wound for 1 of 3 residents who met the criteria for review of pressure ulcers. (Resident #26)</p> <p>Findings include:</p> <p>Resident #26 was observed 2/4/15 at 2:50 P.M., sitting in a wheel chair with soft boots on the bilateral lower extremities.</p> <p>The clinical record of Resident #26 was reviewed on 2/9/2015 at 10:19 A.M. The record indicated Resident #26 was</p>	F000272	<p>It is the practice of the facility to assess residents by using the RAI specified by State. The chart of resident #26 and the charts of other residents with the potential to be affected by this deficiency were reviewed. Assessments and careplans have been updated as needed. The skin assessment policy, assessments and documentation practices was reviewed with the MDS Coordinator and Director of Nursing on February 25, 2015. The MDS Coordinator will continue to monitor through review of careplans, documentation, visual and the nurse aide assignment sheets. To monitor for compliance, the HFA and/or designee will audit a minimum of two clinical records weekly for assessments and careplans. To monitor for continued compliance, concerns will be reviewed during careplan meetings and addressed at the</p>	03/06/2015

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	<p>admitted to the facility on 7/10/14 with diagnoses including, but not limited to, CVA (Cerebrovascular Accident).</p> <p>A significant change MDS (Minimum Data Set) assessment dated 12/20/14 indicated Resident #26 was not at risk to develop a pressure ulcer, and had not developed a pressure ulcer.</p> <p>The Re-admission MDS assessment dated 1/17/15 indicated Resident #26 was not at risk to develop a pressure ulcer, had not developed a pressure ulcer, and had experienced a surgical wound to the left heel.</p> <p>A Skin Risk Assessment dated 12/18/14 indicated Resident #26 was at risk for the development of pressure.</p> <p>A Skin Risk Assessment dated 12/24/14 indicated Resident #26 was at risk for the development of pressure.</p> <p>A Skin Progress note dated 12/29/14 at 9:45 A.M. indicated, "...blister to left heal (sic) approximatly (sic) the size of a softball... "</p> <p>A Skin Assessment dated 12/30/14 at 11:23 A.M. indicated, "... blister to left heel...8.4 cm (centimeters) X 7 cm..."</p>		QAPI meeting monthly for six months and then quarterly thereafter.				

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	<p>During an interview on 2/9/15 at 10:25 A.M., LPN #10 indicated, Resident #26 experienced a facility acquired blister on the left heel. LPN #10 further indicated, at that time, Resident #26 had returned to the hospital for a scheduled surgical repair of a left hip replacement and the blister had been surgically debrided by the surgeon during the admission.</p> <p>During an observation of care on 2/9/15 at 3:30 P.M., for Resident #26 was observed to have an unstageable pressure wound on the inner aspect of the left heel. During an interview, at that time, RN #2 indicated the wound was unstageable, measured 3.5 X 3.0 with a necrotic wound bed. RN #2 further indicated, at that time, had started as a blister.</p> <p>During an interview on 2/10/15 at 11:00 A.M., the MDS nurse indicated the area on the left heel was coded as a surgical wound on the 1/17/15 Admission MDS because the wound had started as a blister and became a surgical wound after surgical debridement.</p> <p>The MDS nurse then indicated the clinical record lacked supportive documentation to indicate Resident #26 had a history of pressure and/or was at risk for the development of pressure. The</p>			

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	<p>MDS nurse further indicated, at that time, the skin assessment documentation had been referenced to complete the 1/17/15 MDS and she had not assessed the area to verify the information. The MDS nurse then stated, "...It doesn't say anywhere that I have to assess the wound...A blister is not pressure, it is a blister..."</p> <p>The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual May 2013 Chapter 3 page M-2 provided by the MDS nurse on 2/10/15 at 11:10 A.M. indicated, "...Determination of Pressure Ulcer Risk...Steps for Assessment</p> <ol style="list-style-type: none"> 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer risk assessments... 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observation of the resident. 3. Examine the resident and determine whether any ulcers, ...are present. Assess key areas for pressure ulcer development (e.g. (for example) ...heels)..." <p>The Skin Treatment Management Protocol provided by the DON on 2/10/15 at 2:50 P.M. indicated, "Definition ...Pressure Ulcer Category</p>						

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F000279 SS=D	<p>II...May also present as an intact or open/ruptured serum-filled blister..."</p> <p>3.1-31(d)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a care plan was developed, in that, a resident who received anti-hypertensive medication did not have a care plan to monitor blood pressure for 1 of 5</p>	F000279	It is the practice of the facility to develop careplans for residents after assessment.The chart of resident #32 and the charts of other residents with potential to be affected by this deficiency were reviewed. The careplans/orders were updated as needed.An inservice was held	03/06/2015

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	<p>residents who met the criteria for review of unnecessary medications. (Resident #32)</p> <p>Findings include:</p> <p>Resident #32 was observed on 2/4/15 at 1:50 P.M., lying in bed, in no apparent distress.</p> <p>The clinical record of Resident #32 was reviewed on 2/9/2015 at 3:32 P.M. The record indicated the diagnoses of Resident #32 included, but were not limited to, hypertension (high blood pressure).</p> <p>The Quarterly MDS (Minimum Data Set) assessment indicated Resident #32 experienced hypertension.</p> <p>The December 2014 Physician's Order Recap included, but was not limited to an order for "...Clonidine [a medication to treat high blood pressure]...0.2 mg [milligrams] take (1) tablet by mouth 3 times daily. Dx: [Diagnosis] HTN [hypertension]..."</p> <p>The January 2015 Physician's Order Recap included, but was not limited to an order for "...Clonidine...0.2 mg take (1) tablet by mouth 3 times daily. Dx: HTN..."</p>		<p>on February 20, 2015 with the licensed nursing staff to review protocol for monitoring blood pressure and clonidine use. To monitor for compliance, the Director of Nursing and/or designee will review weekly documentation on blood pressures. Any concerns will be addressed with the nursing staff and the HFA. To ensure continued compliance, any findings will be reviewed through the monthly QAPI meeting for six months and then quarterly thereafter.</p>		

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	<p>The PDR (Physician's Drug Reference) 2014 Edition Nurse's Drug Handbook pages 193-194 indicated, "...Clonidine...Indications: Treatment of HTN...Nursing Considerations...Monitoring: Monitor BP [blood pressure]..."</p> <p>The Plan of Care dated 11/5/14 lacked any care plan to monitor the blood pressure of Resident #26.</p> <p>The December 2014 MAR (Medication Administration Record) indicated, Resident #26 received, "...Clonidine...0.2 mg ...three times daily...for : Hypertension Therapeutic Goal: systolic BP < (less than) 150..." The MAR lacked any documentation of blood pressure monitoring.</p> <p>The January 2015 MAR indicated, Resident #26 received, "...Clonidine...0.2 mg ...three times daily...for : Hypertension Therapeutic Goal: systolic BP < (less than) 150..." The MAR lacked any documentation of blood pressure monitoring.</p> <p>A Vital Sign report from 10/1/14 through 2/9/15 provided by LPN #10 on 2/9/15 at 3:55 P.M., indicated the blood pressure had been checked one time on 1/16/15.</p>			

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	<p>During an interview on 2/9/15 at 3:45 P.M., LPN #13 indicated the blood pressure of Resident #32 should be checked before administering Clonidine. LPN #13 further indicated, at that time, sometimes she checked the blood pressure of Resident #32, but could not provide any documentation of blood pressure monitoring.</p> <p>During an interview on 2/9/15 at 3:50 P.M. RN #2 indicated the nursing staff was not required to check the blood pressure of Resident #32 because the doctor had not ordered it.</p> <p>During an interview on 2/10/15 at 11:30 A.M. the DON (Director of Nursing) indicated there was no medication policy related to monitoring the blood pressure of a resident receiving anti-hypertensive medication. The DON further indicated, at that time, the blood pressure would only be checked if ordered by the physician.</p> <p>During an interview on 2/11/15 at 3:15 P.M., the DON indicated routine blood pressure monitoring would be performed as a nursing measure for residents who received anti-hypertensive medication.</p> <p>3.1-35(a)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the plan of care was followed, in that, a resident was not provided supervision according to the plan of care and/or insulin was not administered according to the physician's orders for 2 of 26 residents who met the criteria for review of care plan. (Resident #44, Resident #42)</p> <p>Findings include:</p> <p>1. On 2/4/15 at 2:32 P.M., Resident #44 was observed sitting in a recliner with fading facial bruising.</p> <p>The clinical record of Resident #44 was reviewed on 2/5/15 at 10:30 A.M. The record indicated the diagnoses of Resident #44 included, but were not limited to, Alzheimer's dementia.</p> <p>A Fall Assessment dated 12/5/14 at 3:46 P.M., indicated Resident #44 was at risk to experience a fall.</p>	F000282	<p>The facility does provide services by qualified persons in accordance with each resident's written plan of care. The charts of the residents affected by this deficiency and the charts of other residents with potential to be affected by this deficiency were reviewed and careplans updated as needed. An inservice was conducted with licensed nursing staff on February 23, 2015 to review careplans regarding medication administration and fall risk residents. The MDS Coordinator and Director of Nursing shall complete a clinical record audit of resident's plan of care and update as needed. To monitor for compliance, the Director of Nursing will review careplans and medication administration documentation two times a week for three months and then weekly thereafter. Any negative findings will be reported to the HFA and monitored through QAPI meetings for three months and then quarterly thereafter.</p>	03/06/2015			

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	<p>The Quarterly MDS (Minimum Data Set) assessment dated 12/7/14 indicated Resident #44 experienced moderate cognitive impairment.</p> <p>A Care Plan for Falls dated 12/16/14 included, but was not limited to, an intervention of "...monitor closely..."</p> <p>A Fall report dated 1/30/15 at 3:18 P.M., indicated Resident #44 was observed on the floor of the resident's room at 2:30 P.M. The report further indicated, "...called husband, he stated he just left facility... [Resident #44] was asleep in recliner...witnesses: none..."</p> <p>During an interview on 2/5/2015 at 11:34 A.M., RN #11 indicated Resident #44 experienced short term memory impairment and had recently experienced a fall. RN #11 further indicated, at that time, Resident #44 was alone at the time of the fall, because the spouse had left the facility.</p> <p>During an interview on 2/10/15 at 3:15 P.M., the DON (Director of Nursing) indicated the facility had no specific policy for fall prevention, but it was the policy of the facility to ensure the safety of each resident.</p>			

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	<p>During an interview on 2/10/15 at 3:45 P.M., RN #11 indicated no supervision was provided to Resident #44 prior to the fall on 1/30/15 because no staff was aware the resident was alone in the room.</p> <p>2. During an observation on 2/05/15 at 10:54 A.M., Resident #42 was observed sitting in his recliner.</p> <p>The clinical record of Resident #42 was reviewed on 2/6/15 at 1:21 P.M. The record indicated the diagnoses of Resident #42 included, but were not limited to, IDDM (insulin dependent diabetic mellitus), dementia.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/18/15 indicated Resident #42 experienced severe cognitive impairment and received insulin injections daily.</p> <p>The Physician's Order dated 9/16/14 read as follows: "...HUMALIN R S/S (sliding scale) AS FOLLOWS: 151- 200 = 2 U (units); 201 -250 =4 U... "</p> <p>The Medication Administration Record (MAR) for February 2015 documented Resident #42 had a blood sugar level of 173 on 2/7/15 and a blood sugar level of 151 on 2/8/15. Documentation was lacking in the MAR that Resident #42</p>			

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	<p>had received the 2 units of Humalin R insulin prescribed by the physician for sliding coverage for both days 2/7/15 and 2/8/15.</p> <p>During an interview on 2/9/15 at 2:30 P.M., LPN #10 was made aware of a medication error for Resident #42 concerning his sliding scale coverage for Humalin R insulin. LPN #10 indicated Resident #42 should have received insulin per sliding scale and the MAR indicated no insulin had been administered. LPN #10 further indicated insulin errors had occurred.</p> <p>A Care Plan for fluctuating blood sugars dated 1/21/15 read as follows: "...APPROACH...Follow physicians orders related to diabetes..."</p> <p>During an interview on 2/10/15 at 2:30 P.M., the Director of Nursing (DON) indicated a medication error had occurred and Resident # 42 should have received 2 units of Humalin R insulin on both days 2/7/25 and 2/8/15.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<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>A. Based on observation, interview, and record review, the facility failed to ensure services were provided, in that, a resident's bowel movements were not effectively monitored and/or interventions were not implemented to prevent a fecal impaction for 1 of 1 residents who met the criteria for review of fecal impaction. (Resident #44)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure a resident receiving dialysis was adequately monitored, in that, the dialysis fistula was not assessed as ordered by the physician. (Resident #55)</p> <p>Findings include:</p> <p>A. During a confidential interview on 2/4/15 at 2:32 P.M., the interviewee indicated Resident #44 had been hospitalized for a fecal impaction in</p>	F000309	It is the practice of the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of residents in accordance with their plan of care. The chart of resident #44 was reviewed and updated as needed. Resident #55 has discharged from the facility. The charts of other residents with potential to be affected by this deficiency were reviewed and updated as needed. The nursing staff was inserviced on February 23, 2015 to review policy and practice for monitoring, documenting and assessment related to bowel movement and dialysis. To monitor for compliance, the Director of Nursing and HFA will review nursing documentation, nurse aide documentation, 24 hour reports and physician orders during morning meetings. Any negative findings will be reviewed with the nursing staff. To ensure continued compliance, negative	03/06/2015

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	<p>October of 2014 after several days of experiencing abdominal pain, nausea, and constipation.</p> <p>On 2/4/15 at 2:45 P.M., Resident #44 was observed sitting in a recliner, in no apparent distress.</p> <p>The clinical record of Resident #44 was reviewed on 2/5/15 at 10:30 A.M. The record indicated the diagnoses of Resident #44 included, but were not limited to, Alzheimer's, dementia.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 09/14/14 indicated Resident #44 experienced moderate cognitive impairment and/or no bowel incontinence, required the extensive assist of two staff for toileting, was not on a toileting program and experienced no constipation.</p> <p>The Quarterly MDS assessment dated 12/7/14 indicated Resident #44 experienced moderate cognitive impairment and/or occasional bowel incontinence, required the extensive assist of two staff for toileting and was not on a toileting program.</p> <p>The October 2014 Physician's Order Recap included, but was not limited to, orders for, "...Dulcolax [a laxative] supp</p>		findings will be reviewed through the monthly QAPI meeting for six months and then quarterly thereafter.				

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	<p>[suppository] 10 mg [milligrams] insert 1 suppository rectally daily as needed for constipation..."</p> <p>A Physician's Telephone Order dated 10/25/14 indicated an order for, "DOK/DSS [Colace] [a stool softener] 1 capsule/100 mg by mouth daily at 1100 (11:00 A.M.) for Constipation..."</p> <p>The October 2014 MAR (Medication Administration Record) indicated no Dulcolax suppositories were administered to Resident #44 from 10/22/14 through 10/27/14.</p> <p>An ADL (Activities of Daily Living) report from 10/22/14 through 10/28/14 indicated the following stool output:</p> <p>"10/22/14 4:23 AM (morning)...Incontinent X (times) 1... Medium...Fluffy pieces with ragged edges, a mushy stool"...</p> <p>10/23/14 6:05 A.M....No BM (bowel movement)...12:44 P.M....No BM...9:33 PM (evening)...No BM...</p> <p>10/24/14 6:00 AM...No BM...11:04 AM...Continent X1 Medium...</p> <p>10/25/14 6:07 AM...No BM...</p>			

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	<p>10/26/14 5:36 AM...No BM...12:21 A.M...No BM...</p> <p>10/27/14 04:22 AM ...No BM...12:06 PM...Continent X1 small...</p> <p>10/28/14 1:53 AM...No BM...1:35 PM...No BM..."</p> <p>The ADL report lacked any documentation related to stool output on 10/22/14 evening shift, 10/24/14 evening shift, and 10/25/14 day and evening shift.</p> <p>A Nurse's note dated 10/23/14 at 7:07 A.M. indicated Resident #44 experienced nausea.</p> <p>A Nurse's note dated 10/28/14 at 12:17 P.M. indicated Resident #44 experienced nausea.</p> <p>A Nurse's note dated 10/28/14 at 3:31 P.M. indicated, "...husband called (name of physician) stating he wanted his wife sent to hosp [hospital] d/t [due to] nausea..."</p> <p>A (name of hospital) History and Physical dated 10/28/14 indicated, "...Chief Complaint: Abdominal pain with nausea and vomiting...Impression: 1. Fecal Impaction...Plan: the patient is going to be admitted for treatment</p>						

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	<p>of...fecal impaction...put ...on Miralax (a laxative)...routinely...also give...a ...enema..."</p> <p>An X-ray report dated 10/28/14 indicated, "...Indication: Lower abdominal pain. Nausea. Vomiting...Impression: Rectal sigmoid (lower colon) fecal impaction..."</p> <p>A (name of hospital) Patient Transfer Form dated 10/30/14 included, but was not limited to, a discharge diagnosis of fecal impaction.</p> <p>During an interview on 2/5/14 at 3:40 P.M. LPN #14 indicated nurses have to manually check the CNA documentation for each resident to determine if a resident is having bowel movements. LPN #14 further indicated, at that time, if the CNA's didn't document the BM's there was no way for the nurse's to know if a resident was experiencing a problem with their bowels.</p> <p>During an interview on 2/10/14 at 3:30 P.M., RN #11 indicated it was difficult to monitor the BM's for Resident #44 because the spouse usually toileted the resident and the CNA's had no way of knowing if the resident had a BM or not.</p> <p>A Bowel Elimination Tracking Policy</p>			

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	<p>and Procedure provided by the DON (Director of Nursing) on 2/5/15 at 4:00 P.M. indicated, "...Purpose: To ensure bowel elimination patterns are tracked by caregivers when the resident...is unable to verbalize adequate bowel elimination...4. The tracking will be monitored daily and used to develop the resident's bowel elimination plan of care and help prevent problems and guide appropriate interventions.."</p> <p>During an interview on 2/5/15 at 4:05 P.M., the DON indicated the spouse of Resident #44 frequently assisted the resident with toileting needs and did not report bowel movements to the staff. The DON further indicated accurate documentation of stool output for Resident #44 could not be provided from 10/22/14 through 10/28/14.</p> <p>B. On 2/6/15 at 10:05 A.M., Resident #55 was observed sitting up in a wheelchair in her room.</p> <p>The clinical record for Resident #55 was reviewed on 2/6/15 at 11:59 A.M., diagnoses include, but were not limited to, end stage renal disease, atrial fibulation, and seizure disorder.</p>			

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	<p>A physicians orders dated 1/10/15 included "Dialysis M-W-F [Monday, Wednesday, and Friday]."</p> <p>An order dated 1/15/15 included "Palpate [touch] R [right] AV [arteriovenous] fistula graft for thrill and auscultate [listen] for bruit [wooshing sound] q [every] shift starting in 1/15/15."</p> <p>The care plans include, but were not limited to, a problem of self care deficit (initiated 1/10/15). A problem of potential for infection related to dialysis fistula (initiated on 2/3/15) the interventions included, but were not limited to, monitor for signs and symptoms of infection. The care plans also addressed, a problem of potential for tissue integrity impairment related to the dialysis fistula (initiated 1/28/15) the interventions included, but were not limited to monitor for thrill at site.</p> <p>The treatment record for Resident #55 was reviewed on 2/6/15 at 11:59 A.M, it indicated documentation was lacking that the resident's dialysis fistula was assessed on the following days:</p> <p>1/15/15 on evening shift, 1/16/15 on days and evenings shift, 1/17/15 on night shift, 1/22/15 on evening shift, 1/23/15 on night shift, 1/24/15 on days and evening</p>			

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	<p>shift, 1/25/15 on days and evening shift, 1/26/15 on day shift, 1/30/15 on day and evening shift, and 1/21/15 on evening shift, 2/3/15 on day and evening shift, 2/4/15 on day shift, 2/5/15 evening shift, 2/6/15 on day, evening and night shift, 2/7/15 day and evening shift, 2/8/15 on day and evening shift and 2/10/15 on day and evening shift.</p> <p>On 2/10/15 at 10:00 A.M., during an interview with LPN #10, she indicated the documentation for assessment of Resident #55 would be in the treatment record. She further indicated a dialysis fistula should be checked every shift.</p> <p>On 2/10/15 at 2:50 P.M., during an interview with the Director of Nursing (DON) she indicated the facility did not have a policy on dialysis. She indicated they used the Mosby nursing practice manual.</p> <p>The facility's copy of the Mosby's manual titled "Nursing Interventions and Clinical Skills" 3rd edition printed in 2004 was reviewed on 2/10/15 at 3:01 P.M. On page 918 it included "...7. For care of access, a. palpate fistula or graft for thrill and auscultate for bruit..."</p> <p>3.1-37(a)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, dependent residents admitted without pressure areas, developed Stage 2 pressure areas for 2 of 3 residents who met the criteria for review of pressure. (Resident #26, Resident #31)</p> <p>Findings include:</p> <p>1. Resident #26 was observed 2/4/15 at 2:50 P.M., sitting in a wheel chair with soft boots on the bilateral lower extremities.</p> <p>The clinical record of Resident #26 was reviewed on 2/9/2015 at 10:19 A.M. The record indicated Resident #26 was</p>	F000314	<p>Based on the comprehensive assessment of a resident, the facility does ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless clinical conditions demonstrate they are unavoidable and (2) a resident having pressure sores receive necessary treatment to promote healing, prevent infection and prevent new sores from developing. All facility nurses will follow the facility skin care management policy and procedure. If potential skin breakdown is noted, the nurse will initiate appropriate preventative measures and ass the interventions to the resident's plan of care. Resident #26 assessment and careplan have been updated. Resident #31 has discharged from the facility. All licensed nurses have been</p>	03/06/2015

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	<p>admitted to the facility on 7/10/14 with diagnoses including, but not limited to, CVA (Cerebrovascular Accident) with left sided weakness, history of deep vein thrombosis to the left lower extremity, generalised (sic) weakness, generalised (sic) debility, hip surgery for femoral neck fx (fracture).</p> <p>A Physician's Telephone Order dated 11/9/14 at 8:06 P.M., indicated, "...Apply multi podus boots [a pressure off loading device] while in bed..."</p> <p>A significant change MDS (Minimum Data Set) assessment dated 12/20/14 indicated Resident #26 experienced moderate cognitive impairment, functional range of motion impairment to one side of the lower body, required the extensive assist of two staff for bed mobility, was not at risk to develop a pressure ulcer, and had not developed a pressure ulcer.</p> <p>The Admission MDS assessment dated 1/17/15 indicated Resident #26 experienced moderate cognitive impairment, functional range of motion impairment to one side of the lower body, required the extensive assist of two staff for bed mobility, was not at risk to develop a pressure ulcer, had not developed a pressure ulcer, and had</p>		<p>retrained on February 23, 2105 on the facility skin management policy/procedure, wound documentation/treatment and physician notification. The MDS Coordinator and Director of Nursing has reviewed the RAI manual for documentation for pressure areas on the MDS.To monitor for compliance, the Director of Nursing and/or wound care nurse will observe two treatments and/or assessments weekly for six months to ensure accuracy in staging and treatments. Careplans will be reviewed at that time to ensure they are updated. The IDT will review documentation and 24 hour report during morning meetings. Residents with skin issues will be reviewed weekly during PAR (persons at risk) meetings.To ensure continued compliance, any areas of concern will be reviewed with the HFA and brought to the monthly QAPI meeting ongoing.</p>		

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	<p>experienced a surgical wound to the left heel.</p> <p>A Skin Risk Assessment dated 12/18/14 indicated Resident #26 was at risk for the development of pressure.</p> <p>A Skin Risk Assessment dated 12/24/14 indicated Resident #26 was at risk for the development of pressure.</p> <p>An Care Plan intervention report from 7/14/14 through 2/3/15, provided by LPN #10 on 2/9/15 at 12:00 P.M., lacked documentation pressure relief interventions were implemented during that time period.</p> <p>The Care Plan initiated on 12/15/14 and updated on 1/11/15 for "Potential for Tissue Integrity Impairment" included an undated handwritten notation of, "...area to Lt. [left] heel..." and included, but was not limited to, interventions of, "...pillow between legs while in bed..." The plan of care lacked any interventions related to pressure relief to the left heel.</p> <p>A Skin Progress note dated 12/29/14 at 9:45 A.M., indicated, "...blister to left heal [sic] approximatly [sic] the size of a softball... consulted therapy...or input on positioning and possibly boots to be worn in bed..."</p>			

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	<p>A Skin Assessment dated 12/30/14 at 11:23 A.M. indicated, "... blister to left heel...no pressure ulcers...blister to left heel 8.4 cm [centimeters] X 7 cm..."</p> <p>A Hospital Patient Transfer Report dated 12/31/14 indicated, "...debridement was performed of approximately the entire area of the posterior heel,...recommend to offload the ulcer with ...offloading boot..."</p> <p>The CNA Assignment Sheet provided by LPN #10 on 2/9/15 at 11:00 A.M. indicated Resident #26 required, "...assist of 2, full body lift...Prompting required assist of 2 for turning repositioning..."</p> <p>The CNA Assignment Sheet lacked any documentation related to providing pressure relief to the left heel.</p> <p>During an interview on 2/9/15 at 10:25 A.M., LPN #10 indicated Resident #26 experienced a facility acquired blister on the left heel. LPN #10 further indicated, at that time, Resident #26 had returned to the hospital for a scheduled surgical repair of a left hip replacement and the blister had been surgically debrided by the surgeon during the admission.</p> <p>During an interview on 2/9/15 at 11:30 A.M., the DON (Director of Nursing)</p>			

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	<p>indicated no documentation could be provided to indicate pressure relief had been provided to the left heel of Resident #26.</p> <p>During an observation of care for Resident #26 on 2/9/15 at 3:30 P.M., a necrotic wound was observed on the inner aspect of the left heel. During an interview, at that time, RN #2 indicated the wound was unstageable, measured 3.5 cm X 3.0 cm. with a necrotic wound bed. RN #2 further indicated, at that time, the wound was facility acquired, and had started as a blister. RN #2 was then observed to apply a soft boot and position the lower left extremity directly on the surface of the bed. The lower left extremity was observed, at that time, to not have complete pressure relief. RN #2 was then observed to exit the room of Resident #26 without providing complete pressure relief to the left heel. During an interview, at that time, RN #2 indicated there was no order to float the heels and nursing staff would only float the heels if they had a physician's order and further stated, "...the boot is the only thing the doctor ordered...we would not float the heels without a doctor's order..."</p> <p>On 2/10/15 at 9:15 A.M. Resident #26 was observed lying in bed. The inner aspect of the left heel was observed to be</p>			

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	<p>in contact with the surface of the mattress. The soft boot was observed in the chair at the foot of the bed. Resident #26 was observed to not have complete pressure relief to the left heel.</p> <p>During an interview on 2/10/15 at 10:30, the DON indicated pressure relief should have been provided to the left heel of Resident #26 as a nursing measure.</p> <p>During an interview on 2/10/15 at 11:00 A.M., the MDS nurse indicated the area on the left heel was coded as a surgical wound on the 1/17/15 Admission MDS because the wound had started as a blister and became a surgical wound after surgical debridement and stated, "...A blister is not pressure, it is a blister..."</p> <p>The Skin Treatment Management Protocol provided by the DON on 2/10/15 at 2:50 P.M., indicated "Definition ...Pressure Ulcer Category II Partial Thickness...partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister...Treatment Protocol:...Protect heels from pressure..."</p> <p>During an interview on 2/12/15 at 3:20 P.M., the DON indicated comprehensive</p>			

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	<p>wound assessment documentation was reviewed during the daily morning meeting as part of the QA (Quality Assurance) process. The DON then indicated any documentation related to the QA process would not be accessible for review.</p> <p>2. The clinical record of Resident #31 was reviewed on 2/6/15 at 4:15 P.M. The record indicated the diagnoses of Resident #31 included, but were not limited to, Alzheimers disease and incontinence.</p> <p>The Admission Assessment for Resident #31 dated 10/3/14 read as follows, "...ACTIVITY: 2. chairfast-ability to walk severely limited/none. Can't bear wt (weight). MOBILITY: 2. Very limited - Makes occ. (occasional) slight changes in body/extremity position-can't make freq/signif (frequent/significant) changes alone...FRICTION/SHEAR: 2. Potential problem - Moves w/min (with minimal) assist. Some sliding w/repositioning. Occ slides down in bed/chair...Comprehension/Communicati on Problems: unable to communicate needs..."</p> <p>The Admission MDS (Minimum Data</p>			

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	<p>Set) assessment dated 10/13/14 indicated Resident #31 experienced severe cognitive impairment, required the extensive assistance of two plus staff for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), was at risk for the development of pressure ulcers, and had no pressure ulcers upon admission.</p> <p>The Care Plan for Impairment of Skin Integrity dated 10/3/14 read as follows: "...PROBLEM: Impairment of skin integrity, Nurses--- Assess skin daily and note any changes, Treat as ordered, Bandage as appropiate (sic), Keep clean and dry, Measure area, weekly times four weeks Instruct on the importance of good skin care..." The Care Plan interventions were updated on 10/15/15 to include "...turn and reposition approximately every 2 hours and PRN (as needed)..." The Care Plan for Impaired skin integrity lacked interventions for monitoring Resident #31 sliding down in her wheelchair.</p> <p>The Physician's Order dated 10/17/14 read as follows: "...Apply thin duoderm to red raw area to left buttock every three days..." A physician's order for treatment to the Stage 2 pressure area on the coccyx was requested but was not provided by</p>			

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	<p>the facility.</p> <p>A Braden Risk Assessment dated 10/3/14 indicated Resident #31 "...BRADEN SCALE SCORE: 15...(16 or below indicates resident is at risk to develop a pressure sore)..."</p> <p>A Nurse's Note dated 10/17/14 at 9:40 A.M. indicated, "...SKIN PROBLEM: **NEW AREA** superficial red raw area noted to left buttock, appearance of sheering (sic)...SURFACE AREA: 2.5 cm (centimeters) x (by) 2 cm,..."</p> <p>A Nurse's Note dated 10/22/14 at 1:40 P.M. indicated, "...WEEKLY SKIN ASSESSMENT: SKIN PROBLEM: open area, red and raw, appearance of sherating [sic] left buttock...SURFACE AREA: 2.2 cm (centimeters) x (by) 1.8 cm...duoderm every 3 days..."</p> <p>A Nurse's Note dated 10/27/14 at 12:05 P.M. indicated, "...COMMENTS: resident continues to slide in w/c (wheelchair) Appears could be cause of open area to buttocks."</p> <p>A Nurse's Note dated 10/31/14 at 9:47 A.M. indicated, "...WEEKLY SKIN ASSESSMENT: ...SKIN PROBLEM: open area to left buttock...SURFACE AREA: 2.7 cm (centimeters) x (by) 2.5</p>			

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	<p>cm..."</p> <p>A Nurse's Note dated 11/12/14 at 12:30 P.M. indicated, "...WEEKLY SKIN ASSESSMENT: SKIN PROBLEM: ...open area on upper coccyx ...LOCATION: upper coccyx...LENGTH 1.1 cm...WIDTH 0.9 cm..."</p> <p>A Nurse's Note dated 11/19/14 at 10:57 A.M. indicated, "...SKIN PROBLEM: ...open area on coccyx...PRESSURE ULCER: sheared area on coccyx ...LOCATION: upper coccyx...LENGTH 1.0 cm...WIDTH 0.9 cm..."</p> <p>A Nurse's Note dated 11/19/14 at 10:57 A.M. indicated, "...resident is frequently noted sliding down in chair after being repositioned..."</p> <p>A Policy and Procedure for "Skin Treatment Management Protocol" provided by the DON on 2/10/15 at 2:50 P.M., was reviewed at that time and read as follows: "...Pressure Ulcer Category 2: Partial thickness...loss of dermis presenting as a shallow open ulcer with red pink wound bed...Treatment Protocol...Evaluate positioning and repositioning regime...Re-evaluate...wheelchair surfaces..."</p>						

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F000323	<p>During an interview on 2/10/15 at 10:15 A.M., the Director of Nursing (DON) indicated Resident #31 did not have a pressure area upon admission, but was at risk of developing a pressure ulcer. The DON further indicated Resident #31 had developed a stage 2 pressure area to her left buttock on 10/22/14.</p> <p>During an interview on 2/10/15 at 10:30 A.M., with RN #2, in the DON's office, she indicated Resident # 31 had developed a stage 2 pressure area to the coccyx, due to shearing, which was caused by Resident #31 continuing to slide down in the wheelchair.</p> <p>3.1-40(a)(1)</p>			
	483.25(h)			

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SS=E	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided, and/or effective interventions were not implemented, in that, a resident identified as at risk to experience a fall was not provided supervision for 3 of 3 residents who met the criteria for review of accidents. (Resident #44, Resident #57, Resident #8)</p> <p>Findings include:</p> <p>1. On 2/4/15 at 2:32 P.M., Resident #44 was observed sitting in a recliner. Resident #44 was observed, at that time, to have fading facial bruising.</p> <p>The clinical record of Resident #44 was reviewed on 2/5/15 at 10:30 A.M. The record indicated the diagnoses of Resident #44 included, but were not limited to, Alzheimer's dementia.</p> <p>A Fall Assessment dated 12/5/15 at 3:46 P.M., indicated Resident #44 was at risk to experience a fall.</p>	F000323	<p>The facility does strive to ensure the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. The charts of the residents affected by this deficiency and the charts of all residents with potential to be affected by this deficiency were reviewed. Careplans and assessments were completed as needed. The licensed nursing staff were retrained on February 23, 2015 on facility systems, policies and protocols relating to resident incidents, assessments and interventions. The Director of Nursing will review careplans and assessments for the next four weeks and then monthly. Negative outcomes will be reported during the Safety Committee meeting monthly. The HFA shall monitor for compliance by reviewing nursing notes, 24 hour reports, and incident reports three times a week for eight weeks and weekly for six months. Residents that have an incident reported will be reviewed in the PAR (persons at risk) meetings weekly. To monitor for continued compliance, negative</p>	03/06/2015
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	<p>The Quarterly MDS (Minimum Data Set) assessment dated 12/7/14 indicated Resident #44 experienced Alzheimer's disease, Parkinson's disease, moderate cognitive impairment, balance impairment, functional range of motion impairment to one side of the upper extremities and/or required the extensive assist of two staff for transfers.</p> <p>A Care Plan for Falls dated 12/16/14 included, but was not limited to, an intervention of "...monitor closely..."</p> <p>A Fall report dated 1/30/15 at 3:18 P.M., indicated Resident #44 was observed on the floor of the resident's room at 2:30 P.M. The report further indicated, "...resident states was leaning over to lock w/c [wheel chair] because...wanted to get out of recliner and get in w/c...called husband, he state he just left facility...was asleep in recliner...witnesses: none...immediate intervention implemented: Husband instructed call light needs to be where resident can reach, when he puts...in...chair..."</p> <p>During an interview on 2/5/2015 at 11:34 A.M., RN #11 indicated Resident #44 experienced short term memory impairment and had recently experienced</p>		findings will be reviewed during the QAPI meeting for six months and then quarterly thereafter.				

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	<p>a fall. RN #11 further indicated, at that time, Resident #44 was alone at the time of the fall because the spouse had left the facility without ensuring a call light was within reach and/or the resident may have forgotten she couldn't walk. RN #11 then indicated the immediate intervention to ensure the safety of Resident #44 was to remind the spouse to place the call light within reach.</p> <p>During an interview on 2/10/15 at 3:15 P.M., the DON (Director of Nursing) indicated the facility had no specific policy for fall prevention, but it was the policy of the facility to ensure the safety of each resident.</p> <p>During an interview on 2/10/15 at 3:45 P.M., RN #11 indicated no supervision was provided to Resident #44 prior to the fall on 1/30/15 because no staff was aware the resident was alone in the room.</p> <p>2. During an observation of Resident #57's showering at 10:32 A.M., by CNA #1 on 2/6/2015, bruises were observed on Resident #57's left shoulder, left thigh and left forearm. A skin tear the size of a quarter was also observed on Resident 57's left forearm. At that time CNA #1 indicated the bruising on Resident #57's</p>						

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	<p>body was caused by a recent fall.</p> <p>The clinical record of Resident #57 was reviewed on 2/6/15 at 12:00 P.M. The record indicated Resident #57 was admitted on 1/20/15 with diagnoses including, but not limited to, Alzheimer's dementia.</p> <p>New Admission report in the Nursing notes dated 1/20/15 read as follows: "...91 year old...Fall prevention..."</p> <p>The MDS (Minimum Data Set) assessment dated 1/27/15 indicated Resident #57 experienced severe cognitive impairment and required the assistance of 2 staff with transfers.</p> <p>A Care Plan for falls dated 1/26/15 read as follows: "...PROBLEM: Potential for Trauma-Falls...Nurses --- Observe, record, and report all unsafe conditions and situation,...Anticipate fall times, Monitor closely..."</p> <p>The Fall Risk Assessment completed on dated 2/3/15, provided by the Director of Nursing on 2/6/15, indicated Resident #57 was at a high risk for falls.</p> <p>The AM/PM CNA assignment sheet, provided by the Health Care Administrator on 2/4/15 at 2:06 P.M.,</p>			

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	<p>lacked documentation of safety interventions which were to be used, such as bed alarm, gripper socks, or other interventions.</p> <p>The Incident Reports, provided by the Director of Nursing (DON) on 2/6/15 at 1:30 P.M., indicated Resident #57 fell on the following days:</p> <p>Fall # 1 occurred on 1/28/15 at 3:03 A.M. "...INCIDENT TYPE: Observed on the floor...LOCATION: Resident's room...ACTIVITY AT THE TIME:UK (unknown)...IMMEDIATE INTERVENTION IMPLEMENTED: assess and monitor resident, ensure bed in low position, non slip socks..."</p> <p>Fall # 2 occurred on 2/1/15 at 4:15 A.M. "...INCIDENT TYPE: Observed on the floor...LOCATION: Resident's room...ACTIVITY AT THE TIME: Transferring evidence suggest resident was trying to rise from her bed...Bed not in contact with resident but location where resident was prior to being witnessed on floor...IMMEDIATE INTERVENTION IMPLEMENTED: Low bed Gripper socks/appropriate footwear recommended bed alarm...ASSESSMENT SUPPORTING INTERVENTION: Resident is confused and at times disoriented, interventions</p>			

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	<p>that provide increased safety are best as resident is able will likely try to transfer/ambulate..."</p> <p>Fall # 3 occurred on 2/4/15 at 12:16 A.M. "...INCIDENT TYPE: Observed on the floor...LOCATION: Resident's room...ACTIVITY AT THE TIME: Transferring resident reported that she wanted out of bed...IMMEDIATE INTERVENTION IMPLEMENTED: Night light at night Gripper socks/appropriate footwear Reorient to call light system low bed...bed alarm applied..."</p> <p>Fall # 4 occurred on 2/5/15 at 4:30 A.M. "...INCIDENT TYPE: Observed on floor...LOCATION: Activity room...ACTIVITY AT THE TIME: Sitting in w/c(wheelchair)...IMMEDIATE INTERVENTION IMPLEMENTED: push w/c up to table to be able to reach better..." Documentation was lacking if fall was witnessed or how long resident was on the floor in the activity room.</p> <p>Nurses Note, dated 2/5/15 at 10:00A.M., read as follows: "...CALL PLACED TO: Dr. [Name]...resident fall, hit back of head, reported resident appears to be having difficulty staying asleep, most falls have been very early am hours,</p>			

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	<p>possibly d/t (due to) anxiety d/t new environment, Requested low dose Trazadone per DON...RESULTS: new orders received and noted 2/5/15 Trazadone [sic] 50 mg po every hs..."</p> <p>During an interview on 2/6/15 at 1:30 P.M., the DON indicated that, upon admission, Resident #57's daughter had indicated that Resident #57 was a "faller" and had "stumbled several times". The DON further indicated Resident #57's risk for falling was increased due to confusion, heavy antipsychotic and antianxiety medication use.</p> <p>3. On 02/06/2015 at 10:06 A.M., Resident #8 was observed lying in bed, with her eyes closed.</p> <p>The clinical record for Resident #8 was reviewed on 2/6/15 at 12:39 P.M., diagnoses include, but were not limited to, diabetes type 2, Parkinson's disease and hypertension.</p> <p>The care plans included, but were not limited to, self care deficit, initiated</p>			

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	<p>1/2/15, interventions included, but were not limited to, assist of 2 for care daily, monitor for fatigue and call light within reach. A care plan for potential for falls was initiated 10/13/14, the interventions included, but were not limited to, observe, record and report all unsafe conditions and situations. Other interventions were encourage to ask for assistance, anticipate fall times, monitor closely, assess change in level of consciousness, encourage to ask for assistance, call light in reach, and anticipate needs.</p> <p>Fall #1 occurred on 10/15/15 at 2:15 A.M. The nursing note dated 10/15/15 at 2:15 A.M., indicated Resident #8 was observed on the floor at 10/15/14 at 2:09 A.M. The nursing note indicated she had been resting in bed prior to the fall and had no injuries as a result of the fall. The immediate interventions implemented were to lower the resident's bed, add a night light to the room and reorient Resident #8 to the call light system.</p> <p>An incident report provided by the Director of Nursing (DON) on 2/10/15 at 1:21 P.M., indicated Resident #8 fell out of bed on 10/15/14 at 2:09 A.M. The incident report listed the interventions as low bed, reorient resident to call light system, night light at night. A hand</p>						

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	<p>written note indicated, "Resident[Resident #8] states staff placed her to close to bed edge, maxiguard mattress [a concaved mattress], staff awareness 10/17/14."</p> <p>Fall #2 occurred on 1/1/15 at 11:30 P.M. The nursing note dated 1/2/15 at 12:13 A.M., indicated Resident #8 was observed on floor on 1/1/15 at 11:30 P.M., it indicated Resident #8 had been in bed prior to her fall and had a bruise to the right temporal area as a result of the fall. Documentation of an immediate intervention was lacking.</p> <p>Fall #3 occurred on 1/14/15 at 2:40 P.M. The nursing note dated 1/14/15 at 4:31 P.M., indicated Resident #8 was observed on the floor in her room, it indicated Resident #8 had been in bed prior to the fall. The nurses note listed the bedside table was involved in the fall and Resident #8 had experienced no injuries as a result of the fall. The immediate interventions included, call light will be clipped to the resident's clothing and the bedside table will not be left next to bed.</p> <p>An incident report provided by the DON on 2/10/15 at 1:21 P.M., indicated Resident #8 fell out of bed on 1/14/15 at 2:40 P.M. The immediate interventions were listed as call light will be clipped to</p>			

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	<p>resident's clothing, and the bedside table will not be left next to bed. The incident report also contained a hand written note indicating, "1/15/15 Call light repaired."</p> <p>During an interview with the DON on 2/6/15 at 2:15 P.M., she indicated Resident #8 suffered from Parkinson's disease and occasionally experienced a change in level of cognition. She indicated the first fall occurred on 10/15/14 at 2:09 A.M., Resident #8 had been resting in bed and was observed lying on the floor. She indicated the intervention put into place were lowering the bed and a maxigaurd mattress. She had interviewed Resident #8 and had concluded Resident #8 was placed too close to the edge of the bed and staff had been in-serviced on positioning. The DON indicated the 2nd fall had occurred on 1/1/15 11:30 P.M., she indicated Resident #8 had fallen out of bed and at that time she could not recall the interventions. She further indicated the 3rd fall occurred on 1/14/15 at 2:40 P.M., she indicated Resident #8 had been attempting to use the bedside table to steady her to scoot up in the bed and fell. She further indicated Resident #8 did not have her call light because it was out of reach. She indicated the interventions put into place were removing the bedside table from bedside, adding positioning</p>			

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	<p>bars to the bed and replacing the call light with one that could be clipped to Resident #8's clothing.</p> <p>During an observation on 2/09/2015 9:45 A.M., Resident #8 was observed in her room sitting in wheelchair watching television, the call light fastened to the top of the positioning bar on her bed. Resident #8 attempted to reach the call light but was unable to do so. Resident #8 indicated she could not reach the call light while it was fastened to the positioning bar.</p> <p>A policy titled "Fall/Injury Prevention and Reeducation Interventions" dated 1/14 was provided by the facility on 2/9/15 at 3:20 P.M., it included "Purpose: To provide examples of interventions that can be utilized for fall and/or injury prevention and reduction." The policy lacked any guidelines for assessing effectiveness of interventions, procedures, and notification.</p> <p>During an interview on 2/10/15 at 11:00 A.M., The DON indicated the fall that occurred on 1/2/15 had occurred as a result of resident falling out of the wheel chair when a new certified nursing assistant (CNA) had forgotten to put her to bed. She further indicated the CNA</p>			

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F000329 SS=D	<p>involved had been in-serviced. She indicated she was unaware the nursing documentation indicated Resident #8 was in bed prior to the fall. At that time the DON indicated there were no other fall policies for the facility and did not indicate how the facility monitored the effectiveness of interventions.</p> <p>3.1-45(a)(2)</p> <p>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.</p> <p>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</p>						

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was clinically indicated, in that, the blood pressure was not monitored for a resident who received an anti-hypertensive medication for 1 of 5 residents who met the criteria for review of unnecessary medication. (Resident #32)</p> <p>Findings include:</p> <p>Resident #32 was observed on 2/4/15 at 1:50 P.M., lying in bed in no apparent distress.</p> <p>The clinical record of Resident #32 was reviewed on 2/9/2015 at 3:32 P.M. The record indicated the diagnoses of Resident #32 included, but were not limited to, hypertension (high blood pressure).</p> <p>The Quarterly MDS (Minimum Data Set) assessment indicated Resident #32 experienced hypertension.</p> <p>The Plan of Care dated 11/5/14 lacked any care plan to monitor the blood</p>	F000329	<p>It is the practice of the facility to have each resident's drug regimen free from unnecessary drugs. The chart of resident #32 and the charts of other residents with potential to be affected by this deficiency were reviewed. Careplans/orders were updated as needed. An inservice was held on February 20, 2015 by the consultant pharmacist with the licensed nursing staff on monitoring hypertension and medications. To monitor for compliance, the clinical record will be reviewed weekly by the Director of Nursing and/or designee for documentation for monitoring hypertension and medications. Any negative findings will be reported to the HFA and monitored through the monthly QAPI meetings ongoing.</p>	03/06/2015			

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	<p>pressure of Resident #26.</p> <p>The December 2014 Physician's Order Recap included, but was not limited to, an order for "...Clonidine [a medication to treat high blood pressure]...0.2 mg [milligrams] take (1) tablet by mouth 3 times daily. Dx: [Diagnosis] HTN [hypertension]..."</p> <p>The January 2015 Physician's Order Recap included, but was not limited to an order for "...Clonidine...0.2 mg take (1) tablet by mouth 3 times daily. Dx: HTN..."</p> <p>The December 2014 MAR (Medication Administration Record) indicated Resident #26 received, "...Clonidine...0.2 mg ...three times daily...for: Hypertension Therapeutic Goal: systolic BP < (less than) 150..." The MAR lacked any documentation of blood pressure monitoring.</p> <p>The January 2015 MAR indicated Resident #26 received, "...Clonidine...0.2 mg ...three times daily...for : Hypertension Therapeutic Goal: systolic BP < (less than) 150..." The MAR lacked any documentation of blood pressure monitoring.</p> <p>A Vital Sign report from 10/1/14 through</p>				

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	<p>2/9/15 provided by LPN #10 on 2/9/15 at 3:55 P.M., indicated the blood pressure had been checked on 1/16/15.</p> <p>The PDR (Physician's Drug Reference) 2014 Edition Nurse's Drug Handbook pages 193-194 indicated, "...Clonidine...Indications: Treatment of HTN...Nursing Considerations...Monitoring: Monitor BP [blood pressure]..."</p> <p>During an interview on 2/9/15 at 3:45 P.M., LPN #13 indicated the blood pressure of Resident #32 should be checked before administering Clonidine. LPN #13 further indicated, at that time, sometimes she checked the blood pressure of Resident #32, but could not provide any documentation of blood pressure monitoring.</p> <p>During an interview on 2/9/15 at 3:50 P.M., RN #2 indicated the nursing staff was not required to check the blood pressure of Resident #32 because the doctor had not ordered it.</p> <p>During an interview on 2/10/15 at 11:30 A.M., the DON (Director of Nursing) indicated there was no medication policy related to monitoring the blood pressure of a resident receiving anti-hypertensive medication. The DON further indicated,</p>			

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F000364 SS=F	<p>at that time, the blood pressure would only be checked if ordered by the physician.</p> <p>During an interview on 2/11/15 at 3:15 P.M., the DON indicated routine blood pressure monitoring would be performed as a nursing measure for residents who received anti-hypertensive medication.</p> <p>3.1-48(a)(3)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was served according to the recipe, in that, staff did not follow the recipe for the service of chicken and dumplings for 1 of 2 observations of food service. This had the potential to affect 39 of 40 residents who resided in the facility.</p> <p>Findings include:</p> <p>The following was observed on 2/4/15 from 12:15 P.M. through 12:45 P.M.:</p>	F000364	<p>It is the practice of the facility to provide food prepared by methods that conserve nutritive value, flavor and appearance. An inservice was held with dietary staff on February 6, 2015 to review following menus, reading menus, preparation of food, and portion sizes. Eight ounce ladles have been purchased. To monitor for compliance, the dietary manager will observe food preparation and serving portions daily for six weeks and then two times a week for six months. After that time, meal service will be monitored for each meal at least one time a week. Any findings will be reported to the</p>	03/06/2015			

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F000371 SS=F	<p>During an interview, Cook #1 indicated she was using a 6 oz (ounce) ladle to serve Chicken and Dumplings for the lunch meal. Cook #1 was observed to serve the Chicken and Dumplings for the entire lunch meal using a 6 oz ladle.</p> <p>A recipe for Turkey and Dumpling Soup provided by the CDM (Certified Dietary Manager) on 2/4/15 at 1:00 P.M. indicated, "...Portion: 8 oz L (ladle)...Method...6. Serve each portion using an 8 oz ladle..." During an interview, at that time, the CDM indicated, that same recipe was used for Chicken and Dumplings.</p> <p>On 2/5/15 at 9:00 A.M., no 8 oz ladles were observed in the kitchen. During an interview, at that time, the CDM indicated 8 oz ladles were not available for the kitchen staff to use and 8 oz ladles would be ordered that day. The CDM further indicated, at that time, it was the policy of the facility to follow the recipe for food service.</p> <p>3.1-21(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>		HFA and reviewed through QAPI meetings for six months. If no negative findings, the review with be reduced to quarterly.				

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure kitchen equipment was clean, food was stored, prepared, and/or served under sanitary conditions, in that, kitchen equipment, food storage areas, were not clean during 3 of 3 kitchen observations, staff did not have hair completely contained in a hair restraint, water used for sanitation was not maintained, staff did not perform proper handwashing and/or hand hygiene during 1 of 3 kitchen observations,</p> <p>This had the potential to affect 39 of 40 residents who resided in the building.</p> <p>Findings include:</p> <p>The following was observed on 2/4/15 at 9:10 A.M.:</p> <ol style="list-style-type: none"> 1. The top of the stove had food spillage and burnt food debris. 2. The stove drip pans had burnt food debris. 3. Three uncovered pans of cookies and one uncovered sheet cake in the food prep area underneath a ceiling air vent with peeling paint. 	F000371	<p>The facility does procure, prepare, store and serve food under sanitary conditions. Routine cleaning schedules are completed for all equipment, food contact surfaces, nonfood contact surfaces to include floors. The cleaning schedules have been reviewed with the dietary staff. The stove was cleaned, the door cleaned, drip pans emptied and cleaned, vent and paint fixed. All dietary staff were retrained on February 6, 2015 to include cleaning schedules, proper sanitation techniques, wearing hairnets, handwashing and glove use. To ensure ongoing compliance, the dietary manager will make a minimum of three random audits of cleaning schedules, handwashing, glove use, hairnets and sanitation for four weeks and then weekly thereafter. The HFA will make rounds in the dietary department weekly to monitor for cleanliness and sanitation. Any negative findings will be reported and reviewed through the monthly QAPI meetings ongoing.</p>	03/06/2015

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	<p>4. A dried potato, dry cereal, and black debris were on floor underneath the shelving in the dry storage area.</p> <p>5. A large amount of black debris in the corners and around the perimeter of the kitchen floor.</p> <p>6. Dried food spillage on the floor throughout the entire kitchen.</p> <p>7. A thick black build-up around the door handle of the kitchen door.</p> <p>8. On 2/4/15 at 9:20 A.M., Cook #1 was observed to perform a chemical test on sanitation bucket #1. During an interview, at that time, Cook #1 indicated the result of the chemical test was 400 ppm (parts per million) and the acceptable range result was 300-400 ppm. Cook #1 then indicated, the sanitation bucket water had been changed at 8:15 A.M. and it was usual facility practice to change the sanitation bucket water after each meal service.</p> <p>The following was observed on 2/4/14 at 11:15 A.M.:</p> <p>9. The top of the stove had food spillage and burnt food debris.</p> <p>10. The stove drip pans had burnt food debris.</p> <p>11. A ceiling air vent in the food prep area above had peeling paint.</p> <p>12. A dried potato, dry cereal, and black</p>			

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	<p>debris were on floor underneath the shelving in the dry storage area.</p> <p>13. A large amount of black debris in the corners and around the perimeter of the kitchen floor.</p> <p>14. Dried food spillage on the floor throughout the kitchen.</p> <p>15. A thick black build-up around the door handle of the kitchen door.</p> <p>16. Cook #1 was working in the food prep area with hair extruding from a hairnet.</p> <p>17. DA (Dietary Assistant) #1 was working in the food prep area with hair extruding from a hairnet.</p> <p>18. On 2/4/15 at 11: 23 A.M., Cook #1 was observed to clean the food prep table using a bare hand and rag dipped in sanitation bucket #1 and place a container of hamburger patties on the food prep table. Cook #1 was then observed to perform a chemical test on sanitation bucket #1. During an interview, at that time, Cook #1 indicated the result of the chemical test was 100 ppm. Cook #1 then indicated, she had would change the sanitation bucket water after lunch and was observed to apply gloves and return to the serving area of the kitchen and grasp a serving utensil without performing handwashing and/or hand hygiene.</p>				

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	<p>During an interview 2/4/15 at 12:15 P.M., DA #1 indicated the cookies and cakes should have been covered to prevent contamination.</p> <p>On 2/5/15 at 9:00 A.M., the following was observed:</p> <p>19. The top of the stove had food spillage and burnt food debris. 20. The stove drip pans had burnt food debris. 21. A ceiling air vent in the food prep area had peeling paint. 22. A dried potato, dry cereal, and black debris were on floor underneath the shelving in the dry storage area. 23. A large amount of black debris in the corners and around the perimeter of the kitchen floor. 24. Dried food spillage on the floor throughout the kitchen. 25. A thick black build-up around the door handle of the kitchen door.</p> <p>On 2/5/15 at 9:30 A.M., the CDM was observed to remove an area of build up from the kitchen exit door and indicated during an interview, at that time, the door needed to be cleaned.</p> <p>The Policy and Procedure for Personal Cleanliness provided by the CDM on 2/9/15 at 8:30 A.M. indicated, "...When</p>			

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	<p>to wash...(F) During Food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks...(H) before donning [applying] gloves for working with food...(I) After engaging in other activities that contaminate the hands..."</p> <p>The Policy and Procedure for Hair Restraints provided by the CDM on 2/9/15 at 8:30 A.M. indicated, "...food employees shall wear hair restraints...worn to effectively keep their hair from contacting exposed food..."</p> <p>The Policy and Procedure for Sanitizing Solutions, Testing Devices provided by the CDM on 2/9/15 at 8:30 A.M., lacked any documentation related to maintenance of the kitchen sanitation bucket.</p> <p>The Cleaning Schedule for A.M. Cook provided by the CDM on 2/9/15 at 8:30 A.M., indicated, "...10. Clean stove...and drip pans at the end of shift..."</p> <p>The Daily Cleaning Schedule for #1 A.M. Assistant provided by the CDM on 2/9/15 at 8:30 A.M., indicated, "...11. ...mop floor..."</p> <p>The Daily Cleaning Schedule for P.M.</p>			

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F000431 SS=D	<p>Assistant provided by the CDM on 2/9/15 at 8:30 A.M., indicated, "...18. Sweep & (and) mop kitchen floor..."</p> <p>During an interview on 2/9/15 at 8:40 A.M., the CDM indicated the stove and drip pans should be clean, the ceiling air vent should not have peeling paint, the dry storage area and kitchen floor should be clean, hair should be completely contained in a hair restraint, the sanitation bucket should always test at least 200 ppm, proper handwashing and/or hand hygiene should be performed.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently</p>			

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	<p>accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications which had a high likelihood of abuse were stored behind 2 locks in 1 of 1 medication storage room reviewed, in that, an unlocked Emergency Drug Kit (EDK) containing Ativan (an anti-anxiety medication) was stored in an unlocked refrigerator.</p> <p>The medication storage room was observed on 2/9/15 at 3:01 P.M., with LPN #5. During the observation on the top shelf of the unlocked refrigerator was an unsealed EDK box. The EDK box</p>	F000431	A pharmacist services are used by the facility and a system is established to record receipt and disposition of drugs and that drugs are labeled in accordance with currently accepted practices. The Director of Nursing checked the medication room and EDK. The drugs were counted at that time and the EDK resealed. The licensed nursing staff was inserviced on February 23, 2015 on the facility's controlled substance policy and monitoring the EDK. To monitor for compliance, the Director of Nursing and/or designee will check the EDK weekly and after use to ensure it is secured properly. The nurses will check	03/06/2015

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	<p>contained four sealed 2 milligram (mg) vials of injectable Ativan (an anti-anxiety medication) and one 60mg bottle of Ativain intensol (a sublingual anti-anxiety medication). At the same time during interview LPN #5 indicated the EDK box had been opened and it should be sealed with a numbered tag and zip tie.</p> <p>On 2/10/15 at 10:00 A.M., during an interview with LPN #10 she indicated the refrigerated EDK box was stored in medication refrigerator. She further indicated it needed to be sealed because it contained Ativan.</p> <p>On 2/10/15 at 2:50 P.M., during an interview with the Director of Nursing (DON) she indicated the refrigerated EDK was stored in the medication storage room and was only to be opened by two nurses and should be resealed after the needed medication was retrieved.</p> <p>A policy titled "Controlled Substance Policy" dated 10/14 was provided by the facility on 2/10/15 at 3:01 P.M., it included, "...i. controlled substances requiring refrigeration must be double locked and counted with all others..."</p> <p>3.1-25(r)</p>		<p>on delivery. The consultant pharmacist will audit during monthly visit. To ensure continued compliance, any adverse findings will be reported to the HFA and reviewed through the monthly QAPI meetings ongoing.</p>				

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F000465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review the facility failed to ensure a community shower/bathroom used by CNAs to shower and toilet residents was clean and sanitary for 1 of 1 shower rooms reviewed. This had the potential to affect 40 of 40 residents.</p> <p>Findings include:</p> <p>During an observation on 2/6/15 at 10:32 A.M. of CNA #1 showering a resident in the community shower room on the 300 hall, a 5 foot gray shower mat, which was covered with drainage holes, covered the entire shower floor. Embedded between the drainage holes was black, soft soap scum. The black soap scum covered 45% of the shower mat. Soap scum covered the shower walls. The shower chair,</p>	F000465	<p>It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for the residents, staff and public. The shower room was thoroughly cleaned on February 6, 2015 by housekeeping. The shower chair was cleaned on February 6, 2015. The rubber matting was replaced on February 6, 2015. An inservice will be held on March 2, 2015 with the environmental staff to review cleaning practices of the facility. The housekeeping staff will monitor for concerns. The housekeeping supervisor will make rounds daily to ensure compliance with cleaning schedules and report any negative findings to the HFA. To ensure continued compliance, the HFA and/or designee will make rounds weekly and address any concerns with the housekeeping staff. Negative outcomes will be reviewed monthly during the</p>	03/06/2015

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	<p>which was made of white plastic, had a blue mesh back rest, which was also covered with soap scum. Splatters of a dark, unidentifiable substance appeared on the painted walls below the window.</p> <p>After CNA #1 completed the resident's shower, CNA #1 placed the shower chair in the shower and sprayed the chair down with water and removed the trash can liner. CNA# 1 did not spray the shower or shower chair with a sanitizer to disinfect the chair and the shower area after showering the resident.</p> <p>The policy and protocol for "...Transmission-Based Precautions" was provided by the Health Care Administrator on 2/6/15 at 1:00 P.M., and it read as follows: "...5. Resident Care Equipment: ...If common use of equipment for multiple residents is unavoidable, clean and disinfect such equipment before use on another resident."</p> <p>The policy and protocol for "HOUSEKEEPING: WET MOPPING" was provided by the Health Care Administrator on 2/6/15 at 1:00 P.M., and it read as follows: "...iv. Clean hard to clean spots with a scrub brush and scouring powder..."</p>		QAPI meeting for six months and then quarterly thereafter.		

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	<p>During an interview on 2/6/15 at 2:30 P.M., CNA #22 indicated that there was no shower sanitizer in the shower room when CNA #1 was observed showering the above referenced resident. CNA #22 indicated the staff had since replaced the sanitizer.</p> <p>During an interview with Housekeeper #2 on the 300 hall on 2/6/2015 at 11:15 A.M., Housekeeper #2 indicated she had just cleaned the bathroom/shower room earlier that morning. Upon viewing the shower and shower mat, Housekeeper #2 indicated she could not successfully remove the black, mildew-ridden scum. After demonstrating the removal of some of this material with a ball point pen, Housekeeper #2 indicated the facility did not allow bleach to be used in the shower. Housekeeper #2 indicated the shower chair was cleaned daily with a sanitizer. After pointing out the soap scum build-up on the mesh area of the chair back to Housekeeper #2, Housekeeper #2 indicated the back side must have been missed during the daily sanitizing procedure.</p> <p>During an interview on 2/6/15 at 11:30 A.M., the Heath Care Administrator was made aware of the shower conditions. During the follow-up observation, the Heath Care Administrator acknowledged</p>			

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F000514 SS=D	<p>she could see the problem.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the clinical record was complete and/or accurately documented, in that, the clinical record lacked complete information related to a medication error for 1 of 5 residents who met the criteria for review of unnecessary medications and/or lacked complete information related to bowel movement</p>	F000514	It is the practice of the facility to maintain complete and accurate clinical records on each resident. The charts of the residents affected by this deficiency and the charts of other residents with the potential to be affected by this deficiency were reviewed. Assessments and careplans were updated as needed. An inservice was held with the licensed nursing staff on	03/06/2015

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	<p>monitoring for 1 of 1 residents who met the criteria for review of fecal impaction. (Resident #42, Resident #8, Resident #55, Resident #44)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #42 was reviewed on 2/6/15 at 1:21 P.M. The record indicated the diagnoses of Resident #42 included, but were not limited to, IDDM (insulin dependent diabetic mellitus), dementia.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/18/15 indicated Resident #42 experienced severe cognitive impairment and received insulin injections daily.</p> <p>The Medication Administration Record (MAR) for February 2015 documented Resident #42 had a blood sugar level of 173 on 2/7/15 and a blood sugar level of 151 on 2/8/15. Documentation was lacking in the MAR that Resident #42 had received the 2 units of Humulin R (a fast acting insulin) insulin prescribed by the physician for sliding coverage for both 2/7/15 and 2/8/15.</p> <p>The clinical record was reviewed for the following days, 2/7/15, 2/8/15 and 2/9/15, and documentation was lacking a</p>		<p>February 23, 2015 to review policies relating to diabetic care, dialysis care, monitoring bowel movement and constipation. To monitor for compliance, the Director of Nursing and/or designee will review nursing and nurse aide documentation daily to monitor for completion of documenting provided care. Any negative findings will be reported to the HFA. To monitor for continued compliance, any adverse findings will be reviewed at the QAPI meeting monthly for six months. If no concerns are noted, monitoring will be reduced to quarterly.</p>	

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	<p>medication error had occurred or that the physician had been notified of the medication error.</p> <p>The Physician's Order dated 9/16/14 read as follows: "...HUMULIN R S/S (sliding scale) AS FOLLOWS: 151- 200 = 2 U (units); 201 -250 =4 U..."</p> <p>During an interview on 2/9/15 at 2:30 P.M., LPN #10 was made aware of a medication error for Resident #42 concerning Resident #42's sliding scale coverage for Humulin R insulin. LPN #10 indicated Resident #42 should have received insulin per sliding scale and the MAR indicated no insulin had been administered. LPN#10 further indicated an insulin error had occurred.</p> <p>During an interview on 2/10/15 at 2:00 P.M., RN #11 indicated that when a medication error occurred the nurse completes a form concerning the error and gave it to the Director of Nursing. LPN #11 further indicated the information was not recorded in the medical record; rather, the information is then communicated verbally during shift report.</p> <p>The clinical record was reviewed for the following days, 2/9/15 through 2/11/15, and documentation was lacking that an</p>			

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	<p>insulin medication administration error had occurred on 2/7/15 and/or 2/8/15, or that the physician had been notified concerning the medication error.</p> <p>A Care Plan for fluctuating blood sugars dated 1/21/15 read as follows: "...APPROACH...Follow physicians (sic) orders related to diabetes..."</p> <p>During an interview on 2/10/15 at 2:30 P.M., the Director of Nursing (DON) indicated medication errors, physician's notification of medication errors, family notification of medication errors and follow up assessment concerning the medication errors were not documented in the resident's clinical record. The DON further indicated the information was part of their Quality Assurance Program (QA) and that the information concerning the medication error was for QA and personal management only and therefore could not be provided to the survey team.</p> <p>2. The clinical record for Resident #8 was reviewed on 2/6/15 at 12:39 P.M., diagnosis include, but were not limited to, diabetes type 2, Parkinson's disease</p>				

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	<p>and hypertension.</p> <p>The care plan included, but were not limited to, self care deficit, initiated 1/2/15, interventions included, but were not limited to, assist of 2 for care daily, monitor for fatigue and call light within reach. A care plan for potential for falls was initiated on 10/13/14, the interventions included, but were not limited to, observe, record and report all unsafe conditions and situations. Other intervention were encourage to ask for assistance, anticipate fall times, monitor closely, assess change in level of consciousness, encourage to ask for assistance, call light in reach, and anticipate needs.</p> <p>On 2/6/15 at 10:06 A.M., a nursing note for Resident #8 was reviewed, it included, but was not limited to, A nursing note dated 1/2/15 at 12:13 A.M., which indicated Resident #8 was observed on floor on 1/1/15 at 11:30 P.M., the nursing note also indicated Resident #8 had been in bed prior to her fall and had a bruise to the right temporal area as a result of the fall. Documentation of an immediate intervention was lacking.</p> <p>The intake and ADL report from 1/11/15 through 2/10/15 for Resident #8 was</p>			

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	<p>reviewed on 2/11/15 at 9:50 A.M., it lacked any documentation related to intake, including, but not limited to, meal intake on, 1/11/15 dinner, 1/16/15 dinner, 1/17/15 dinner, 1/18/15 lunch and dinner, 1/19/15 dinner, 1/20/15 dinner, 1/21/15 dinner, 1/22/15 dinner, 1/23/15 dinner, 1/24/15 dinner, 1/25/15 dinner, 1/26/15 dinner, 1/27/15 dinner, 1/28/15 dinner, 1/29/15 dinner, 1/30/15 dinner, 1/21/15 dinner, 2/1/15 dinner, 2/2/15 dinner, 2/3/15 dinner, 2/4/15 dinner, 2/5/15 dinner, 2/6/15 dinner, 2/7/15 dinner.</p> <p>During an interview on 2/10/15 at 11:00 A.M., The DON indicated the fall that occurred on 1/1/15 had occurred as a result of Resident #8 falling out of the wheelchair when a new certified nursing assistant (CNA) had forgotten to put her to bed. She further indicated the CNA involved had been inserviced. She indicated she was unaware the nursing documentation indicated Resident #8 was in bed prior to the fall.</p> <p>3. The clinical record for Resident #55 was reviewed on 2/6/15, at 11:59 A.M., diagnoses include, but not limited to, end stage renal disease, atrial fibulation, and seizure disorder.</p> <p>A physicians order dated 1/10/15 included "Dialysis M-W-F [Monday,</p>			

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	<p>Wednesday, and Friday]."</p> <p>An order dated 1/15/15/ included "Palpate [touch] R [right AV [arteriovenous] fistula graft for thrilland auscultate [listen] for bruit [wooshing sound] q [every] shift starting 1/15/15."</p> <p>The care plan include, but were not limited to, a problem of self care deficit (initiated 1/10/15). A problem of potential for infection related to dialysis fistula (initiated on 2/3/15) the interventions included, but were not limited to, monitor for signs and symptoms of infection. The care plans also addressed, a problem of potential for tissue integrity impairment related to the dialysis fistula (initated 1/28/15) the interventions included, but were not limited to monitor for thrill at site.</p> <p>The intake and ADL report form 1/11/15 through 2/10/15 for Resident #55 was Reviewed on 2/11/15 at 10:00 A.M., it lacked any documentation related to intake, but not limited to, meal intake on 1/13/15 dinner, 1/14/15 dinner, 1/16/15 Lunch, 1/19/15 Breakfast and Lunch, 1/20/15 Breakfast and Lunch, 1/21/15 dinner, 1/22/15 breakfast, lunch, supper, 1/23/15 lunch, 1/25/15 dinner, 1/27/15 dinner, 1/28/15 breakfast, lunch and dinner, 1/29/15 breakfast, lunch and</p>			

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	<p>dinner, 1/30/15 breakfast, lunch and dinner, 1/31/15 lunch, 2/1/15 breakfast, lunch, and dinner, 2/2/15 dinner, 2/3/15 dinner, 2/4/15 breakfast, lunch, dinner, 2/5/15 dinner, 2/6/15 lunch and supper, 2/7/15 lunch, 2/8/15 lunch and supper, 2/9/15 supper, and 2/10/15 lunch and supper.</p> <p>The nursing notes for Resident #55 were reviewed on 2/10/15 at 3:01 P.M. A nursing note dated 1/16/15 at 4:23 P.M., included, but not limited, "ABD/GU EXAM: ...No fecal impaction noted upon digital exam."</p> <p>A nursing note dated 1/29/15 at 3:30 P.M., included, but was not limited to, "ABD/GU Exam: ... No fecal impaction noted upon digital exam."</p> <p>During an interview with CNA #10 she indicated meal intakes for all meals are recorded in the facility computer system. She indicated if a resident were to refuse a meal they would notify the nurse and document the refusal and the reason why it was refused.</p> <p>During an interview on 2/10/15 at 11:00 A.M., the Director of Nursing indicated the documentation indicating Resident #55 had received a digital exam for fecal impaction was an error.</p>			

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	<p>4. On 2/4/15 at 2:45 P.M., Resident #44 was observed sitting in a recliner.</p> <p>During a confidential interview on 2/4/15 at 2:32 P.M., the interviewee indicated Resident #44 had been hospitalized for a fecal impaction in October of 2014 after several days of experiencing abdominal pain, nausea, and constipation.</p> <p>The clinical record of Resident #44 was reviewed on 2/5/15 at 10:30 A.M. The record indicated the diagnoses of Resident #44 included, but were not limited to, Alzheimer's, dementia, and constipation.</p> <p>An ADL (Activities of Daily Living) report from 10/22/14 through 10/28/14 indicated the following stool output:</p> <p>"10/22/14 4:23 AM (morning)...Incontinent X (times) 1... Medium...Fluffy pieces with ragged edges, a mushy stool"...</p> <p>10/23/14 6:05 A.M....No BM (bowel movement)...12:44 P.M....No BM...9:33 PM (evening)...No BM...</p> <p>10/24/14 6:00 AM...No BM...11:04 AM...Continent X1 Medium...</p>						

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	<p>10/25/14 6:07 AM...No BM...</p> <p>10/26/14 5:36 AM...No BM...12:21 A.M....No BM...</p> <p>10/27/14 04:22 AM ...No BM...12:06 PM...Continent X1 small...</p> <p>10/28/14 1:53 AM...No BM...1:35 PM...No BM..."</p> <p>The ADL (Activities of Daily Living) report for Resident #44 from 10/15/14 through 10/28/14 was reviewed. It lacked any documentation related to care provided including, but not limited to, BM's (bowel movements) on, 10/15/14 evening shift, 10/16/15 evening shift, 10/17/15 evening shift, 10/19/14 evening shift, 10/21/15 evening shift, 10/22/14 evening shift, 10/24/15 evening shift and 10/25/14 day and evening shifts.</p> <p>The ADL report lacked any documentation related to stool output on 10/22/14 evening shift, 10/24/14 evening shift, and 10/25/14 day and evening shift.</p> <p>During an interview on 2/10/14 at 3:30 P.M., RN #11 indicated it was difficult to monitor the BM's for Resident #44 because the spouse usually toileted the resident and the CNA's had no way of knowing if the resident had a BM or not.</p>			

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	<p>During an interview on 2/5/14 at 3:40 P.M., LPN #14 indicated nurses have to manually check the CNA documentation for each resident to determine if a resident is having bowel movements. LPN #14 further indicated, at that time, if the CNA's didn't document the BM's there was no way for the nurse's to know if a resident was experiencing a problem with their bowels.</p> <p>A Bowel Elimination Tracking Policy and Procedure provided by the DON (Director of Nursing) on 2/5/15 at 4:00 P.M. indicated, "...Purpose: To ensure bowel elimination patterns are tracked by caregivers when the resident...is unable to verbalize adequate bowel elimination...4. The tracking will be monitored daily and used to develop the resident's bowel elimination plan of care and help prevent problems and guide appropriate interventions..."</p> <p>During an interview on 2/5/15 at 4:05 P.M., the DON indicated the spouse of Resident #44 frequently assisted the resident with toileting needs and did not report bowel movements to the staff. The DON further indicated accurate documentation of stool output for Resident #44 could not be provided from 10/22/14 through 10/28/14.</p>						

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R000000	3.1-50(a)(1) 3.1-50(a)(2) The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	Preparation and execution of this Plan of Correction does not constitute admission or agreement by the facility 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 law. Submission of the 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 against interest of the facility, the HFA or any employees, agents or other individuals who draft or may be discussed in the response and Plan of Correction. This Plan of Correction shall constitute this facility's credible allegation of compliance on or before March 6, 2015.		
R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the				

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	<p>overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p>			

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	<p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the state agency was notified of an unusual occurrence, in that, a cognitively impaired, inadequately dressed resident who was found outside of the facility was not reported to the state agency. (R#15)</p> <p>Findings include:</p> <p>The clinical record for R#15 was reviewed on 2/11/15 at 2:30 P.M., diagnoses include, but were not limited to, schizophrenia, hypertension, diabetes and urinary incontinence.</p> <p>A document titled "ORDER APPOINTING CO-GUARDIANS OVER PERSON AND SOLE GUARDIAN OVER ESTATE OF INCAPACITATED PERSON" dated 6/29/2003 included, "...is incapable of handling her person and property because of Paranoid Schizophrenia, chronic, with continuous hallucinations and delusion and is hereby found to be incapacitated person under Indiana law." The document continued and included "IT IS TEREFORE ORDERED, ADJUGED, AND DECREED by the court that: "1. [name</p>	R000090	The HFA does follow regulations provide overall management in the facility.The unusual reporting to States lists the reportable occurrence as 1. a cognitively impaired resident was found outside the facility and whose whereabouts had been unknown and 2. any circumstance of elopement which required police notification. Neither of these events occurred as the resident was still on facility property and an individual that volunteers in the facility was with her.The HFA reviewed facility elopement/wandering policy and State process for reporting unusual occurrences. The staff was inserviced on February 23, 2015 on reporting unusual occurrences and notification of the HFA.To monitor for compliance, the HFA will review 24 hour reports and nursing documentation for the residential unit daily to monitor for any unusual occurrences that occur.Any incidents will be reviewed monthly during the safety committee meetings.	03/06/2015	

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	<p>of resident] by reason of her incapacity is unable to care for person or property and is therefore adjudicated to be an incapacitated person and the appointment of a guardian over her person and estate is necessary."</p> <p>A nursing note dated 12/20/14 at 6:15 P.M., included, "Resident went out front door down driveway out on Ramsey Rd [road]. was [sic] wearing short coat, nude from waist down. Resident stated 'I'm walking to ER [emergency room]' assisted back in. [name of medical doctor] on call gave order to sent [sic] to ER for eval [evaluation]. Prior to wandering out resident in shower room emptying liquid soap all over floor stating 'bleeding all over' no blood noted. ER was called with report. [name of ambulance service] here for transport.</p> <p>A nursing note dated 12/20/14 at 10:00 P.M., included, "Called [local hospital] admitted c [with] UTI [urinary tract infection], AMS [altered mental status] and hyponatremia [low sodium]. Son was called informed mother admitted to [local hospital]."</p> <p>The "AccuWeather Forecast" for December 2014 was reviewed on 2/11/15 at 3:04 P.M. The high temperature for 12/20/14 was listed as 36 degrees</p>			

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R000247	<p>Fahrenheit and the low was listed as 24 degrees Fahrenheit.</p> <p>The Administrator was interviewed on 2/11/15 at 3:20 P.M., she indicated the facility had not notified the state agency of the occurrence because it occurred on the residential unit and she was unaware that R#15 had left the grounds.</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication errors were documeted in the clinical record and/or the phyician was notified of the errors, in that, medication records and nursing notes related to the medication administration errors were not complete and/or accurate. (R#13, R#4)</p> <p>Findings include:</p> <p>1. During an interview on 2/10/15 at 2:30 P.M., The Director of Nursing (DON) indicated there had been a medication</p>	R000247	The facility strives to follow practice of documentation of medication administration error and physician notification. The facility does complete medication error reports in the event that an error occurs. They are reviewed through the monthly QAPI meetings. Residential charts were audited and residents affected by this deficiency were assessed with no adverse affects noted. The licensed nursing staff was retrained on February 23, 2015 to include physician notification and documentation of medication errors in the clinical chart. To monitor for compliance, the Director of Nursing will review	03/06/2015

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	<p>error on 2/6/15. R#13 had received the wrong narcotic pill during the medication pass on 2/6/15. DON further indicated the information concerning the medication error would not be found in R#13's chart because the information was part of facility's Quality Assurance Program (QA) and the information concerning the medication error was for QA and personal management only and therefore could not be made available to the survey team. The DON did not provide the following requested information: the name of the narcotic medication, the time the medication error occurred or the dosage.</p> <p>The clinical record of R#13 was reviewed on 2/10/15 at 2:45 P.M. The record indicated the diagnoses of R13 included, but were not limited to, anxiety, pain and depression.</p> <p>The Physician's Order dated 2/1/15 read as follows: "...HYDROC-APAP 7.5 - 325 NORCO 7.5/325 TABLET TAKE 1 TABLET BY MOUTH TWICE DAILY FOR CHRONIC PAIN...6 AM...8 PM..."</p> <p>The Medication Administration Record (MAR) for February 2015 documented R#13 had received Hydrocodone-Acetaminophen 7.5MG-325MG at 0600 (6:00A.M.) and</p>		<p>medication error reports on occurrence and review resident's clinical record to ensure appropriate notification and documentation is made. To ensure continued compliance, the HFA will review weekly any findings with the Director of Nursing.</p>		

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	<p>2000 (10:00 P.M.)[sic] Documentation was lacking in the MAR that R#13 had received the wrong medication as indicated by the DON.</p> <p>The clinical record was reviewed for the following days, 2/6/15, 2/7/15, 2/8/15 and 2/9/15, and documentation was lacking concerning the medication error the DON had identified as occurring on 2/6/15 or that the physician had been notified of the medication error.</p> <p>2. During an interview on 2/10/15 at 2:30 P.M., the Director of Nursing (DON) indicated there had been a medication error on 2/6/15. R#4 had received her pain pill during the medication pass on 2/6/15, but it had been documented by the nurse as having been administered at a later time and, consequently she did not receive the next does at the correct time. The DON further indicated the information concerning the medication error would not be found in R#4's chart because the information was part of the facility's Quality Assurance Program (QA) and the information concerning the medication error was for QA and personal management only and therefore could not be made available to the survey team. The DON did not provide the following requested information: the name of the</p>				

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	<p>narcotic medication, the time the medication error occurred or the dosage.</p> <p>The clinical record of R#4 was reviewed on 2/10/15 at 2:50 P.M., The record indicated the diagnoses of R#4 included, but were not limited to, pain and depression.</p> <p>The Physician's Order dated 2/1/15 read as follows: "...HYDROC-APAP 7.5-325 NARCO 7.5-325 TABLET TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN...PRN</p> <p>During an interview on 2/11/15 at 3:04 P.M., R#4 indicated she sometimes receives her pain pill late because the nurses document her previous pill was given at 8:00 A.M. instead of 6:00 A.M. which was when she actually took the pill. R#4 further indicated she had to wait 2 more hours before the next pain pill could be given. It was supposed to have been administered every 6 hours, but instead it was administered every 8 hours. R#4 said, "I have pain and I need my pill."</p> <p>During an interview on 2/10/15 at 2:00 P.M., RN #11 indicated that when a medication error occurred the nurse completes a form concerning the error and gave it to the Director of Nursing.</p>			

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	<p>LPN #11 further indicated the information was not recorded in the medical record; rather, the information is then communicated verbally during shift report.</p> <p>During an interview on 2/10/15 at 2:30 P.M., the Director of Nursing (DON) indicated medication errors, physician's notification of medication errors, family notification of medication errors and follow up assessment concerning the medication errors are not documented in the resident's clinical record. The DON indicated the medication errors were passed along verbally between shifts during the shift report. The DON further indicated the information was part of the facility's Quality Assurance Program (QA) and that the information concerning the medication error was for QA and personal management only and therefore could not be provided to the survey team.</p>				