

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2013
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NAME OF PROVIDER OR SUPPLIER  OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included in investigation of Complain Number IN00126181.</p> <p>Complaint IN00126181 substantiated with deficiencies cited at F157 and F282.</p> <p>Survey dates: April 11, 12, 15, 16 and 17 2013</p> <p>Facility number: 000569 Provider number: 155531 AIM number: 100267660</p> <p>Survey team: Toni Maley, BSW- TC Linn Mackey, RN (4/16/13, 4/17/13) Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicare: 5 Medicaid: 29 Other: 2 Total: 36</p> <p>These deficiencies also reflect state</p>	F000000	<p>Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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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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	findings cited in accordance with 410 IAC 16.2.  Quality Review completed by Debora Barth, RN.				

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F000157 SS=D	<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 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 notify the family of unavailability of medications for 1 of 20 residents reviewed for medication availability [Resident #B]</p>	F000157	<p>F157</p> <p>1. Residents B, 7, and 14 were assessed and no negative outcome was noted. Resident B's family was notified of a medication not being given for two days. Residents 7 and</p>	05/13/2013

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	<p>and failed to notify the physician of blood sugars outside of the set parameters for 2 of 3 residents reviewed for blood sugar monitors. [Resident #'s 7 and 44]</p> <p>Findings include:</p> <p>1.) Resident #B's clinical record was reviewed on 4/15/13 at 2:55 p.m. The resident's diagnoses included, but were not limited to, dementia with delusions, depression, and behavioral and cognitive decline.</p> <p>The resident's current physician's orders were signed on 4/10/13. The resident had an order for Fazaclo [an antipsychotic medication] 25 mg give one half tablet by mouth at 4:00 p.m. and give one 25 mg tablet at bedtime. This order originated on 2/11/13.</p> <p>Review of the March, 2013, Medication Administration Record indicated the resident did not receive the Fazaclo medication on March 11 and 12, 2013 due to unavailability.</p> <p>Review of the Nurse's Notes for 3/11/13, indicated the pharmacy could not send the refill for Fazaclo until the results of the resident's blood test were faxed to the pharmacy. The facility contacted the laboratory</p>		<p>14's responsible party and Physician were notified of blood sugars outside parameters.</p> <p>2. Chart audits for all residents were completed to assure proper family and physician notification of medication not available, and blood sugar results out of parameter. No other irregularities noted.</p> <p>3. The Licensed nursing staff will be re-educated on 05-13-2013 on the facility policy and procedure for notifying Physician and family. The DON and/or designee will audit resident charts 5 x weekly to determine ongoing compliance. (Attachment A and B). Should non-compliance be noted, immediate corrective action shall be taken.</p> <p>4. The DON and/or designee will report the findings of these audits, and any corrective actions taken, to the QA committee monthly x 3 months and quarterly thereafter.</p> <p>5. 5-13-13</p>		

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	<p>requesting the results, but received no response.</p> <p>The results were received and faxed to the pharmacy on 3/12/13 at 8:00 a.m. The pharmacy indicated they would not be able to deliver the medication to the facility until the normal delivery that night. They indicated the medication could not be obtained from the back up pharmacy. The Nurse's Notes indicated the resident's prescribing physician was contacted and new orders were received. The record lacked an indication of the family being notified of the medication not being given for two days.</p> <p>During an interview with the resident's family on 4/15/13 at 11:05 a.m., the family indicated the facility had not told them the Fazaclo had not been given for two days. The family indicated they had only been informed of the new medication orders. They indicated the Nurse Practitioner had told a family member about the medications not being given on 3/13/13.</p> <p>During an interview on 4/15/13 at 4:08 p.m., the Director of Nursing indicated the facility had not informed the family of the medication not being</p>			

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	<p>available for two days.</p> <p>2.) The clinical record for Resident #7 was reviewed on 4/16/13 at 10:41 a.m.</p> <p>Resident #7's current diagnoses included, but were not limited to, hypertension, diabetes mellitus, congestive heart failure, delusions and depression.</p> <p>A physician's order, dated 1/20/12, indicated Resident #7 was to have her blood sugar checked in the morning and at bedtime. The physician was to be notified if the blood sugar result was below 60 or greater than 350.</p> <p>The "BLOOD GLUCOSE MONITORING RECORD" for March 2013 indicated on March 12 the resident's blood sugar was 24 at 12:20 p.m.</p> <p>The clinical record lacked any information to indicate the physician was notified of the blood sugar result of 24. The nursing note entries dated 3/12/13 were not related to the resident's blood sugar result.</p> <p>During an interview with the RN Consultant on 4/17/13 at 3:00 p.m., additional information was requested</p>			

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	<p>related to the lack of physician notification for Resident #7's blood sugar on 3/12/13.</p> <p>The facility failed to provide any additional information as of exit on 4/17/13.</p> <p>3.) The clinical record for Resident #44 was reviewed on 4/17/13 at 9:35 a.m..</p> <p>Resident #44's current diagnoses included, but were not limited to, hypertension, diabetes mellitus, dementia and depression.</p> <p>A health care plan problem, dated 3/2/13, indicated Resident #44 had diabetes mellitus. One of the interventions for this problem was to "Notify physician of blood sugar result less than 60 or greater than 300".</p> <p>A physician's order, dated 3/20/13, clarified the parameters to notify the physician regarding blood sugar results. The parameters were changed from notifying the physician when the blood sugar result was below 60 or greater than 300, to below 60 or greater than 400.</p> <p>The "BLOOD GLUCOSE MONITORING RECORD" for March,</p>			

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	<p>2013 and the nursing notes for the following dates and times lacked any information related to the physician having been notified of blood sugar results greater than 300:</p> <p>March 2, at 11:30 a.m. blood sugar result of 339. March 15, at 4:30 p.m. blood sugar result of 392. March 15, at 9:00 p.m. blood sugar result of 381. March 16, at 4:30 p.m. blood sugar result of 378. March 18, at 9:00 p.m. blood sugar result of 374.</p> <p>During an interview with the DoN on 4/17/13 at 10:30 a.m., additional information was requested related to the lack of physician notification for Resident #44's blood sugar results in March.</p> <p>During an interview with the DoN on 4/17/13 at 10:47 a.m., she indicated she had no other information to provide regarding the physician notification of the March blood sugar results for the resident.</p> <p>4.) Review of a current, facility policy titled "Hypoglycemia treatment procedure," dated 1/14/09, which was provided by the RN nurse consultant on 4/17/13 at 3:10 p.m., indicated the</p>			

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	<p>following: "The physician shall be notified of hypoglycemia in a timely manner...If a blood glucose is below with or without symptoms....Nursing staff shall document: the results of the blood glucose test, notification of responsible party, specific treatment used, resident response to treatment, and any follow up."</p> <p>Review of a current, facility policy titled "Nursing Department Charting Policy and Procedure," dated 1/08, which was provided by the nurses consultant on 4/17/13 at 11:12 a.m., indicated the following: " Purpose: To accurately document in an organized manner all pertinent information related to the residents in the nurses' notes and other designated sections of the clinical record.... Pertinent Charting (PRN): includes but is not limited to the following....any physical or emotional symptoms or complaint....any condition change refer to shift change report sheet for follow changes.....any follow-up to a new medication or treatment. Shift Charting: Charting each shift will be completed on all residents experiencing a condition change until stable...."</p>			

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	This Federal tag relates to Complaint IN000126181.  3.1-5(a)				

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F000161 SS=B	<p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS</p> <p>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on interview and record review, the facility failed to ensure the purchased surety bond was in an amount large enough to cover the personal fund accounts for 25 residents with personal accounts of the 36 residents residing in the facility. (Residents #3, 7, 28, 34, 43, 39, 11, 26, 21, 14, 35, 24, 15, 9, 30, 42, 36, 5, 22, 4, 10, 46, 18, 29 and 40)</p> <p>Findings include:</p> <p>An interview with Business Office Manager, on 4/16/13 at 11:00 a.m., indicated the facility held a surety bond for \$20,000.00 for the personal funds of residents who deposited funds with the facility.</p> <p>She provided a statement of the personal funds daily ending balance. Review of the bank statements for residents' accounts for January, 2013 indicated on 1/3/13 and 1/4/13 a daily balance of \$22,272.39. Review of bank statements for February and</p>	F000161	<p>F161</p> <ol style="list-style-type: none"> <li>Residents # 3, 7, 28, 34, 43, 39, 11, 26, 21, 14, 35, 24, 15, 9, 30, 42, 36, 5, 22, 4, 10, 46, 18, 29, and 40, were not affected. The Business Office Manager contacted the Corporate Office on 4/16/13 to obtain a new Surety Bond for the amount of \$30,000.00 to ensure that the personal funds of all residents with a trust account were covered.</li> <li>All residents with a resident trust account had the potential to be affected by deficient amount of the Surety Bond. The new Surety Bond was obtained on 4/16/13 in the amount of \$30,000.00 to ensure that the personal funds of all residents with a trust account were covered.</li> <li>The Business Office Manager will monitor the average daily balances of the Resident Trust fund on a monthly basis to assure the Surety Bond will cover the largest balance on the Trust Fund. Business Office Manager will log on the Monthly Resident Trust Reconciliation Form the surety Bond Amount and verify the Surety Bond</li> </ol>	05/13/2013			

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	<p>March of 2013 indicated the daily balance did not exceed the surety bond amount of \$20,0000 dollars.</p> <p>Interview with the Business Office Manager, on 4/16/13 at 11:10 a.m., indicated that the balance was only above the surety bond amount for a short time.</p> <p>Interview with the nurse consultant, on 4/17/13 at 10:00 a.m., indicated the facility did not have a policy on the surety bond. They followed federal and state regulations.</p> <p>3.1-6(i)</p>		<p>continues to cover the balance. Should the bond in place be insufficient, the Business Office Manager will notify the corporate office in an effort corrective action may be taken to increase the bond accordingly.</p> <p>4. Results of the aforementioned monthly audit will be reported to the Quality Assurance Committee monthly x 3 months then quarterly thereafter.</p> <p>5. 5-13-13</p>		

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F000248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide weekend and evening activities for 4 of 4 residents who indicated they were regular activity attendees in a sample of 18 residents who were interviewed regarding the activity program (Residents #39, #26, #24 and #30) and 3 of 3 residents who required staff assistance for attending activities and entertainment. This deficient practice also had the potential to impact 7 of 7 residents who required staff assistance for attending activities and entertainment.</p> <p>Findings Include:</p> <p>1.) During a 4/12/13, 9:09 a.m., interview Resident #30 indicated there were no weekend or evening activities, "They play a movie over the TV channel you can watch in your room on weekends. Weekends are more or less on your own to play games or work puzzles. I do not know what the people who can't</p>	F000248	<p>F248</p> <p>1. Residents # 39, 26, 24, and 30 were interviewed to determine the times and the types of activities they would like to participate in on the weekends and in the evenings. The Activity Director completed a revision of the Activity Calendar to include weekend and evening activities.</p> <p>2. All other alert and oriented residents were interviewed to determine the times and types of activities they would like to participate in on the weekends and evenings. Families of the cognitively impaired residents were contacted to get a better understanding of potential types of activities their family members may be interested in. The Revised Activity Calendar will reflect activities of interest for all residents.</p> <p>3. The Activity Director will interview 3 residents/family members per week x 4 weeks then monthly thereafter, to assure activities provided continue to meet the needs and interests of the residents. The results of the interviews will be shared with</p>	05/13/2013			

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	<p>entertain themselves do." He indicated he was a regular attendee of activities and would attend structured weekend and evening activities if they were offered.</p> <p>Resident #30's record was reviewed on 4/17/13 at 12:30 p.m.</p> <p>Resident #30's current diagnoses included, but were not limited to, congestive heart failure, lower back pain and insomnia.</p> <p>Resident #30 had a current 4/15/13, care plan problem/need regarding his ability to choose activities and "...very social [with] everyone &amp; participates [with] most activities..."</p> <p>2.) During a 4/15/13, 9:34 a.m. interview, Resident #39 indicated there were no activities in the evening or on the weekend. "After supper you go to your room and do the best you can do. You usually just watch TV after supper then go to bed. On the weekend there is not much to do and you get bored. On the weekends you just have to entertain yourself." She indicated she was a regular activity attendee and would attend weekend and evening activities if they were offered. "I do not know what the ones who can't entertain themselves</p>		<p>administration ongoing in an effort to continue to evaluate efficacy of the activity program.</p> <p>4. Results of the aforementioned interviews and any revisions in programming as a result of the interviews will be reported to the QA committee quarterly for review.</p> <p>5. 5-13-13</p>		

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	<p>do on the weekends."</p> <p>Resident #39's record was reviewed on 4/15/13, 3:15 p.m. Resident #39's current diagnoses included, but were not limited to, asthma, dementia and depression.</p> <p>Resident #39 had a current 4/12/13 care plan problem/need regarding the resident's being activity and enjoying activities.</p> <p>3.) During a 4/15/13, 9:09 a.m., interview, Resident #24 indicated "the facility offers evening activities about two times a month." She would enjoy more evening activities. She liked to stay up later, about 10:00 p.m. If she got bored, she went to bed earlier. No one from the activity department worked on the weekend. There were no weekend activities."Sometimes the nurse puts a movie on. [On weekends]. I get bored on weekends. [On weekends] People just sit and watch TV. There is nothing for those who need help to do on the weekends." She indicated she attended activities regularly and would attend on weekends and evening if activities were offered.</p> <p>Resident #24's record was reviewed</p>			

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	<p>on 4/16/13 at 2:30 p.m. Resident #24's current diagnoses included, but were not limited to, anxiety, depression and dementia.</p> <p>Resident #24 had a current 4/12/13 care plan problem/need which indicated the resident could choose her own activities.</p> <p>4.) During a 4/15/13, 11:28 a.m., interview, Resident #26 indicated "there are no evening activities. In the evening, you watch TV. There were no weekend activities. There is not much to do on the weekend so you just nap." She indicated she regularly attended activities and if the facility offered activities of interest on the weekend and in the evening she would attend.</p> <p>Resident #26's record was reviewed on 4/17/13 at 10:40 a.m. Resident #26's current diagnoses included but were not limited to, dementia, cerebral palsy, seizure disorder and episodic mood disorder.</p> <p>Resident #26 had a current 2/28/13 care plan problem/need which indicated she was able to make her own activity preferences.</p> <p>5.) Resident #20's record was</p>			

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	<p>reviewed on 4/16/13, 3:55 p.m. Resident #20's current diagnoses included, but were not limited to, dementia, depression and anxiety.</p> <p>Resident #20 had a current 4/8/13, care plan problem regarding anxiety. An approach to this problem was "Encourage activities of preference such as: TV, being [with] family, conversing."</p> <p>Resident #20 had a current 4/8/13, care plan problem regarding depression. An approach to this problem was "Encourage activities of choice such as: being [with] family, talking about the news."</p> <p>During a 4/11/13, 12:31 p.m., observation, Resident #20 was conversing with a visitor.</p> <p>6.) Resident #38's record was reviewed on 4/17/13 at 10:45 a.m. Resident #38's diagnoses included, but were not limited to, anxiety, hypertension and sick sinus syndrome.</p> <p>Resident #38 had a current 3/4/13, care plan problem regarding anxiety. An approach to this problem was "Encourage activities of preferences such as: TV western, music, snacks,</p>			

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	<p>conversation."</p> <p>Review of Resident #38's activity attendance record for April 1 to 16 2013 indicated he attended and participated in Sensory Stimulation Group and snack activities and one to one activities during week days. However Resident #38 did not participate in any weekend activities.</p> <p>7.) Resident #45's record was reviewed on 4/17/13 at 10:40 a.m. Resident #45's current diagnoses included, but were not limited to, post cerebral vascular accident, depression and dementia.</p> <p>Resident #45 had a current 4/11/13, care plan problem regarding depression. An approach to this problem was "Encourage activities of choice and interest."</p> <p>Review of Resident #45's activity attendance record for April 1 to 16 2013 indicated the resident attended Sensory Stimulation Group and Snack activities during the week and had not attended any activities on the weekend.</p> <p>8.) During a 4/16/13, 12:10 p.m., interview, the Activity Director/Social Service Director indicated the</p>			

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	<p>following:</p> <p>a.) No member of the activity department worked on weekends. No volunteer covered weekend activities. Nursing staff on duty were responsible for weekend activities.</p> <p>b.) 10:00 a.m. Saturday "Social Visit" was staff members assisting the residents to the lounge so they could talk with one another. No staff stay in the room during this event. Residents must initiate and maintain the conversation.</p> <p>c.) 3:00 p.m. Saturday "Afternoon Movie" was staff members assisting the residents to the lounge and playing a movie. This movie was also able to be observed on a channel in the resident's rooms. No staff stay in the room during the activity.</p> <p>d.) Sunday 3:00 p.m. "TV in lounge" was staff members assisting the residents to the lounge where they watch TV as a group. No staff stay in the room during this activity. No one initiated a conversation about the TV program. "Although the TV is on in the lounge most of the time, Sunday TV in lounge is considered an activity because there are more residents in the room."</p>				

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	<p>e.) She tried to schedule weekend activities that "are as easy as possible for the staff to provide."</p> <p>f.) Wednesday and Friday 7:00 p.m. "Table Games" was games left in the activity room and a resident volunteer helped get the game started. This activity was designed for residents who could independently participate in activities.</p> <p>g.) The cognitively impaired residents could go to the lounge for movies or TV on the weekend, but no weekend activities were designed for residents with cognitive impairment.</p> <p>9.) During a 4/17/13, 9:00 a.m., interview, the Activity Director/Social Service Director indicated 7 of the facility's residents were unable to entertain themselves or participate in activities without assistance. Resident #20, #45 and #38 were included in this group.</p> <p>10.) Review of the facility activity calendars for April, March, February and January 2013, which were provided by the Administrator on 4/16/13 at 11:50 a.m. indicated the following:</p>			
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	<p>a.) 17 of 17 Sundays had two activities scheduled "10:00 a.m. -Church and 3:00 p.m. TV in lounge."</p> <p>b.) 17 of 17 Saturdays had two activities scheduled " 10:00 a.m. -Social visit in lounge and 3:00 p.m. Afternoon movie."</p> <p>c.) 34 of 34 Wednesday and Fridays reviewed had "7:00 p.m. Table games" scheduled. No other day had an activity scheduled after the evening meal.</p> <p>3.1-.33(c) 3.1-33(b)</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 record review and interview, the facility failed to ensure physician orders for medications were followed for 1 of 20 residents. [Resident #C]</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 4/17/13 at 9:45 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, type II diabetes mellitus, osteoporosis, macular degeneration and dementia.</p> <p>The resident's current Physician's Orders were signed on 2/7/13. The orders included, but were not limited to, aspirin 81 mg enteric coated give 1 by mouth everyday; surfak [a stool softner] 240 mg capsule give 1 everyday by mouth; hydrochlorothiazide [a diuretic] 12.5 mg one capsule by mouth every morning; levothyroxine [a thyroid medication] 50 mcg [micrograms] tablet take one tablet by mouth everyday; omeprazole dr [for gastro</p>	F000282	<p>F282</p> <ol style="list-style-type: none"> <li>Resident C's physician was notified immediately of medication error and orders were received. The nurse making the medication error was re-educated immediately concerning medication administration and the 5 rights of medication pass, with emphasis placed on identification of the correct resident.</li> <li>Any medication error reports from the past 30 days have again been reviewed to confirm appropriate notifications and to ensure involved staff received appropriate re-education. As all residents could be affected, the licensed nursing staff will be reeducated on 05-13-2013 on the facility policy addressing Medication Administration and the 5 rights of medication administration, with emphasis placed on identification of the correct resident.</li> <li>The facility will continue to identify residents utilizing pictures to assist with correct medication pass and will alert newly hired nurses of the need to reference the pictures during the orientation process. The DON and/or designee will continue to review and evaluate</li> </ol>	05/13/2013	

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	<p>esophageal reflux disease] 20 mg one capsule by mouth once daily; Preservision Areds [eye vitamin] softgel one capsule by mouth two times a day; oyster calcium 500 mg with vitamin D give one tablet by mouth two times a day; Tylenol Arthritis caplet 650 mg take one tablet by mouth two times daily as needed for arthritic pain; acetaminophen 325 mg tablets give 2 tablets by mouth every 4 hours as needed for mild pain or elevated temperature; diphenox-atrop [for diarrhea] 2.5 mg tablets take 2 tablets by mouth 3 times a day as needed for loose stools; Metamucil packet [bulk laxative] mix 1 packet in liquid and give by mouth 2 times a day as needed; and Milk of Magnesia suspension [a laxative] take 30 milligrams by mouth once a day as needed for constipation.</p> <p>The resident had a 2/18/13 quarterly Minimum Data Set assessment including her "Brief Interview for Mental Status" which indicated the resident had no cognitive impairment.</p> <p>During an interview with Resident #C on 4/12/13 at 10:00 a.m., she indicated she had received another resident's medication.</p>		<p>Medication Errors, should they occur, identifying the root cause of the error and ensuring corrective action is taken to mitigate the risk of repeat error.</p> <p>4. Medication Errors, analysis of causal factor, and corrective actions taken shall be reported to the QA Committee on a quarterly basis.</p> <p>5. 5-13-13 pass observation results to the Monthly QA committee every month ongoing.5. 5-13-13</p>		

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	<p>A 3/5/13, 9:50 p.m., "Medication Error Report" indicated the resident was given a Fazaclo [an antipsychotic] 25 mg, simvastatin [for high cholesterol] 40 mg, Klonopin [an anticonvulsant] 0.5 mg, and Namenda [for Alzheimer's disease] 10 mg.</p> <p>A 3/5/13, 10:00 p.m., Nurse's Note indicated "res [resident] nurse into room. Concerned about pills just given to her since she doesn't receive pills @ [at] noc [night.] Res given roommate's pills...."</p> <p>During a 4/15/13, 2:55 p.m., interview with the Director of Nursing, she indicated there was a new nurse working on second shift on 3/5/13. She indicated Resident #C had been given Resident B's medications.</p> <p>This Federal tag relates to Complaint IN00126181.</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure water temperatures were within safe parameters for the 18 residents who resided on the 100 hall. This deficient practice had the potential to impact the 10 residents whom the facility indicated were able to turn on the water by themselves (Resident #30, #24, #41, #25, #36, #44, #42, #37, #11 and #34).</p> <p>Findings Include:</p> <p>On 4/12/13 at 10:15 a.m., resident bathroom 124 was tested and registered 124 degrees Fahrenheit (F).</p> <p>During a 4/12/13, 10:20 a.m., water temperature audit conducted with the Maintenance Supervisor the following resident bathroom temperatures in excess of 120 degrees Fahrenheit were obtained:</p> <p>Resident Room 109 - 123 degrees F Resident Room 106 - 123 degrees F</p>	F000323	<p>F323</p> <p>1. Residents # 30, 24, 41, 25, 36, 44, 42, 37, 11, and 34 had the potential to be affected as water temperatures in their rooms exceeded 120 degrees. There were no negative outcomes due to the issue of the water in rooms exceeding 120 degrees. The Maintenance Supervisor adjusted the hot water heater for the 100 hall on 4/12/13 to a lower heat setting. The 100 hall water temperatures were monitored every hour for every room from 4/12/13 through 4/15/13, and then were monitored randomly through 4/17/13 every 2 hours with no temperatures exceeding 120 degrees.</p> <p>2. All residents in the building have the potential to be affected. Maintenance Supervisor monitored Water temperatures for compliance each day for consistency from 4/12/13-4/17/13 with no negative findings.</p> <p>3. The preventative maintenance program has been revised to include assessing water temperatures in at least 3 random resident rooms from each hall on a weekly basis. Any temperatures</p>	05/13/2013			

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	<p>Resident Room 104 - 121 degrees F Resident Room 119 - 127 degrees F Resident Room 117 - 128 degrees F</p> <p>During a 4/12/13, 10:25 a.m., interview the Maintenance Supervisor indicated he was aware that water temperatures must be under 120 degrees F. He tried to keep temperatures around 115 degrees F. All of the water on the 100 hall was provided by one water heater. The temperatures in excess of 120 degrees posed a risk to the residents and he would adjust the mixing valve immediately in order to reduce water temperatures.</p> <p>On 4/12/13 at 10:50 a.m., the Director of Nursing provided an untitled document which indicated 10 of the 18 residents who lived on the 100 hall were able to turn on the water without any assistance. The form indicated these residents were Resident #30, #24, #41, #25, #36, #44, #42, #37, #11 and #34.</p> <p>Review of a current, facility policy titled " Preventive Maintenance Program " which was provided by the Administrator on 4/17/13 at 8:50 a.m., indicated the following: "Water Temps In that resident room water temperatures are assessed on at</p>		<p>exceeding 120 degrees will be reported immediately to the Administrator and corrective action implemented. ( Attachments D,E,F)</p> <p>4. Maintenance Supervisor will monitor weekly water temperatures as a part of the Preventative Maintenance program. Results of the monitoring, and any corrective actions taken, will be reviewed at least quarterly at the QA meetings.</p> <p>5. 5-13-13</p>				

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	<p>least a quarterly basis with resident room observation, the water temperatures of all shower rooms (both shower and sink temperatures) shall be taken and logged on a weekly basis. These temperatures are of great importance, as the residents are routinely showered / bathed in these areas."</p> <p>3.1-45 (a)(1)</p>			

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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 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 residents were only given antipsychotic medication with proper indications for use and had gradual dose reduction attempted or a statement of contraindication for 2 of 10 residents reviewed for unnecessary medications (Resident #35 and Resident #39).</p> <p>Findings Include:</p>	F000329	<p>F329</p> <ol style="list-style-type: none"> <li>The Physicians of resident #35 and 39 were contacted relative to psychoactive medication use/justification and potential for GDR.</li> <li>The Pharmacy Consultant reviewed records of all residents with ordered psychoactive medications to confirm rationale for use, and evaluate potential for Gradual Dose Reduction. Applicable Physicians were notified immediately of any pharmacy</li> </ol>	05/13/2013

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	<p>1.) Resident #35's record was reviewed on 4/16/13 at 10:25 a.m. Resident #'35's current diagnoses included, but were not limited to hypertension, depression and Parkinson's disease.</p> <p>Resident #35 had a current 4/13 physician's order for: Zyprexa (an antipsychotic medication) 2.5 mg one time daily. This order originated 2/8/13.</p> <p>Resident #35's record lacked documentation of any behavioral symptoms or clinical indication for the use of an antipsychotic medication prior to the initiation of this medication. Since Resident #35 had received the medication, the clinical record lacked any documented behavioral symptoms or clinical indication for the use of an antipsychotic medication.</p> <p>Resident #35 had a 2/4/13, admission, Minimum Data Set (assessment) which indicated the resident did not display maladaptive behaviors.</p> <p>During a 4/16/13, 11:40 a.m. interview, the Director of Nursing (DoN) indicated Resident #35 was started on Zyprexa for hallucination's</p>		<p>recommendations. The Pharmacy Consultant will monitor monthly for response to recommendations from the prior review, with notification of the DON and/or the Administrator, should concern be noted in regard to physician response and/or lack of response.</p> <p>3. The DON will monitor Psychotropic drugs and Resident behaviors at the monthly behavior meetings, in an effort to ensure appropriate rationale is present and documented for revised dosage and/or addition of a psychoactive medication. Should concerns be noted, corrective action shall be taken, including re-education and/or clarification sought by the physician, as indicated (Attachment G)</p> <p>4. The Pharmacy Consultant and/or designee will report the findings of monthly audits to the QA Committee meeting monthly x 3 months, then quarterly thereafter. The DON and/or designee will report findings of the psychotic Monitoring Audits and any corrective actions taken to the QA committee meeting monthly x 3 months then quarterly thereafter.</p> <p>5. 5-13-13</p>				

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	<p>associated with Parkinson's disease. She indicated the facility staff never witnessed any hallucinations. The family had witnessed the hallucinations and told the facility Resident #35 was seeing things run across the floor in her room and also felt someone was out to get her. The DoN additionally indicated the facility staff never witnessed any of the symptoms and had not asked the family to get a staff when the resident had the symptoms in order to observe and assess the resident when these events were occurring. The DoN indicated the family had literature they wanted the doctor to read regarding the use of antipsychotic medication to treat Parkinson's hallucinations. This literature was faxed to the physician and he ordered the antipsychotic medication in response to the family's request. The physician's did not come in to assess the resident in response to the request. The physician did order a urinary culture be completed prior to starting the medication and if the resident was infection free to then start the antipsychotic medication. The DoN indicated the facility had never witnessed any hallucinations or paranoid thinking by Resident #35.</p> <p>During a 4/17/13, 1:11 p.m.,</p>			

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	<p>interview, the Activity Assistant indicated Resident #35 was pleasant and co-operative and had never displayed negative behaviors.</p> <p>During a 4/17/13, 1:32 p.m., interview, CNA #1 indicated Resident #35 had never displayed any behaviors which caused the resident distress or impacted the resident's quality of life or quality of care.</p> <p>During a 4/15/13, 9:59 a.m., observation, Resident #35 was seated in her recliner in her room napping.</p> <p>2.) Resident #39's record was reviewed on 4/15/13, 3:15 p.m. Resident #39's current diagnoses included, but were not limited to, asthma, dementia and depression.</p> <p>Resident #39 had a current 4/13 (no day) physician's order for Abilify 0.25 mg daily at bed time (an antipsychotic medication also used to treat depression). This order originated 10/7/11.</p> <p>Resident #39's clinical record indicated a gradual dose reduction of this medication had not been attempted since it had been started for the resident.</p>			

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	<p>Resident #39 had a 9/28/12 pharmacy recommendation which indicated Abilify and the medication Risperdone were both due for a gradual dose reduction. The physician's response addressed the Risperdone, but not the Abilify.</p> <p>Review of Resident #39's "Mood and Behavior Monthly Flow Record" for April 2013 (1-15), March, 2013, February 2013, and January 2013 indicated the resident had not displayed any maladaptive behaviors during this period.</p> <p>Review of Resident #39's Nursing Notes from 4/16/13 to 1/9/13 contained no documented behaviors.</p> <p>Resident #39 had a 1/10/13, Quarterly, Minimum Data Set Assessment which indicated the resident did not display maladaptive behaviors.</p> <p>During a 4/16/13, 10:05 a.m., interview, the DoN indicated Resident #39's Abilify had never been reduced since it was started on 10/7/11. She indicated the resident did not currently display behaviors that negatively impacted her life or care.</p>			

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	<p>During a 4/17/13, 1:05 p.m., interview, CNA #2, indicated Resident #39 did not have behaviors that negatively impacted the resident's quality of life or quality of care.</p> <p>During a 4/17/13, 1:07 p.m., interview, RN #3 indicated Resident #39 did not have behaviors that negatively impacted the resident's quality of life or quality of care.</p> <p>During a 4/17/13, 1:11 p.m., interview, the Activity Assistant indicated Resident #39 had strong opinions but never had behaviors that negatively impacted her quality of life or quality of care.</p> <p>During a 4/27/13, 1:30 p.m., interview, CNA #4 indicated Resident #39 did not have behaviors which negatively impacted her quality of life or quality of care.</p> <p>During a 4/17/13, 1:32 p.m., interview, CNA #1 indicated Resident #39 did not have behaviors which negatively impacted the residents quality of life or quality of care. Review of a current, facility policy titled "Antipsychotic Drug Use Policy," which was provided by the RN consultant on 4/17/13 9:00 a.m., indicated the following:</p>			

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	<p>"Purpose: to ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practical mental, physical, and psychosocial well-being.....In addition, the use of an antipsychotic must meet the criteria and applicable, additional requirements listed below: Criteria: Since diagnosis alone do not [sic] the warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria.... a. The symptoms are identified as being due to mania or psychosis.... b. The behavioral symptoms present a danger to the resident or to others. c. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress, a significant decline in function, and or substantial difficulty receiving needed care. "</p> <p>3.1-48(a)(4) 3.1-48(b)(2)</p>				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the Consultant Pharmacist reviewed medication orders to ensure directions were clear to understand for 2 of 10 residents reviewed for unnecessary medications. (Resident #'s 7, and 37)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #7 was reviewed on 4/16/13 at 10:41 a.m.</p> <p>Resident #7's current diagnoses included, but were not limited to, hypertension, diabetes mellitus, congestive heart failure, delusions and depression.</p> <p>Current physician's orders for Resident #7 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a medication for pain) 325</p>	F000428	<p>F428</p> <p>1. The Physician of Resident #7 was notified immediately and medications clarified to include the pain level at which "as needed" pain medications would be administered (i.e., mild, moderate, severe). Resident # 37's Physician was notified immediately and medications were clarified to include the pain level at which "as needed" pain medications would be administered (mild, moderate, severe).</p> <p>2. The Pharmacy consultant reviewed all resident records to assure PRN medication orders included appropriate instruction/direction regarding appropriate administration. For example, the pain level at which "as needed" pain medications should be given. Any Pharmacy recommendations made as a result of this review were followed up immediately. The licensed nursing staff will be re-educated on 05-13-2013 regarding the facility policy for administering</p>	05/13/2013	

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	<p>milligrams (mg) 2 capsules by mouth every 4 hours as needed for pain and/or temperature. The original order date was 4/19/12.</p> <p>b. Tylenol with Codeine #3 (a medication for pain) 325 mg/30 mg give 1 or 2 tablets by mouth every 4 hours as needed for pain. The original order date was 4/19/12.</p> <p>c. Ultram (a medication for pain) 50 mg give 2 tablets by mouth every 8 hours as needed for pain. The original order date was 4/19/12.</p> <p>The clinical record lacked any information or directions from the physician related to the pain level at which the "as needed" pain medications should be given.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 1/24/13, 2/28/13, and 3/28/13 with no recommendations having been made for the Tylenol, the Tylenol with Codeine #3, or the Ultram "as needed" orders.</p> <p>During an interview with the RN Consultant on 4/17/13 at 3:00 p.m., additional information was requested related to the lack of physician</p>		<p>medications, and Charting policy and procedure.</p> <p>3. The DON and/or designee will audit the PRN medication Administration records 5 x per week to determine PRN orders are followed as ordered. (Attachment H) Should concerns be noted, corrective action shall be taken. The Pharmacy Consultant will continue to monitor all records on a monthly basis to assure resident PRN orders include appropriate directive/instruction in regard to administration.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA Committee monthly x 3 months and quarterly thereafter. The Pharmacy consultant will report findings to the QA committee monthly x 3 months than quarterly thereafter.</p> <p>5. 5-13-13</p>	

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	<p>clarification of pain medication orders for Resident #7.</p> <p>The facility failed to provide any additional information as of exit on 4/17/13.</p> <p>2.) The clinical record for Resident #37 was reviewed on 4/17/13 at 1:41 p.m.</p> <p>Resident #37's current diagnoses included, but were not limited to, rheumatoid arthritis, neuropathy, and depression.</p> <p>Current physician's orders for Resident #37 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a medication for pain) 500 milligrams (mg) 2 capsules by mouth every 6 hours as needed for pain and/or temperature. The original order date was 3/20/13.</p> <p>b. Vicodin 5-500 (a medication for pain ) 5 mg hydrocodone and 500 mg acetaminophen 1 tablet by mouth every 4 times a day as needed. The original order date was 2/8/13.</p> <p>c. Ultracet 37.5- 325 (a medication for pain) 37.5 mg tramadol and 325 mg acetaminophen 1 tablet by mouth</p>			

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	<p>every 6 hours as needed for pain. The original order date was 3/20/13.</p> <p>The clinical record lacked any information or directions from the physician related to the pain level at which the "as needed" pain medications should be given.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 2/28/13 and 3/28/13 with no recommendations having been made for the Tylenol, the Vicodin, or the Ultracet "as needed" orders.</p> <p>During an interview with the RN Consultant on 4/17/13 at 3:00 p.m., additional information was requested related to the lack of physician clarification of pain medication orders for Resident #37.</p> <p>The facility failed to provide any additional information as of exit on 4/17/13.</p> <p>Review of the current undated facility policy, titled "CONSULTANT PHARMACIST," provided by the RN Consultant on 4/17/13 at 3:30 p.m., included, but was not limited to, the following:</p>			

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	<p>"...Procedures...</p> <p>...5. Report irregularities in drug acquisition, storage, handling, administration, and disposition in writing to the administrator and director of nursing...."</p> <p>3.1-25(h) 3.1-25(i) 3.1-25(b)</p>				

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F000514 SS=D	<p>483.75(I)(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 record review and interview, the facility failed to ensure medication orders were complete and dosage information was clear to ensure medications were given correctly and for accurate indication for 2 of 10 residents reviewed for unnecessary medications. (Resident #'s 7, and 37)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #7 was reviewed on 4/16/13 at 10:41 a.m. Resident #7's current diagnoses included, but were not limited to, hypertension, diabetes mellitus, congestive heart failure, delusions and depression.</p> <p>Current physician's orders for</p>	F000514	<p>F514</p> <p>1. The Physician of Resident #7 was notified immediately and medications clarified to include the pain level at which "as needed" pain medications would be administered (i.e., mild, moderate, severe). Resident # 37's Physician was notified immediately and medications were clarified to include the pain level at which "as needed" pain medications would be administered (mild, moderate, severe).</p> <p>2. The Pharmacy consultant reviewed all resident records to assure PRN medication orders included appropriate instruction/direction regarding appropriate administration. For example, the pain level at which "as needed" pain medications should be given. Any Pharmacy</p>	05/13/2013			

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	<p>Resident #7 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a medication for pain) 325 milligrams (mg) 2 capsules by mouth every 4 hours as needed for pain and/or temperature. The original order date was 4/19/12.</p> <p>b. Tylenol with Codeine #3 (a medication for pain) 325 mg/30 mg give 1 or 2 tablets by mouth every 4 hours as needed for pain. The original order date was 4/19/12.</p> <p>c. Ultram (a medication for pain) 50 mg give 2 tablets by mouth every 8 hours as needed for pain. The original order date was 4/19/12.</p> <p>The clinical record lacked any information or directions from the physician related to the pain level at which the "as needed" pain medications should be given.</p> <p>During an interview with the RN Consultant on 4/17/13 at 3:00 p.m., additional information was requested related to the lack of physician clarification of pain medication orders for Resident #7.</p> <p>The facility failed to provide any</p>		<p>recommendations made as a result of this review were followed up immediately. The licensed nursing staff will be re-educated on 05-13-2013 regarding the facility policy for administering medications, and Charting policy and procedure.</p> <p>3. The DON and/or designee will audit the PRN medication Administration records 5 x per week to determine PRN orders are followed as ordered. (Attachment H) Should concerns be noted, corrective action shall be taken. The Pharmacy Consultant will continue to monitor all records on a monthly basis to assure resident PRN orders include appropriate directive/instruction in regard to administration.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA Committee monthly x 3 months and quarterly thereafter. The Pharmacy consultant will report findings to the QA committee monthly x 3 months than quarterly thereafter.</p> <p>5. 5-13-13</p>		

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	<p>additional information as of exit on 4/17/13.</p> <p>2.) The clinical record for Resident #37 was reviewed on 4/17/13 at 1:41 p.m. Resident #37's current diagnoses included, but were not limited to, rheumatoid arthritis, neuropathy, and depression.</p> <p>Current physician's orders for Resident #37 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a medication for pain) 500 milligrams (mg) 2 capsules by mouth every 6 hours as needed for pain and/or temperature. The original order date was 3/20/13.</p> <p>b. Vicodin 5-500 (a medication for pain ) 5 mg hydrocodone and 500 mg acetaminophen 1 tablet by mouth every 4 times a day as needed. The original order date was 2/8/13.</p> <p>c. Ultracet 37.5- 325 (a medication for pain) 37.5 mg tramadol and 325 mg acetaminophen 1 tablet by mouth every 6 hours as needed for pain. The original order date was 3/20/13.</p> <p>The clinical record lacked any information or directions from the</p>			

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NAME OF PROVIDER OR SUPPLIER  OAKBROOK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>physician related to the pain level at which the "as needed" pain medications should be given.</p> <p>During an interview with the RN Consultant on 4/17/13 at 3:00 p.m., additional information was requested related to the lack of physician clarification of pain medication orders for Resident #37.</p> <p>The facility failed to provide any additional information as of exit on 4/17/13.</p> <p>Review of a current, facility policy titled "Nursing Department Charting Policy and Procedure" with a date of 1/08 was received for the nurse consultant on 4/17/13 11:12 a.m. It indicated the following: "Purpose: to accurately document in an organized manner all pertinent information related to the resident in the nurses' notes and other designated sections of the clinical record..... be complete,concise and factual."</p> <p>3.1-50 (a)(1) 3.1-50 (a)(2)</p>						