| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 07/02/2015 |
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| UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY | 1380 E COUNTY LINE RD S<br>INDIANAPOLIS, IN 46227 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00174871.<br><br>This visit was in conjunction with the Investigation of Complaint IN00176856.<br><br>Complaint IN00174871 - Substantiated. No deficiencies related to the allegation(s) are cited.<br>Survey dates: June 24, 25, 26, 29, and 30, 2015 and July 1 and 2, 2015<br><br>Facility number: 000220<br>Provider number: 155327<br>AIM number: 100267650<br><br>Census bed type:<br>SNF: 21<br>SNF/NF: 137<br>Total: 158<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 114<br>Other: 30<br>Total: 158<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC | F 0000 | Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. University Heights Health and LivingCommunity respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a PostSurvey Re-visit on or after 07.24.15. | |

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

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

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| | 16.2-3.1. | | | |
| F 0278<br>SS=D<br>Bldg. 00 | 483.20(g) - (j)<br>ASSESSMENT<br>ACCURACY/COORDINATION/CERTIFIED<br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br>Based on interview and record review, the facility failed to ensure the Minimal Data Set (MDS) assessments accurately | F 0278 | Corrective Action: It is the practice of this community to provide complete assessments that accurately reflect the status of its residents. The MDS for | 07/24/2015 |

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| | reflected the residents' status for 2 of 4 residents reviewed for urinary incontinence (Resident #250 and Resident #265), and 1 of 3 residents reviewed for functional limitation in range of motion (Resident #1), for 28 Stage II residents reviewed for accuracy of the assessment.<br>Findings include:<br>1. The clinical record for Resident #250 was reviewed on 06/29/2015 at 2:19 p.m. Diagnoses included, but were not limited to, chronic airway obstruction and depressive disorder.<br>The 5-day MDS (Minimum Data Set) assessment Section H0300 completed on 02/07/2015, assessed Resident #250 as always being continent of urine.<br>A review of the voiding record dated 02/01/2015 through 02/07/2015, for Resident #250 for 7 days prior to the 5-day MDS assessment, indicated Resident #250 had 1 urine incontinence episode on 02/02/2015.<br>During an interview on 06/30/2015 at 3:15 p.m., the MDS Coordinator indicated the MDS assessment section H0300 dated 02/07/2015, for Resident #250 was coded incorrectly. The MDS | | residents #250, #265, and #1 were modified, in accordance with the Resident Assessment Instrument Comprehensive User Manual, and re-submitted. How others are identified: Section H0300 of the MDS for residents who are identified as having urinary incontinence and Section G0400 functional limitation in range of motion will be audited by the MDS Coordinator/designee, and modifications will be completed as indicated.<br>Systemic Change: In-service training relative to MDScoding and completion will be completed by the MDS Coordinator by 07.16.15. MDS coordinator/designee will review vital signs report for urinary incontinence. Based on RAI manual guidelines, the MDS coordinator/designee will complete the assessment. The Unit Managers will complete initial assessments to identify residents with functional limitation. MDS coordinator/designee will review documentation and assess individual resident for complete passive ROM of all joints in upper and lower extremities. A second check will be performed by a licensed nurse, trained in MDS completion, to ensure the assessments are accurate. The community will ensure each section of the assessment accurately reflects a resident's status by performing at least five random audits weekly (to be | |

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| | Coordinator indicated section H0300 should have been coded as occasionally incontinent of urine.<br>A review of Signature of Persons Completing the Assessment or Entry/Death Reporting, section Z04000 dated 02/11/2015, indicated the MDS Coordinator signed this section, certifying that the accompanying information accurately reflected resident assessment information for Resident #250.<br>The Resident Assessment Instrument Comprehensive User Manual, Version 3.0, copy right 2009, page 578 indicated, " ...Z0400: Signatures of Persons Completing the Assessment ....Item Rationale - To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement .... "<br>2. The clinical record for Resident #265 was reviewed on 06/29/2015 at 3:11 p.m. Diagnoses included, but were not limited | | completed by the MDS Coordinator) and at least three random audits weekly (to be completed by the Corporate MDS Consultant. These audits will be on-going with no stop date Monitoring: MDS audit tool (attachment #1) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by MDS Coordinator and/or designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI teamwill re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | to, depressive disorder and ischemic heart disease.<br>The Admission MDS (Minimum Data Set) assessment section H0300 completed on 02/06/2015, assessed Resident #265 as occasionally being incontinent of urine.<br>A review of the voiding record dated 01/31/2015 through 02/06/2015, for Resident #265 for 7 days prior to the Admission MDS assessment, indicated Resident #265 had 7 urine incontinence episodes total on 01/31/2015, 02/03/2015, 02/04/2015, 02/05/2015, and 02/06/2015.<br>During an interview on 06/30/2015 at 3:15 p.m., the MDS Coordinator indicated the MDS assessment section H0300 dated 02/06/2015, for Resident #265 was coded incorrectly. The MDS Coordinator indicated section H0300 should have been coded as frequently incontinent of urine.<br>A review of Signature of Persons Completing the Assessment or Entry/Death Reporting, section Z04000 dated 02/09/2015, indicated the MDS Coordinator signed this section, certifying that the accompanying | | | |

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| | information accurately reflects resident assessment information for Resident #265.<br>The Resident Assessment Instrument Comprehensive User Manual, Version 3.0, copy right 2009, page 578 included, " ...Z0400: Signatures of Persons Completing the Assessment ....Item Rationale - To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement ....<br>3. The clinical record of Resident #1 was reviewed on 7/1/15 at 11:33 a.m. Diagnoses for the resident included, but were not limited to, hand contracture (shortening of muscle tissue making it resistant to stretching), paraplegia and shoulder pain.<br><br>An observation on 6/24/15 at 2:00 p.m. indicated Resident #1 had a contracture of his left hand and neck. The resident indicated and demonstrated he was unable to open his left hand or hold his head in an upright position. | | | |

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| | A quarterly Minimum Data Set (MDS) assessment, dated 5/28/15, indicated Resident #1 had no functional limitation of the upper and lower extremities. The Assessment Administration page for this MDS indicated, "I certify that the accompanying information accurately reflects resident assessment information for this resident..." and was signed by RN #6 on 5/29/15.<br><br>On 7/1/15 at 11:56 a.m., RN #6, who signed the MDS, indicated the functional limitation assessment of the resident was not accurate, and should have indicated Resident #1 had impairment to both sides of his upper and lower extremities.<br><br>3.1-31(i) | | | |
| F 0282<br>SS=D<br>Bldg. 00 | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, interview, and record review, the facility failed to provide services in accordance with the residents' written plan of care in that a resident receiving a blood thinner did not have laboratory monitoring of the blood | F 0282 | CorrectiveAction: It is the practice of this community to provide services by qualified persons in accordance with each resident's written plan of care.<br>PT/INR orders were reviewed and followed for Resident #4. An | 07/24/2015 |

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| | levels (Resident #4 ), a resident receiving an antipsychotic medication lacked monitoring for abnormal involuntary movements (Resident #25), nail care, oral care, and the removal of facial hair was not provided to dependent residents (Resident #224 and Resident #85 ).<br><br>Findings include:<br><br>1. The clinical record of Resident #4 was reviewed on 7/2/15 at 3:58 p.m. Diagnoses for the resident included, but were not limited to, atrial fibrillation (an irregular, often rapid heart beat which can lead to blood clots forming in the heart).<br><br>A physician's order dated 5/1/15, indicated Resident #4 was to receive Coumadin 1.5 milligrams on Sunday, Tuesday, Thursday, and Saturday, and 1.0 milligram on Monday, Wednesday, and Friday. Coumadin is a medication that thins the blood and causes an increased risk for bleeding.<br><br>A care plan dated 7/18/13, current through 9/30/15, indicated a problem of the resident being at risk for bruising related to anticoagulant therapy. An approach was, "PT/INR per MD [medical doctor] order. Report results to MD."<br><br>Review of an Anticoagulant Monthly | | AIMS assessment was completed for resident #20. The nails of resident #224 were trimmed. Resident #85 was shaved and provided oral care. How other residents will be identified: Audits were performed by the DON and/or designee from 06.30.15 through 07.02.15 of all resident's requiring PT/INR monitoring (attachment #2), all residents currently receiving antipsychotics (attachment #3), and all residents requiring assistance with ADLs (attachment #4) to ensure compliance with orders. Based on audits, AIMS will be/have been completed for residents who are currently receiving an anti-psychotic if one has not been completed within the last 90 days and/or there has been an increase in the dose of the antipsychotic medication. Additionally, ADL care will be provided for residents to include nail care and shave should the audit identify residents in need of additional care. Systemic changes: In-service training will be completed by 07.16.15 by the Director of Nursing regarding PT/INR, orders, ADL care and AIMS. Upon receipt of an order, a charge nurse and/or nurse designee will input the PT/INR order into the electronic medical record system and record the order in the PT/INR log. The PT/INR log will be reviewed Monday through Friday by the Unit Managers and/or DON and | |

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| | Tracking Form, dated May 2015, indicated the physician had changed the resident's Coumadin dose on 5/9/15 and ordered a recheck of the resident's PT/INR on 5/16/15. A PT/INR is a laboratory blood test which measures how long it takes the blood to clot (stop bleeding). A PT/INR was not done on 5/16/15. According to the nurses' notes and tracking form another PT/INR was not done until 5/30/15.<br><br>The tracking form indicated a PT/INR was done on 6/19/15, and the physician wanted another one done, "next week." No results of this blood test were found in the resident's record. On 7/2/15 at 4:57 p.m., the Director of Nursing indicated no PT/INR blood tests had been done since 6/19/15 and one would be done immediately.<br><br>2. The clinical record of Resident #25 was reviewed on 6/30/15 at 1:43 p.m. Diagnoses for the resident included, but were not limited to, senile dementia, depressive disorder, and delusional disorder.<br><br>A physician's order, dated 3/13/15, indicated Resident #25 was to start receiving Seroquel, 25 milligrams every evening. The resident received the first dose on 3/14/15. Seroquel is an | | on weekends by the nurse manager on duty. All logs will be submitted to the DON for review Monday through Friday. The DONand/or designee will review the log for accuracy and completion. Upon admission, a nurse will input the new orders and verify all orders with another licensed nurse. Monday through Friday the unit manager (nurse manager on duty during the weekend) will conduct the Unit Manager Admission audit and ensure all medications are available and administered. The Unit Manager/designee will submit the audit and the clinical admission packet to Medical Records. The medical records nurse/designee will complete the medical records admission audit and ensure all medication has been administered and is available. All audits will be submitted to the DON/designee for additional review. Unit manager/designee will complete the cart audit with new admissions. Receiving nurse will input orders on a daily basis. Social services director/designee will review all antipsychotic orders for the building and will direct unit manager/designee to complete an AIMS when necessary. Deficient practice will immediately be brought to the attention of the Director of Nursing and immediate corrective action will be taken. To assist in monitoring ADLs each resident will have an | |

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| | antipsychotic medication used for treatment of depression, schizophrenia and bipolar disorder. Side effects can include abnormal involuntary movements.<br><br>A care plan for Resident #25, dated 3/23/15 and current through 8/19/15, indicated the resident had a diagnosis of delusional disorder that required the use of antipsychotic medication. Approaches included, "Complete a Routine AIMs [Abnormal Involuntary Movement scale] observation...on 3rd Tue [Tuesday] of Every 6th Month..."<br><br>On 6/29/15 at 2:00 P.M. the Administer provided a policy titled Behavior Management Program, dated October, 2013, and indicated it was the policy currently used by the facility. The policy indicated, "AIMS monitoring will be performed within 48 hours of a new anti-psychotic medication... increased dosage...new admission admitted with an anti-psychotic medication...AIMS monitoring will be done every 6 months after the initial AIMS assessment..."<br><br>No AIMS was present in Resident #25's record after Seroquel was initiated on 3/14/15. On 7/1/15 at 12:05 p.m., Social Service staff #20 indicated an AIMS assessment had not been performed on | | associate assigned to them. The assigned representatives will assist in monitoring the resident to ensure compliance with ADL care. Monitoring: The Unit Manager's Admission (attachment #5 and #5A), Unnecessary Drugs (attachment #6), PT/INR log (attachment #2), and ADL (attachment #4) audit tools will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | Resident #20 when the Seroquel was started.<br><br>3. The clinical record of Resident #224 was reviewed on 7/1/15 at 9:17 a.m. Diagnoses for the resident included, but were not limited to, muscle weakness and diabetes mellitus. Diabetes is a condition where the body is not able to effectively transport sugar from the blood into the cells. Diabetics are prone to infection.<br><br>On 6/26/15 at 9:21 a.m., Resident #224 was observed to have very long nails on his left hand. There appeared to be dirt under the nails. The resident indicated his nails, "needed some work."<br><br>An admission Minimum Data Set assessment, dated 6/26/15, indicated the resident needed extensive assistance of 1 staff for personal hygiene.<br><br>A care plan for the resident, dated 5/7/15 and current through 8/6/15, indicated Resident #224 needed extensive assistance with his activities of daily living. Approaches included, "Assist Resident to finish hygiene/dressing/grooming..."<br><br>On 6/29/15 at 5:05 p.m., the Corporate Nurse Consultant provided a policy titled, "Care of Fingernails/Toenails," dated | | | |

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| | October, 2010, and indicated it was the policy currently used by the facility. The policy indicated fingernails needed daily cleaning and regular trimming, and the date and time that nail care was given should be recorded in the resident's record. The policy indicated, "Unless otherwise permitted, do not trim the nails of diabetic residents..." On 7/1/15 at 12:10 p.m., the Corporate Nurse Consultant indicated nurses were permitted to<br>trim the fingernails of diabetics in the facility.<br><br>4. During a Stage 1 interview with Resident #85 on 6/26/15 at 3:45 p.m., the resident indicated the staff would sometimes assist with removing facial hair and providing oral care, and sometimes would not. Facial hair was observed to be approximately 1/4 inch in length on the chin, and debris was noted in the resident's teeth. Resident #85 voiced a preference for having a clean shaven face and for having oral care provided on a regular basis.<br><br>The clinical record review of Resident #85, completed on 6/29/15 at 3:42 p.m., indicated the resident had contractures (fixed resistance to passive stretch of a muscle) of both hands. | | | |

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| NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227 | |

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| | A written care plan dated 6/28/15, indicated the resident required total assistance of staff for the performance of Activities of Daily Living (ADLs), including hygiene, grooming, and dressing.<br><br>During an interview with the resident on 6/29/15 at 3:43 p.m., the resident indicated no staff had offered to shave the hair on the chin since last week, which was observed to be longer and more pronounced than on 6/26/15, and oral care had not been provided. While talking with the resident Certified Nursing Assistant (CNA) #14 entered the room, and indicated the resident had requested to be changed. When asked about the facial hair on the chin, CNA #14 indicated the resident had not asked to be shaved but ensure the resident was shaved before leaving the room.<br><br>During an interview with the Director of Nursing (DON) and the Administrator on 6/26/29/15 at 5:00 p.m., the DON provided shower sheets for the month of June 2015 for Resident #85. A sheet dated 6/26/15, indicated the resident received a shower and was shaved during the shower. The DON and Administrator were informed of the comments from Resident #85 and the continued presence of facial hair. | | | |

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| | During an interview with the Corporate Nurse Consultant on 7/1/15 at 12:10 p.m., the Nurse Consultant indicated the electronic record system currently used by the facility did not have an area where the provision of specific ADLs could be documented, including shaving and oral care. The Nurse Consultant indicated the expectation was for the staff to shave residents as the resident preferred and to provide oral care at least twice a day and more often if needed.<br><br>3.1-35(g)(2) | | | |
| F 0312<br>SS=D<br>Bldg. 00 | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>Based on record review, observation, and interview, the facility failed to ensure activities of daily living (ADL's) services were provided for care of fingernails (Resident #224), facial hair and oral care (Resident #85) for 2 of 8 residents who met the criteria for review of activities of daily living.<br><br>Findings include: | F 0312 | Corrective Action: It is the practice of this community to provide services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, personal and oral hygiene. The nails of resident #224 were trimmed. Resident #85 was shaved and provided oral care. How other residents will be identified: An audit was | 07/24/2015 |

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| | 1. The clinical record of Resident #224 was reviewed on 7/1/15 at 9:17 a.m. Diagnoses for the resident included, but were not limited to, muscle weakness and diabetes mellitus. Diabetes is a condition where the body is not able to effectively transport sugar from the blood into the cells. Diabetics are prone to infection.<br><br>On 6/26/15 at 9:21 a.m., Resident #224 was observed to have very long nails on his left hand. There appeared to be dirt under the nails. The resident indicated his nails, "needed some work."<br><br>An admission Minimum Data Set assessment, dated 6/26/15, indicated the resident needed extensive assistance of 1 staff for personal hygiene.<br><br>A care plan for the resident, dated 5/7/15 and current through 8/6/15, indicated Resident #224 needed extensive assistance with his activities of daily living. Approaches included, "Assist Resident to finish hygiene/dressing/grooming..."<br><br>On 6/29/15 at 5:05 p.m., the Corporate Nurse Consultant provided a policy titled, "Care of Fingernails/Toenails," dated October, 2010, and indicated it was the policy currently used by the facility. The | | performed by the DON and/or designee from 06.30.15 through 07.02.15 of all resident's requiring assistance with ADLs to ensure compliance with orders.<br>Systemic changes: In-service training will be completed by 07.16.15 by the Director of Nursing regarding ADL care. Certified Nursing Assistants will complete ADLs for their assigned residents in accordance with identified needs, preferences, and policy. Charge Nurses will be responsible to ensure care needs are met to include nail care, shaving, and oral care. Each resident will have an associate assigned to them. The assigned representatives will assist in monitoring the resident to ensure compliance with ADL care.<br>Monitoring: An ADL audit (attachment #4) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | policy indicated fingernails needed daily cleaning and regular trimming, and the date and time that nail care was given should be recorded in the resident's record. The policy indicated, "Unless otherwise permitted, do not trim the nails of diabetic residents..."<br><br>On 7/1/15 at 12:10 p.m., the Corporate Nurse Consultant indicated nurses were permitted to trim the fingernails of diabetics in the facility.<br><br>2. During a Stage 1 interview with Resident #85 on 6/26/15 at 3:45 p.m., the resident indicated the staff would sometimes assist with removing facial hair and providing oral care and sometimes would not. Facial hair was observed to be approximately 1/4 inch in length on the chin and debris was noted in the resident's teeth. Resident #85 voiced a preference for having a clean shaven face and for having oral care provided on a regular basis.<br><br>The clinical record review of Resident #85, completed on 6/29/15 at 3:42 p.m., indicated the resident had contractures (fixed resistance to passive stretch of a muscle) of both hands.<br><br>A written care plan dated 6/28/15, indicated the resident required total | | | |

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| | assistance of staff for the performance of Activities of Daily Living (ADLs), including hygiene, grooming, and dressing.<br><br>During an interview with the resident on 6/29/15 at 3:43 p.m., the resident indicated no staff had offered to shave the hair on the chin since last week, which was observed to be longer and more pronounced than on 6/26/15, and oral care had not been provided. While talking with the resident Certified Nursing Assistant (CNA) #14 entered the room, and indicated the resident had requested to be changed. When asked about the facial hair on the chin, CNA #14 indicated the resident had not asked to be shaved but ensure the resident was shaved before leaving the room.<br><br>During an interview with the Director of Nursing (DON) and the Administrator on 6/26/29/15 at 5:00 p.m., the DON provided shower sheets for the month of June 2015 for Resident #85. A sheet dated 6/26/15, indicated the resident received a shower and was shaved during the shower. The DON and Administrator were informed of the comments from Resident #85 and the continued presence of facial hair.<br><br>During an interview with the Corporate | | | |

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| | Nurse Consultant on 7/1/15 at 12:10 p.m., the Nurse Consultant indicated the electronic record system currently used by the facility did not have an area where the provision of specific ADLs could be documented, including shaving and oral care. The Nurse Consultant indicated the expectation was for the staff to shave residents as the resident preferred and to provide oral care at least twice a day and more often if needed.<br><br>3.1-38(a)(3)(C)<br>3.1-38(a)(3)(D)<br>3.1-38(a)(3)(E) | | | |
| F 0329<br>SS=D<br>Bldg. 00 | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>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.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic | | | |

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| | 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.<br><br>Based on record review and interview, the facility failed to ensure a resident receiving an anticoagulant medication to prevent blood clots was monitored for the effectiveness of the medication (Resident #4), and residents receiving antipsychotic medications were monitored for side effects (Residents #25 and #130) for 3 of 5 residents who met the criteria for review of unnecessary medication use.<br><br>Findings include:<br><br>1. The clinical record of Resident #4 was reviewed on 7/2/15 at 3:58 p.m. Diagnoses for the resident included, but were not limited to atrial fibrillation, an irregular, often rapid heart beat which can lead to blood clots forming in the heart.<br><br>A physician's order dated 5/1/15, indicated Resident #4 was to receive Coumadin 1.5 milligrams on Sunday, Tuesday, Thursday, and Saturday, and 1.0 milligram on Monday, Wednesday, and Friday. Coumadin is a medication | F 0329 | Corrective Action: It is the practice of this community to provide that resident's drug regimens are free from unnecessary drugs. A PT/INR was completed for resident #4. AIMS assessments were completed for resident#25 and #130. How other residents will be identified: Audits were performed by the DON and/or designee from 06.30.15 through 07.02.15 of all resident's requiring PT/INR monitoring and all residents currently receiving antipsychotics. Based on audits, AIMS will be/have been completed for residents who are currently receiving an antipsychotic if one has not been completed within the last 90 days and/or there has been an increase in the dose of the antipsychotic medication. Additionally, PT/INR will occur for residents identified. Systemic changes: In-service training will be completed by 07.16.15 by the Director of Nursing regarding PT/INR, orders and AIMS. Upon receipt of an order, a charge nurse and/or nurse designee will input the PT/INR order into the | 07/24/2015 |

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| | that thins the blood and causes an increased risk for bleeding.<br><br>A care plan dated 7/18/13, current through 9/30/15, indicated a problem of the resident being at risk for bruising related to anticoagulant therapy. An approach was, "PT/INR per MD [medical doctor] order. Report results to MD."<br><br>Review of an Anticoagulant Monthly Tracking Form, dated May 2015, indicated the physician had changed the resident's Coumadin dose on 5/9/15, and ordered a recheck of the resident's PT/INR on 5/16/15. A PT/INR is a laboratory blood test which measures how long it takes the blood to clot (stop bleeding). A PT/INR was not done on 5/16/15. According to the nurses' notes and tracking form, another PT/INR was not done until 5/30/15.<br><br>The tracking form indicated a PT/INR was done on 6/19/15, and the physician wanted another one done, "next week." No results of this blood test were found in the resident's record. On 7/2/15 at 4:57 p.m., the Director of Nursing indicated no PT/INR blood tests had been done since 6/19/15, and one would be done immediately.<br><br>2. a. The clinical record of Resident #25 | | electronic medical record system and record the order in the PT/INR log. The PT/INR logwill be reviewed Monday through Friday by the Unit Managers and/or DON and on weekends by the nurse manager on duty. All logs will be submitted to the DON for review Monday through Friday. The DONand/or designee will review the log for accuracy and completion. Upon admission, a nurse will input the new orders and verify all orders with another licensed nurse. Monday through Friday the unit manager (nurse manager on duty during the weekend) will conduct the Unit Manager Admission audit and ensure all medications are available and administered. The Unit Manager/designee will submit the audit and the clinical admission packet to Medical Records. The medical records nurse/designee will complete the medical records admission audit and ensure all medication has been administered and is available. All audits will be submitted to theDON/designee for additional review. Unit manager/designee will complete the cart audit with new admissions. Receiving nurse will input orders on a daily basis. Social services director/designeewill review all antipsychotic orders for the community and will direct unit manager/designee to complete an AIMS. Non-compliant practice | |

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| | was reviewed on 6/30/15 at 1:43 p.m. Diagnoses for the resident included, but were not limited to, senile dementia, depressive disorder, and delusional disorder.<br><br>A physician's order, dated 3/13/15, indicated Resident #25 was to start receiving Seroquel, 25 milligrams every evening. The resident received the first dose on 3/14/15. Seroquel is an antipsychotic medication used for treatment of depression, schizophrenia and bipolar disorder. Side effects can include abnormal involuntary movements.<br><br>On 6/29/15 at 2:00 P.M. the Administer provided a policy titled Behavior Management Program, dated October, 2013, and indicated it was the policy currently used by the facility. The policy indicated, "AIMS [abnormal involuntary movement scale] monitoring will be performed within 48 hours of a new anti-psychotic medication... increased dosage...new admission admitted with an anti-psychotic medication...AIMS monitoring will be done every 6 months after the initial AIMS assessment..."<br><br>No AIMs was found in Resident #25's record after Seroquel was initiated on 3/14/15. On 7/1/15 at 12:05 p.m., Social | | will immediately be brought to the attention of the Director of Nursing and immediate corrective action will be taken. Monitoring: The Unit Manager's Admission audit (attachment #5 and #5A), PT/INR log audit (attachment #2), and Unnecessary Drugs (attachment #6) audit tools will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | Service staff #20 indicated an AIMS assessment had not been performed on Resident #20 when the Seroquel was started.<br><br>2.b. The clinical record review of Resident #130, completed 7/1/15 at 11:54 a.m., indicated the resident had diagnoses including, but not limited to, dementia with delusions.<br><br>The recapitulation of physician's orders dated 12/1/14 through 7/1/15, indicated the resident was prescribed quetiapine (an antipsychotic medication used to bipolar disorder) 25 mg (milligrams) once a day starting on 12/31/14. A resident with bipolar disorder may have mood swings ranging from depression to extreme excitability. Resident #130 had a current physician's order for quetiapine 25 mg every day for the treatment of delusional disorder.<br><br>Antipsychotic medications have been known to cause abnormal involuntary movements. The resident was first assessed for abnormal involuntary movements using an AIMS (Abnormal Involuntary Movement Scale) on 4/8/15, 98 days after the medication was prescribed.<br><br>During an interview with the Social | | | |

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| | Services Director (SSD) on 7/1/15 at 2:44 p.m., the SSD indicated the AIMS assessment must have been missed at the time of admission, as the resident was admitted with an order for quetiapine and an AIMS assessment should have been completed.<br><br>The 34th Edition Nursing 2014 Drug Handbook, copyright 2014, indicated quetiapine was not indicated for use in elderly residents with dementia related psychosis and residents receiving the medication should be monitored for tardive dyskinesia (a movement disorder caused by taking antipsychotic medications) and extrapyramidal effects (drug induced movement disorders).<br><br>3.1-48(a)(3) | | | |
| F 0425<br>SS=D<br>Bldg. 00 | 483.60(a),(b)<br>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure | | | |

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| | the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on record and interview, the facility failed to ensure a newly admitted resident received physician ordered medication in a timely manner. (Resident #309)<br><br>Finding include:<br><br>The clinical record of Resident #309 was reviewed on 6/29/15 at 2:23 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus. Diabetes is a condition where the body is unable to produce enough insulin to effectively transport sugar from the blood stream into the body's cells.<br><br>Resident #309 was admitted to the facility on 6/19/15 at 9:44 a.m.<br><br>During an interview on 6/25/15 at 11:03 a.m., the resident indicated, "I didn't get any insulin for 24 hours after I arrived."<br><br>Physician orders dated 6/19/15, indicated the resident was to receive 6 units of NovoLog insulin every morning at 8:00 | F 0425 | Corrective Action: It is the practice of this community to provide routine and emergency drugs. Resident #309 receives physician ordered medication in a timely manner. An audit for all residents receiving insulin was completed by the DON/designee on 07.02.15. If discrepancies were found, physician and family notification was done and corrective measures were taken for identified residents. Systemic Change: In-service training relative to obtaining medications on new admissions, use of the EDK and obtaining medications from the back up pharmacy, if needed will be completed by 07.16.15, by the Director of Nursing. Upon admission the admitting nurse will communicate medication orders to the pharmacy. The afterhour's pharmacy system will be utilized for new orders that occur after hours if the drug is not in the EDK. If the medication is not available from the pharmacy, the backup pharmacy will be contacted for supply. Education will include:<br>·Procedure for ordering | 07/24/2015 |

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| | a.m., and 8 units of NovoLog insulin every day at 12:00 p.m. and 5:00 p.m.<br><br>A review of a Medication Administration Record(MAR) for the resident indicated she did not get any NovoLog insulin on 6/19/15. The resident received her first dose on 6/20/15.<br><br>Physician orders dated 6/20/15 indicated the resident was to receive Levemir insulin 30 units twice a day at 8:00 a.m. and 8:00 p.m. A review of a MAR for the resident indicated she did receive her first dose of the Levemir insulin until 6/21/15.<br><br>On 7/1/15 at 1:53 p.m., the Director of Nursing and Executive Director indicated Resident #309 should have received her NovoLog insulin on the day of her admission, and her Levemir insulin on the day it was ordered. The nurses should have checked to see if the insulins were in the EDK (emergency drug kit). If not, they should have notified the physician, then notified the pharmacy that the insulin was needed right away. If the pharmacy couldn't provide it right away, then, "We can get it from a local pharmacy. The resident should have had her insulin."<br><br>Review of an Emergency Drug Kit | | medications for admits/readmits or needed medication and the systemic changes described above.<br>·Useof the EDK<br>·Importance of timely drug administration<br>·Notification of the DON or administrative nurse when medications are not available.<br>Monitoring: Admission Chart Review (attachment #5) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | supply list, provided by the Nurse Consultant on 7/1/15 at 1:50 p.m., indicated NovoLog insulin was in the EDK.<br><br>On 7/1/15 at 1:53 p.m., the Director of Nursing provided a policy titled Focus of the Month New Admissions & Readmissions, dated June, 2015, and indicated it was the policy currently used by the facility. The policy indicated, "Use the EDK (Emergency Drug Kits) when needed for first dosing. The patient does not need to wait for a delivery if it is available in the EDK."<br><br>On 7/1/1 at 12:30 p.m. the Nurse Consultant provided an undated policy titled Admission & Readmission orders, and indicated it was the policy currently used by the facility. The policy indicated, "5. Any admission or readmission medications needed on a more urgent basis should be called in to the pharmacist."<br><br>3.1-25(a) | | | |
| F 0441<br>SS=E<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to | | | |

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| | provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on record review and interview, the facility failed to ensure two-step tuberculin skin tests were administered to new employees (Dietary Aide #1, Certified Nursing Assistant (CNA) #3 and CNA #5) and previously hired | F 0441 | Corrective Action: It is the practice of this community to provide and maintain an Infection Control Program that provides a safe, sanitary, and comfortable environment and helps to prevent the development and | 07/24/2015 |

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| | employees received their annual tuberculin skin test (Housekeeper #2 and Cook #4) for 5 of 11 employees reviewed for having tuberculin skin tests.<br><br>Findings include:<br><br>A review of employee records on 7/1/15 at 3:00 p.m. indicated the following:<br><br>Dietary Aide #1 was hired on 12/2/14. She received her 1st step tuberculin skin test on 12/1/14. No 2nd step was found in the record.<br><br>CNA #3 was hired on 6/9/15. She received her 1st step tuberculin skin test on 6/5/15. No 2nd step was found in the record.<br><br>CNA #5 was hired on 4/14/15. She received her 1st step tuberculin skin test on 4/7/15. No 2nd step was found in the record.<br><br>Housekeeper #2 was hired on 9/28/06. An annual tuberculin skin test was not found in the record.<br><br>Cook #4 was hired on 9/27/02. An annual tuberculin skin test was not found in the record.<br><br>On 7/2/15 at 10:35 a.m., the Executive | | transmission of disease and infection. Employees #1, #3, #5, #2, and #4 received tuberculin skin tests or chest x-ray where skin test was contraindicated. How other residents will be identified: An audit of all active employees was performed from 07.06.15 through 07.08.15 by the Human Resources Director/designee to ensure compliance with tuberculin skin testing. Employees identified as requiring follow-up were tested per facility policy and state and federal regulation. Systemic changes: The HR Director, Administrator, and Director of Nursing receivedin-service training on tuberculin skin testing on 07.13.15 by the Nurse Educator. Prior to an employee's orientation the HR Director will review each personnel file utilizing the Employee Records audit tool (see attachment #8) to ensure compliance. The personnel file and audit tool will be reviewed by the ED/designee for compliance. Employee's whose records are found to be out of compliance will not be allowed to begin employment until all requirements have been satisfied. Additionally, the HR Director/designee will ensure annual compliance through monthly auditing of employee records based onthe date of the last tuberculin skin test. Test will be administered annually. Employees will be | |

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| | Director indicated she was not able to find where any of the above missing tuberculin skin tests had been administered.<br><br>3.1-18(a) | | removed from service until compliance with tuberculin skin testing (chest x-ray where contraindicated) is achieved. Monitoring: The Employee Records audit tool (attachment#8) will be completed for six months for new hires with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95%threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |
| F 0504<br>SS=D<br>Bldg. 00 | 483.75(j)(2)(i)<br>LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br>The facility must provide or obtain laboratory services only when ordered by the attending physician.<br>Based on record review and interview, the facility failed to ensure a physician's order was received prior to drawing laboratory blood tests for 1 of 5 residents reviewed for having physician orders for laboratory blood tests done to monitor medication usage. (Resident #4)<br><br>Findings include: | F 0504 | Corrective Action: It is the practice of this community to provide laboratory services that are ordered by the physician. An order was obtained for laboratory services for Resident #4. How other residents will be identified: An audit was completed on orders for residents who required PT/INRs. Systemic changes: In-service training will be | 07/24/2015 |

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| | The clinical record of Resident #4 was reviewed on 7/2/15 at 3:58 p.m. Diagnoses for the resident included, but were not limited to atrial fibrillation, an irregular, often rapid heart beat which can lead to blood clots forming in the heart. The resident received warfarin, an anticoagulant medication taken to help prevent blood clots.<br><br>Review of a Anticoagulant Monthly Tracking Form for the resident, received from the Director of Nursing on 7/2/15 at 4:35 p.m., indicated a PT/INR blood test (a test used to measure the time it takes blood to clot) was performed for the resident on 5/16/15 and 6/11/15. No orders from the physician were found in the resident's record for these laboratory tests.<br><br>On 7/2/15 at 4:47 p.m., the Director of Nursing indicated the facility did not have orders for these blood tests.<br><br>3.1-49(f)(1) | | completed by 07.16.15 by the Director of Nursing regarding orders. Upon receipt of an order, a charge nurseand/or nurse designee will input the PT/INR order into the electronic medical record system and record the order in the PT/INR log. The PT/INR log will be reviewed Monday through Friday by the Unit Managers and/or DON and on weekends by the nurse manager on duty to verify the existence of the order in the electronic medical record. If the order is not found, the charge nurse/designee will contact the physician for order clarification. Non-compliant practice will immediately bebrought to the attention of the Director of Nursing and immediate correctiveaction will be taken. Monitoring: The PT/INR log audit tool (attachment #2) will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practicewill result in disciplinary action up to and including separation of the responsible employee. | |

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| F 0514<br>SS=D<br>Bldg. 00 | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>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.<br><br>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.<br>Based on record review and interview, the facility failed to ensure a resident's wishes regarding cardiopulmonary resuscitation were clearly and accurately documented in the resident's record for 1 of 2 residents who met the criteria for death review. (Resident #98)<br><br>Findings include:<br><br>The clinical record of Resident #98 was reviewed on 6/29/15 at 2:52 p.m. Diagnoses for the resident included, but were not limited to, impaired kidney function.<br><br>Resident #98 was admitted to the facility on 2/10/15. She passed away at the facility on 2/24/15. | F 0514 | Corrective Action: It is the practice of this community to maintain clinical records on each resident in accordance with accepted professional standards of practice. Resident #98 no longer resides in the facility. How others are identified: A code status audit (attachment #9) for all residents was completed by Medical Records on 06.29.15 If discrepancies are found, code status directives will be verified with the resident/responsible party, as well as an order obtained from the physician. Systemic Change: In-service training will be completed by 07.16.15 by the Director of Nursing regarding clinical records. Upon admission the admitting nurse will input the new orders and verify with another licensed nurse all orders. Monday through Friday the unit manager | 07/24/2015 |

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| | The resident's discharge instructions, prior to admission on 2/10/15, from a local hospital indicated the resident was a, "Full Code" status at the time of discharge, meaning the resident wanted cardiopulmonary resuscitation performed if needed.<br><br>Her admission physician's orders, dated 2/10/15, indicated the resident did not want cardiopulmonary resuscitation performed, if needed, and therefore, was, "DNR [Do Not Resuscitate]."<br><br>A Resident Admission Record, dated 2/10/15, indicated Resident #98 was, "Full Code."<br><br>The History and Physical performed by the physician on 2/17/15, indicated the resident was, "Full Code."<br><br>A nurses's note, dated 2/23/15, indicated the resident's condition was declining, and Resident #98 was a, "Full Code" and the resident's daughter was coming to the facility to sign a DNR form.<br><br>Another physician's order, dated 2/23/15, indicated Resident #98 was a, "DNR (honored at time of death)."<br><br>On 6/30/15 at 11:52 a.m., the Director of Nursing (DON) indicated if a resident | | (weekend manager on duty on weekends) will conduct the Unit Manager Admission audit and submit to medical records. The medical records nurse will complete the medical records admission audit. All audits will be submitted to the DON/designee for additional review. Monitoring: The code status audit (attachment #9) and Unit Manager's Admission audit (attachment #5 and #5A) tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months and then monthly for three months by DNS/designee. The tool will be reviewed monthly by the QAPI committee for six months after which the QAPI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. | |

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| | stopped breathing, nursing would go to the Resident Admission Record to check the resident's code status. This status indicated the resident was a, "Full Code."<br><br>On 6/3015 at 11:52 a.m., the DON and Executive Director (ED) indicated, when a resident was admitted, the nurse put in the admitting orders, another nurse checked the orders for accuracy, the orders were reviewed by medical records to make sure they were entered correctly, and the physician reviewed the orders prior to signing them. The ED indicated she had spoken with the nurse who entered the DNR order when the resident was admitted on 2/10/15, and the nurse indicated she did not know why she would have entered DNR instead of Full Code, as indicated on admission records (prior to 2/23/15). The ED indicated the facility was currently doing a full house audit to make sure the code statuses of all the residents were accurate.<br><br>On 7/2/15 at 2:10 p.m.. the Nurse Consultant indicated the DNR order dated 2/10/15 was a, "transcription error. The resident's admitting code status order should have been, "Full Code."<br><br>3.1-50(a)(2) | | | |

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