

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 24,25,26,27, 28, and 29 2014</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Survey team: Tina Smith Staats, RN-TC Karen Lewis, RN Ginger McNamee, RN Toni Maley, BSW (August 25, 26, 27 and 28 2014)</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 9 Medicaid: 72 Other: 27 Total: 108</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted to meet requirements established by state and federal law.</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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F000157 SS=D	<p>Quality review completed on September 8, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal 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</p>				

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	<p>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 observation, interview and record review, the facility failed to notify the resident's physician when a resident experienced a change in condition that could result in the need to alter medication or treatment regarding weight loss and refusal of treatment for 2 of 3 residents reviewed for physician's notification (Residents #20 and #64).</p> <p>Findings include:</p> <p>1. Resident #20's clinical record was reviewed on 8/28/14 at 2:00 p.m. The resident's diagnoses included, but were not limited to, liver transplant, chronic kidney disease, diabetes type II, hypertension, hyperlipidemia, hypothyroidism, anxiety, and osteoarthritis.</p> <p>The resident had a 9/9/13, physician's order for an ammonia level to be drawn every Tuesday on day shift. This order was changed on 7/22/14 to be checked on 8/22/14 and then every six months.</p> <p>Review of the resident's record indicated the resident had an ammonia level drawn on 4/1/14 and 5/20/14. The record lacked</p>	F000157	<p>It is the policy of this facility to provide notification to resident's physician and responsible party as directed by physician orders and with any change of condition that is noted in the medical record. The weekly ammonia order for Resident #20 was discontinued on 8/29/14 as the resident had requested and lab staff noted on the lab order on April 14, 2014. The weekly labs were obtained as ordered through April 8, 2014. At that time the resident began refusing the draws and refused three times in a row and told the lab that he no longer wanted the weekly draws. Labs were revised on 9/17/14 for CBC,CM. Ammonia, Bilirubin, tacrolimus q 6 months. A lab audit was conducted on August 29, 2014 to see if any other residents had been affected. No other residents were affected by this practice. A second audit was conducted on September 20-21, 2014 as part of the monthly lab audit process. The outcomes have been reviewed by the nursing management team and results forwarded to the Monthly Quality Assurance and Improvement Committee for monitoring the next three months and as needed thereafter. Nurses</p>	09/28/2014

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	<p>an indication of the ammonia levels being checked on the following Tuesdays: April 8, 15, 22, 29, 2014. May 6, 13, 27, 2014. June 3, 10, 17, 24, 2014. July 1, 8, 15, 2014.</p> <p>This resulted in the resident missing 14 ammonia level blood draws. The record lacked any indication of why the test was not performed and lacked an indication of the physician being notified of the test not being performed.</p> <p>An interview with the Director of Nursing on 8/29/14 at 1:25 p.m., indicated the lab had notified the facility of the resident refusing to have his blood drawn and they would discontinue the order if he refused again. She indicated the lab recommended the physician be notified of the resident's refusals. She indicated the physician had not been notified.</p> <p>2. The clinical record for Resident #64 was reviewed on 8/27/14 at 3:06 p.m. Diagnoses for Resident #64 included, but were not limited to, Alzheimer's disease, congestive heart failure, diabetes, and hypertension.</p> <p>A physician's order, dated 9/19/12, indicated Resident #64 was to be weighed daily. The physician was to be notified if the resident had a weight gain</p>		<p>educated by the Director of Clinical Education under the direction of the Director of Nursing Services on 9/24/14 on Changes of Condition and Notification of physician and family as appropriate using the facility's "Clinical Health Status/Change of Condition Guidelines." Charts will be reviewed by the Unit Managers and DNS by 9/28/14 for physician orders and physician and family notification of changes. Results will be forwarded to the Quality Improvement Committee for the next six months and as needed thereafter, based on audits showing over 5% deficiency.</p>				

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	<p>of 2 pounds daily or a 4 pound weight gain weekly.</p> <p>Review of the June and July, 2014 Medication Administration Records (MARs) indicated the following daily weights:</p> <p>6/18/14 - 236 pounds (lbs) and 6/19/14 - 239 lbs., a weight gain of 3 lbs. 6/30/14 - 238 lbs and 7/1/14 - 241 lbs., a weight gain of 3 lbs. 7/6/14 - 234 lbs and 7/7/14 - 240.6 lbs., a weight gain of 6.6 lbs. 7/8/14 - 235.5 lbs and 7/9/14 - 238 lbs., a weight gain of 2.5 lbs.</p> <p>The clinical record lacked any documentation of the physician having been notified of the daily weight gains for Resident #64 on 6/19/14, 7/1/14, 7/7/14, and 7/9/14.</p> <p>During an interview with The Dementia Unit Manager on 8/29/14 at 12:58 p.m., she indicated she did not have any documentation to provide regard physician notification of Resident #64's weight gain. She further indicated the physician should have been notified of the resident's weight gains.</p> <p>A current, 2013, facility policy, titled "Clinical Health Status/Change of</p>			

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F000242 SS=D	<p>Condition Guideline" indicated the following: "The process for identification of change of condition includes gathering of objective data and documenting assessment findings, resident response, physician and family notification. ...What action or recommendation is needed to correct the problem."</p> <p>3.1 - 5(a)(2) 3.1 - 5(a)(3)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to honor a resident's choice/preference regarding the number of showers or baths desired each week for 1 of 17 residents interviewed regarding bathing choices. (Resident #99)</p> <p>Findings Include: During a 8/25/14, 0:03 a.m., interview Resident #99, who was deemed reliable</p>	F000242	It is the policy of the facility to promote the resident's right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care. The care plan for resident #99 has been updated to reflect her desire for three showers a week. She has selected Monday, Wednesday, and Sunday prior to going to church. The Shower Sheets for resident #99 verify that she has received her showers on these	09/28/2014			

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	<p>during the stage 1 survey process, indicated the facility told her she can have 2 showers a week. She indicated she desired to have 3 showers a week. She indicated the facility was aware of her desire to have 3 showers a week.</p> <p>The clinical record for Resident #99 was reviewed on 8/27/14 at 9:44 a.m. The diagnoses for Resident #99 included, but were not limited to, Parkinson's disease, depression, arthritis, and paralysis agitans.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/20/14, indicated Resident #99 had no cognitive limitations, made her own choices, understood others, and was understood by others.</p> <p>During an interview on 8/28/14 at 2:11 p.m., the C Wing Unit Manager indicated residents were assigned shower days according to their room number. The resident were then interviewed to determine their preference for morning or evening showers and how often they would like a shower. The C Wing Unit Manager provided the C Wing shower schedule and Resident #99 was scheduled to have a shower on Tuesdays, Fridays and Saturdays on second shift.</p>		<p>days. Other alert and oriented residents on the skilled unit were interviewed on 9/21-9/24/14 to assure that no other residents had been affected. No other residents verbalized and concern with their shower schedules. Unit Managers collect and review the shower sheets daily to assure schedules are honored and showers are given RN Supervisor reviews on weekends. Staff educated on the importance of allowing the residents the right to make choices. Portions of the Resident Interview regarding choices will be used weekly times 4 weeks to interview 8 residents each week on their right to make choices. Results will be reviewed in the Quality Assurance and Improvement Committee monthly for monitoring for 6 months and thereafter as needed based on any noted deficient practice related to resident choice.</p>		

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	<p>During an interview on 8/28/14 at 2:49 p.m., CNA #3 indicated she regularly worked second shift on hall C-3. CNA #3 indicated Resident #99 liked to receive more than 2 showers a week. CNA #3 indicated Resident #99 liked to have a shower on Saturday night for church on Sunday. CNA # 3 indicated if a resident refused a shower the nurse was informed and the CNA documented the refusal on the shower sheet.</p> <p>Review of July and August 2014, bathing documentation, indicated Resident #99 received a shower or full bed bath on the following days:</p> <p>Shower on 7/4/14, and a shower on 7/11/14 - 6 days without a shower or a full bed bath. Full bed bath on 7/29/14, and a shower on 8/8/14 - 9 days without a shower or a full bed bath. Shower on 8/15/14, and a shower on 8/21/14 - 5 days without a shower or a full bed bath.</p> <p>Review of the July and August 2014, shower sheets, indicated no documentation of refusals of showers for Resident #99.</p> <p>During an interview on 8/29/14 at 1:27 p.m., the C Wing Unit Manager indicated</p>			

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F000279 SS=D	<p>Resident #99 should have received 3 showers a week per her preference.</p> <p>3.1-3(u)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans to address targeted behaviors for residents who used psychoactive medications for 2 of 5 residents reviewed for care plan development related to psychoactive medication use. (Resident #68 and</p>	F000279	The policy of the facility is to use the results of the assessment to develop review, and revise the resident's comprehensive plan of care that includes a measurable objectives, timetables to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the	09/28/2014	

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	<p>#124).</p> <p>Findings include:</p> <p>1. Resident #68's record was reviewed on 8/28/14 at 12:40 p.m. Resident #68's current diagnoses included, but were not limited to, Alzheimer's disease, depression and vascular dementia. Resident #68 had a current physician's order for Seroquel (an anti-psychotic medication) 25 mg tabs- 1 tab every 8 hours for vascular dementia with delusions. This order originated 2/25/14.</p> <p>Resident #68 had a 7/4/14, annual, Minimum Data Set (M.D.S.) assessment which indicated the resident rarely made choices and resisted care 1 to 3 days of the assessment period. Resident #68 had "Behavior Monthly Flow Sheets" for July and August 2014 which indicated the facility was monitoring the resident for hallucinations/delusions, agitation, finger painting feces.</p> <p>Resident #68's record lacked a care plan regarding the targeted behaviors being treated by the use of the anti-psychotic medication Seroquel.</p> <p>During an 8/29/14, 9:00 a.m., The Dementia Unit Director indicated</p>		<p>comprehensive assessment. the care plan for resident #68 was updated to reflect target behaviors of hallucinations/delusions, finger painting with feces, yelling and cursing. Behavioral monitoring sheets are used to quantitatively document episodes of the behaviors. The care plan for resident #124 was updated to reflect target behaviors for the use of Zyprexa, Zolofit and Lorazepam. These behaviors include, delusions, thinking someone is going to kill me, sadness, feeling hopeless, tearfulness, and anxiety when in a crowd.all residents on the Alzheimer's Unit were audited for the presence of target behaviors on the plans of care. All care plans have been updated to reflect those identified behaviors that are monitored and treated with the psychoactive drugs. An audit sheet is used at each care plan meeting to verify that anyone on psychoactive drugs has a care plan in place that addresses target behaviors for which the drugs are used. Social Service Directors are responsible to monitor for ongoing compliance. The Interdisciplinary Care Plan team will be educated on this process on 9/24/14. Random audits will be conducted by the Director of Nursing Services or her designee monthly for three months and as needed thereafter for continued monitoring.</p>				

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	<p>hallucinations/delusions, agitation and finger painting with feces were Resident #68's target behaviors for the use of the anti-psychotic medication. He indicated a care plan to address the targeted behaviors had not been created before a survey inquiry on 8/28/14. He indicated this lack of a care plan had simply been an oversight.</p> <p>2. The clinical record for Resident #124 was reviewed on 8/27/14 at 9:27 a.m. Diagnoses for Resident #124 included, but were not limited to, dementia, anxiety, psychosis (delusions), and depression.</p> <p>Current physician's orders for Resident #124 included, but were not limited to the following orders:</p> <p>a. Zyprexa (an antipsychotic medication) 2.5 milligrams (mg) by mouth daily at bedtime. The original date of this order was 7/2/14.</p> <p>b. Zoloft (an anti-depressant medication) 50 mg give 100 mg by mouth daily. The original date of this order was 5/9/14.</p> <p>c. Lorazepam (an anti-anxiety medication) 1 mg by mouth every 8 hours. The original date of this order was 5/8/14.</p>				

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F000282 SS=D	<p>Resident #124 had a 6/2/14, quarterly, Minimum Data Set (M.D.S.) assessment which indicated the resident had severe cognitive impairment.</p> <p>Resident #124 lacked health care plans with specific targeted behaviors for the use of her antipsychotic, anti-depressant, and anti-anxiety medications.</p> <p>During an interview on 8/29/14 at 1:44 p.m., the Dementia Unit Director indicated he did not have any health care plans with specific targeted behaviors for Resident #124 regarding her use of antipsychotic, anti-depressant, and anti-anxiety medications.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow residents' plan of care related to obtaining laboratory tests (Resident #20) and physician notification of weight gain (Resident #64) as ordered for 2 of 23 residents reviewed for care plans.</p>	F000282	The policy of the facility is that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan or care. The order for weekly ammonia levels has been discontinued as per the resident's wishes and physician's order. The ammonia levels were obtained as	09/28/2014

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	<p>Findings include:</p> <p>1. Resident #20's clinical record was reviewed on 8/28/14 at 2:00 p.m. The resident's diagnoses included, but were not limited to, liver transplant, chronic kidney disease, diabetes type II, hypertension, hyperlipidemia, hypothyroidism, anxiety, and osteoarthritis.</p> <p>The resident had a 9/9/13, physician's order for an ammonia level to be drawn every Tuesday on day shift. This order was changed on 7/22/14 to be checked on 8/22/14 and then every six months.</p> <p>The resident's current care plan included a focus of liver transplant. The care plan originated on 5/15/12. The interventions for the focus were "...Labs as per ordered Notify physician of any changes".</p> <p>Review of the resident's record indicated the resident had an ammonia level drawn on 4/1/14 and 5/20/14. The record lacked an indication of the ammonia levels being checked on the following Tuesdays: April 8, 15, 22, 29, 2014. May 6, 13, 27, 2014. June 3, 10, 17, 24, 2014. July 1, 8, 15, 2014. This resulted in the resident missing 14 ammonia level blood draws. The record</p>		<p>ordered through April 8, 2014. On the 14th of April, the resident began refusing and refused the next three attempts to draw the ammonia level. He told Medlab that he no longer wanted the weekly draws and the lab noted on the lab report the resident's wishes and stated that the physician should be contacted for an order to discontinue the labs at the resident's request. The resident's wishes were honored, but staff delayed in obtaining the discontinue order. That oversight has been corrected. A lab audit was completed on August 29, 2014 and again on September 20-21, 2014 to see if other residents had been affected. No other residents had been affected. Lab audits will be done weekly by the RN weekend manager to verify ongoing compliance. Results will be reviewed by the Director of Nursing Services or her designee as an ongoing practice. Trends or patterns will be referred to the Quality Assurance and Improvement Committee for continued monitoring. The physician reviewed the weight fluctuations for resident #64 for 6/19/14, 7/1/14, 7/7/14, and 7/9/14. Staff will be educated on the Daily Weight Monitoring and reporting requirements on 9/24/14. Unit managers conducted a daily weight audit to assure all daily weights had been obtained and reported as</p>				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304			
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	<p>lacked any indication of why the test was not performed and lacked an indication of the physician being notified of the test not being performed.</p> <p>An interview with the Director of Nursing on 8/29/14 at 1:25 p.m., indicated the lab had notified the facility of the resident refusing to have his blood drawn and they would discontinue the order if he refused again. She indicated the lab recommended the physician be notified of the resident's refusals. She indicated the physician had not been notified.</p> <p>2. The clinical record for Resident #64 was reviewed on 8/27/14 at 3:06 p.m. Diagnoses for Resident #64 included, but were not limited to, Alzheimer's disease, congestive heart failure, diabetes, and hypertension.</p> <p>A health care plan focus, initiated 3/10/11, indicated Resident #64 had impaired cardiovascular status. Interventions for this focus included, but was not limited to, monitor weight and notify physician of weight gain/loss.</p> <p>A health care plan focus, initiated 5/16/11, indicated Resident #64 had potential for alteration in hydration. Interventions for this focus included, but was not limited to, monitor weight and</p>		<p>ordered. Unit managers will conduct audits monday-friday to verify ongoing compliance with obtaining and reporting daily weights. Variances will be reported to the Director of Nursing Services in daily clinical meetings for follow up. Results will be forwarded to the Quality Assurance and Improvement Committee for 3 months and as needed thereafter for continued monitoring.</p>				

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	<p>notify physician of weight gain/loss.</p> <p>A physician's order, dated 9/19/12, indicated Resident #64 was to be weighed daily. The physician was to be notified if the resident had a weight gain of 2 pounds daily or a 4 pound weight gain weekly.</p> <p>Review of the June and July, 2014 Medication Administration Records (MARs) indicated the following daily weights:</p> <p>6/18/14 - 236 pounds (lbs) and 6/19/14 - 239 lbs., a weight gain of 3 lbs. 6/30/14 - 238 lbs and 7/1/14 - 241 lbs., a weight gain of 3 lbs. 7/6/14 - 234 lbs and 7/7/14 - 240.6 lbs., a weight gain of 6.6 lbs. 7/8/14 - 235.5 lbs and 7/9/14 - 238 lbs., a weight gain of 2.5 lbs.</p> <p>The clinical record lacked any documentation of the physician having been notified of the daily weight gains for Resident #64 on 6/19/14, 7/1/14, 7/7/14, and 7/9/14.</p> <p>During an interview with The Dementia Unit Manager on 8/29/14 at 12:58 p.m., she indicated she did not have any documentation to provide regard physician notification of Resident #64's</p>			

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F000309 SS=D	<p>weight gain. She further indicated the physician should have been notified of the resident's weight gains.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure daily monitoring of a fistula was completed for 1 of 1 resident reviewed for dialysis (Resident #61) and failed to monitor for edema in 2 of 2 residents reviewed for edema (Resident #131 and Resident #113).</p> <p>Findings include:</p> <p>1. Resident #61's clinical record was reviewed on 8/27/14 at 10:58 a.m. The resident's diagnoses included, but were not limited to, hypertension, chronic kidney disease, pulmonary hypertension, atrial fibrillation, mitral and aortic valve stenosis.</p>	F000309	Errors indicated please see the attached	09/28/2014	

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	<p>The record indicated Resident #61's fistula in the left arm and went out for dialysis on Mondays, Wednesdays and Fridays.</p> <p>The Nursing Progress Notes dated from 8/1/14 through 8/25/14, indicated the following:</p> <p>Resident #61 had dialysis without post dialysis assessment for the following dates: 8/1/14, 8/4/14, 8/6/14, 8/11/14, 8/13/14, 8/15/14, 8/22/14 and 8/25/14.</p> <p>Resident #61 had dialysis without documented communication between the dialysis center and the facility on the following dates: 8/1/14, 8/4/14, 8/6/14, 8/11/14, 8/13/14, 8/15/14, 8/18/14, 8/20/14, 8/22/14 and 8/25/14.</p> <p>The resident had a, 7/17/14/, care plan problem of Alteration in Kidney Function Due to End Stage Renal Disease. The care plan indicated the staff was to monitor the resident's dialysis site for bruit and thrill daily and check for signs of infection.</p> <p>Review of the July and August 2014 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) indicated the fistula assessment was missing.</p>			

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	<p>Review of the signed physician orders for August 2014 indicated there was no order for fistula assessments or care.</p> <p>During an interview on 8/28/14 at 2:45 p.m., the DoN indicated the fistula's bruit and thrill should have been checked daily and post dialysis and documented in the resident's record. She reviewed the July and August 2014 MAR and TAR and acknowledged the fistula assessments were missing. The DoN acknowledged the physician orders were also missing for fistula assessment and care. The DoN also reviewed the Nursing Progress Notes and the "RAI Hemodialysis Communication Form for Extended Care Facilities" were not completed by the facility nor the dialysis center and indicated the documentation and follow up was not adequate. No further information was provided.</p> <p>The 2013, "Golden Clinical Services Dialysis Guideline" procedure was provided by the Director of Nursing on 8/28/14 at 1:30 p.m. The procedure indicated the fistula should have been monitored daily and the attending physician, dialysis center and responsible party should have been notified of adverse findings.</p>			

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	<p>"...Communication between outpatient dialysis provider and center should include: Written communication form with review of daily weights, any changes in condition or mood... Post Dialysis Protocol: Review Communication Folder for any pertinent information. Remove fistula/graft-dressing evening of dialysis treatment. **Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula). This must be done daily, best after dressing is removed. Documentation on Treatment Sheets Includes: Fistula checks daily: Monitoring for presence of bruit and thrill Checks for signs/symptoms of infection daily..."2. During the following observations, Resident #131 was seated with her feet on the floor. Her legs were shiny, swollen and tight in appearance. Her white socks cut into her legs leaving red rings. Her legs puffed out above the white socks: 8/25/14 - 9:18 a.m., 1:00 p.m., 2:50 p.m. 8/26/14 - 8:42 a.m., 1:30 p.m., 2:45 8/27/14- 9:00 a.m., 11:45 a.m., 3:00 p.m. 8/28/14- 9:05 a.m.</p> <p>Resident #131's record was reviewed on 8/27/14 at 10:20 a.m. Resident #131's current diagnoses included, but were not</p>						

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	<p>limited to, dementia and hypertension. Resident #131 did not have a diagnoses of edema or related disorder. Resident #131 did not have a care plan to address edema. The clinical record lacked any documentation relating to edema.</p> <p>Resident #131 had an 8/26/14, "Resident Shower Sheet" which lacked any documentation of edema.</p> <p>Resident #131 had an 8/24/14, 11:10 a.m., nursing assessment which included an assessment of the residents skin and overall condition which lacked any documentation of edema.</p> <p>During an 8/28/14, 2:10 p.m., observation with the Dementia Unit Manager, the Dementia Unit Manger indicated Resident #131's legs were swollen with non-pitting edema. During an interview at this time, the Unit Manger indicated she was unaware of Resident #131 having any issues with edema and was unaware the residents legs had been swollen for 4 days. The Unit Manager indicated it would be in the resident's best interest for her to elevate her legs when seated in her chair. The Unit Manger then indicated there was no footstool or recliner in the room and one or the other would need to be obtained. The Unit Manger also indicated the resident's</p>				

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	<p>edema should have been noted on shower days or during the nursing weekly assessment.</p> <p>During an 8/28/14, 2:12 p.m., observation and interview, when Resident #131 was questioned by the Unit Manger, the resident indicated her feet and legs had been swollen a few days and her legs were painful "if I swell too bad."</p> <p>3. During observations on the following dates and times, Resident #113 was seated in a chair with her feet on the floor. Her feet were swollen and spilling out over her shoes. Her white ankle socks were cutting into her swollen legs. Her legs where reddish pink and shiny: 8/25/14 - 10:50 a.m., 1:05 p.m., 2:55 p.m. 8/26/14 - 8:47 a.m., 1:35 p.m., 2:48 p.m. 8/27/14 - 9:00 a.m., 11:40 p.m., 3:03 p.m. 8/28/14 - 9:20 a.m., 10:00 a.m.</p> <p>During an 8/28/14, 9:21 a.m., interview, CNA #1 indicated Resident #113 frequently had edema. The CNA indicated when residents have edema CNAs were to notify the nurse. She indicated she had not notified a nurse recently about Resident #113's edema because she believed they were aware.</p>						

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	<p>During an 8/28/14, 9:25 a.m., interview, CNA #2 indicated Resident #113 regularly had edema. She indicated if the resident's feet were swollen she would encourage her to put her feet up and inform the nurse. She indicated she had not been Resident #113's CNA during the past week.</p> <p>Resident #113's clinical record was reviewed on 8/27/14 at 10:50 a.m. Resident #113's current diagnoses included, but were not limited to, dementia, depression and arthritis. Resident #113 did not have a diagnoses of edema or related disorder. Resident #113 did not have a care plan to address edema. The clinical record lacked any documentation relating to edema.</p> <p>Resident #113 had an 8/27/14, "Resident Shower Sheet" which lacked any documentation of edema.</p> <p>Resident #113 had an 8/28/14, 6:39 a.m., nursing assessment which included an assessment of the residents skin and overall condition which lacked any documentation of edema.</p> <p>During an 8/28/14, 1:55 p.m., observation and interview, The Dementia Unit Manager indicated Resident #113</p>			

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F000428 SS=D	<p>had, shiny swollen legs which were spilling out of her shoe, had 1+ pitting edema and needed her shoes removed and her feet elevated. At this time the resident's socks and shoes were removed and her feet elevated. The Resident #113 then stated "that feels better."</p> <p>During an 8/28/14, 2:10 p.m., interview, the Dementia Unit Manger indicated CNAs should be observing for edema during shower days and nurses's should note edema during weekly skin assessments. Doctors should be made aware in order to address treatment when indicated.</p> <p>4. A current, June 2014, facility policy titled "Skin Integrity Guidelines. which was left on the table by the facility on 8/29/14 at 8:10 a.m., indicated the following: "Residents will be observed by the CNA daily for redness/ open areas, edema of feet or sacrum. Changes will be reported to the licensed nurse and documented."</p> <p>3.1-37(a)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p>				

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	<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 record review and interview, the facility failed to ensure the pharmacist reviewed and reported missed laboratory tests for 1 of 5 residents reviewed for unnecessary medications. (Resident #20)</p> <p>Findings include:</p> <p>Resident #20's clinical record was reviewed on 8/28/14 at 2:00 p.m. The resident's diagnoses included, but were not limited to, liver transplant, chronic kidney disease, diabetes type II, hypertension, hyperlipidemia, hypothyroidism, anxiety, and osteoarthritis.</p> <p>The resident had a 9/9/13, physician's order for an ammonia level to be drawn every Tuesday on day shift. This order was changed on 7/22/14 to be checked on 8/22/14 and then every six months.</p> <p>The resident's medications included, but were not limited to, Depakote tablet extended release 250 mg give 250 mg by</p>	F000428	<p>It is the policy of this facility for the drug regimen of each resident to be reviewed by the licensed pharmacist at least once a month. A meeting was held with the Licensed Pharmacist and members of the Interdisciplinary Team on 9/5/14 to discuss the need to focus on lab compliance and high risk medications such as those prescribed for Resident # 20 during the pharmacy review. In collaboration with the Medical Director, the pharmacist will address lab compliance and make recommendations as appropriate. The drug regimen for resident # 20 was discussed with the VA physician and the physician wanted no changes to the medications by the attending physician without consultation with the VA neurologist. An order to this effect was entered into the record on 9/4/14. The resident elected to refuse the weekly ammonia draws as of April 14, 2014. Pharmacy Recommendations will be reviewed monthly in the Quality Assurance and Improvement Committee. Pharmacy consultant has agreed to attend monthly meetings to address areas of</p>	09/28/2014			

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	<p>mouth two times a day related to anxiety and Amiodarone HCl tablet (for atrial fibrillation) 200 mg by daily. The "Nursing 2014 Drug Handbook" indicated both medications should be used cautiously in patients with hepatic disease.</p> <p>Review of the resident's record indicated the resident had an ammonia level drawn on 4/1/14 and 5/20/14. The record lacked an indication of the ammonia levels being checked on the following Tuesdays: April 8, 15, 22, 29, 2014. May 6, 13, 27, 2014. June 3, 10, 17, 24, 2014. July 1, 8, 15, 2014.</p> <p>This resulted in the resident missing 14 ammonia level blood draws. The record lacked any indication of why the test was not performed and lacked an indication of the physician being notified of the test not being performed.</p> <p>Review of the "Clinical Pharmacist Medication Regimen Review Summary" indicated the pharmacist reviewed the resident's record on 4/10/14, 5/15/14, 6/10/14, and 7/9/14.</p> <p>During an interview with Dementia Unit Manager on 8/29/14 at 1:45 p.m., she indicated there were no pharmacy recommendations related to the lack of</p>		<p>concern. The consultant provided a resource list of 20 various medication categories that required specific lab monitoring and recommended frequency. The Director of Nursing Services or designee will review all recommendations monthly and cross reference with the in-house lab audits as a second check. Director of Nursing or Designee responsible.</p>				

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F000514 SS=D	<p>ammonia levels.</p> <p>The 2013, revised "Lab Processing/Tracking Guideline" was provided by the Medical Records Staff on 8/29/14 at 1:40 p.m. The guideline indicated: "Purpose: Diagnostic tests are processed, ordered, obtained and performed and that results are received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record....3. Document the physician notification in the resident's clinical record (progress notes). Include in this documentation: Physician name Date if physician notification Time of physician notification Lab results communicated Method of communication (fax, phone, etc)...."</p> <p>3.1-25(i)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of</p>						

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(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>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 a resident's clinical record was complete and accurate in regards to hospice services for 1 of 1 resident receiving hospice services. (Resident #72)</p> <p>Findings include:</p> <p>Resident #72's clinical record was reviewed on 8/29/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, and type II diabetes.</p> <p>The most current hospice documentation in the chart was dated 7/30/14.</p> <p>During an interview with the C Wing Unit Manager on 8/29/14 at 12:40 p.m., she indicated the hospice staff document their visits on their own computers they carry with them. She indicated they send the notes back to facility at the end of the month and they have not received the notes from the August visits yet.</p> <p>During an interview with the Director of Nursing on 8/29/14 at 1:10 p.m., she indicated the hospice staff send their notes after their visits. She indicated she</p>	F000514	<p>The policy of the facility is to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. Resident # 72 is no longer Hospice due to a stabilized condition. She was discontinued from Hospice on 9/17/14. The progress notes from Hospice have been updated in her record from July 30 to the day of discharge on 9/17/14. Records for Hospice were reviewed to identify other residents that may be affected. Progress notes for all residents on Hospice services are now current. A telephone call was made to the Hospice organization regarding the missing notes on 8/28/14 and a follow up call was made on 9/18/14. An agreement was made with the organization for all progress notes to be in the facility charts for each Hospice resident within 48 hours of the visit to provide for continuity of care and collaboration between the entities. Unit Managers will monitor weekly for compliance. Any deviation from compliance with the agreement will be addressed by the Director of Nursing and Hospice supervision. The Quality Assurance and Improvement Committee will review findings for</p>	09/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2014
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	thought they sent the notes after each visit and did not know they sent them all at the end of the month. 3.1-50(a)(1)		6 months and then as needed thereafter for continued monitoring based on compliance.		