

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2014
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NAME OF PROVIDER OR SUPPLIER PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
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F000000	<p>This visit was for the Recertification and State Licensure Survey</p> <p>Survey dates: November 3, 5, 6, 7 and 10, 2014</p> <p>Facility number: 000148 Provider number: 155526 AIM number: 100275500</p> <p>Survey team: Shelley Reed, RN, TC Jason Mench, RN Angela Selleck, RN</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 10 Medicaid: 40 Other: 15 Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-.31.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. This Plan of correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician</p>	F000157	<p>F157</p> <p>1. Resident 29's physician was notified of the 6 blood glucose levels</p>	11/25/2014

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	<p>when blood glucose levels exceeded the set parameter for 1 of 5 residents reviewed for unnecessary medication use in a sample of 5 (Resident #29).</p> <p>Findings include:</p> <p>The clinical record for Resident #29 was reviewed on 11/6/14 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus type II, congestive heart failure, obesity, renal insufficiency and anemia.</p> <p>Resident #29 had the following physician orders, dated 5/10/14, for sliding scale insulin coverage: "Humalog (insulin) 100 units/mL, inject three times daily according to the following scale: 141-180 (milligrams per deciliter) =1 unit, 181-220=2 units, 221-260=4 units, 261-300=6 units, 301-340=7 units, 341-380=8 units, 381-420=9 units, 421-460=10 units, > [greater than] 460=12 units. Call MD if blood sugar is below 50 or greater than 460." The order indicated the 8:00 p.m. dose of Humalog to be given half the amount and rounded up to the nearest whole unit.</p> <p>Review of the Blood Glucose Monitoring/Sliding Scale Insulin Record, provided by the Nurse Consultant on 11/6/14 at 11:31 p.m., indicated on</p>		<p>which exceeded 460 mg/dl, with no new orders at this time.</p> <p>2. A chart review was conducted for all other residents receiving sliding scale insulin coverage. Physician notified of any further abnormalities. All Licensed nursing staff were re-educated on the policy and procedure regarding blood glucose monitoring, including but not limited to hyper/hypoglycemic reactions and Notification of Change for parameters set forth by the physician.</p> <p>3. As a means to ensure compliance with proper notification of physician for abnormal blood glucose levels outside of parameters set forth by physician, all licensed nursing staff were re-educated on the policy and procedure regarding blood glucose monitoring, including but not limited to hyper/hypoglycemic reactions and Notification of Change for parameters set forth by the physician. The DON and/or her designee will review all residents' records which receive sliding scale insulin, to assure proper notification of physician for blood sugars outside of set parameters, 5 xs per week on scheduled work days x 1 month, 3 xs per week x 1 month, then weekly thereafter, should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, The DON and/or designee will report findings of</p>		

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	<p>August 28, 2014 at 4:00 p.m., Resident #29's blood glucose level was 587 mg/dl. The resident received 12 units of Humalog. At 8:00 p.m., the blood glucose level was 469 mg/dl.</p> <p>On September 2 at 8:00 p.m., the blood glucose level was 480 mg/dl and Resident #29 received 6 units of insulin. On September 11 at 4:00 p.m., the blood glucose level was 514 mg/dl and Resident #29 received 12 units of insulin. On September 21 at 8:00 p.m., the blood glucose level was 494 mg/dl and Resident #29 received 5 units of insulin.</p> <p>On November 1 at 11:00 a.m., the blood glucose level was 462 mg/dl and Resident #29 received 12 units of insulin.</p> <p>The blood glucose level exceeded 460 mg/dl on 6 occasions.</p> <p>A current health care plan, dated 10/23/14, indicated the resident had a problem related to diabetes mellitus and was at risk for experiencing hypoglycemia and hyperglycemia episodes. Interventions for the problem included, but were not limited to, "monitor blood sugar as ordered and more frequently as indicated, notify physician per call parameters, administer meds [medication] per MD orders and</p>		<p>above reviews and any corrective actions taken to the QA committee monthly x 3 months then quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 11-25-14</p>				

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	<p>call MD for BS [blood sugar] <50 or >460."</p> <p>During an interview on 11/7/14 at 11:15 a.m., the Director of Nursing (DoN) indicated no documentation was found related to the physician being notified of blood glucose levels greater than 460 mg/dl for the days listed.</p> <p>Review of a current facility policy dated 10/20/14, provided by the Corporate Nurse on 11/7/14 at 2:45 p.m., titled "NOTIFICATION OF CHANGE " indicated the following:</p> <p>"POLICY: Facility personnel shall immediately inform resident, consult with resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is:</p> <ul style="list-style-type: none"> • An accident involving ... • A significant change in the resident's... • 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) ... • Any response from the physician must be documented in the 			

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F000241 SS=D	<p>clinical record (e.g., new orders received, no new orders received, etc.) "</p> <p>3.1-5(a)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to serve lunch in a timely manner and to assist 1 of 12 dependent residents with 1 of 2 meals observed (Resident #27).</p> <p>Findings include:</p> <p>The clinical record for Resident #27 was reviewed on 11/6/14 at 9:17 a.m. Diagnoses for the resident included, but were not limited to, hospice care, Alzheimer's disease, peripheral vascular disease, diabetes mellitus and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 7/31/14, indicated Resident #27 was moderately cognitively impaired. Resident #27 received the</p>	F000241	<p>F241</p> <ol style="list-style-type: none"> Resident # 27 was not affected. Staff were re-educated concerning dignity during dining services, serving all residents at a table prior to serving next table, and serving residents that need assistance with feeding, when staff are available to assist. All residents have the potential to be affected. Staff were re-educated concerning dignity during dining services, serving all residents' at a table prior to serving next table, and serving residents that need assistance with feeding, when staff are available to assist. As a means to ensure ongoing compliance with dignity during dining services, the DON and/or designee will monitor dining services at varied times/meal services on the memory unit 5 xs per week x 1 	11/25/2014

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	<p>following Activities of Daily Living (ADL) assistance; transfer-extensive assistance with two person assist, dressing-extensive assistance with one person assist, and eating independent with set-up assistance.</p> <p>A health care plan problem, dated 6/9/14, indicated Resident #27 had a problem related to alteration in nutritional/hydration status related to diabetes, depression and loss of appetite. Approaches to the problems included, but were not limited to, "set-up with meals, assist with meals, snacks three times daily and encourage the resident to eat greater than 75% of most meals."</p> <p>During meal observation on 11/3/14 at 11:30 a.m., one Nursing Assistant (NA) was present on the Memory Center. No additional staff members were observed in the Memory Center until the nurse returned at 12:14 p.m. The nurse did not participate in serving meals.</p> <p>The meal arrived shortly after 11:35 a.m. Resident #27 was seated at a table with another resident. At 12:03 p.m., Resident #27 continued to sleep with her meal tray in front of her. The NA continued to randomly serve residents in the dining room and hall tray delivery. Resident #27 continued to sleep with her tray in</p>		<p>month, weekly x 1 month then monthly thereafter. Should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of Quality assurance, the DON and/or designee will report the findings of the above monitoring and any corrective action to the QA committee monthly x 3 months, then quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 11-25-14</p>	

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	<p>front of her. The last meal tray was served at 12:11 p.m.</p> <p>The large table had 5 residents seated around. One of five was served prior to 12:02 p.m. and the last resident seated at the table was served at 12:11 p.m. while NA #2 continued to deliver hall trays and other meal trays.</p> <p>During an interview on 11/3/14 at 12:24 p.m., NA #2 indicated his nurse was off the floor doing an assessment. He stated he normally served 3 male residents first because they were slow eaters, then he just served at random. He indicated a meal service took up to 30 minutes without any help and approximately 15 minutes with help. He stated that he served a lady at the large table first because she would take food from others, but did not serve the others. He indicated he did not have a system for meal service but just served residents at random. He indicated days would vary on whether he had assistance serving meals or not, but was sometimes by himself.</p> <p>At 12:32 p.m., NA #2 sat to assist Resident #27. The meal had been in front of her for more than 45 minutes, uncovered.</p> <p>During an interview on 11/7/14 at 1:38</p>			

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F000282 SS=D	<p>p.m., Hospice Aide #3 indicated Resident #27 could feed herself on some days, but needed assistance on other days. She indicated the resident was more alert on certain days and not as much on other days.</p> <p>During the second meal observation on 11/6/14 at 11:35 a.m., three staff members assisted during meal time for thirteen residents. Resident #27 received her meal at 11:47 a.m., and a CNA was seated to assist the resident at 12:00 p.m.</p> <p>3.1-3(t)</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 observation, interview and record review, the facility failed to ensure the fall interventions for 2 of 3 residents reviewed for accidents were implemented. (Resident #18 and #14). The facility also failed to administer correct insulin coverage for 1 of 5 residents reviewed for unnecessary medications (Resident #29).</p> <p>Findings include:</p>	F000282	F2821. Resident # 18's fall interventions were initiated, including non skid strips installed in front of the toilet, dycem was placed in the wheel chair seat, and the incontinence pad was removed from the wheel chair. Resident # 14 non skid strips were discontinued as the intervention is no longer effective, care plan updated. Resident # 29's MD was notified of incorrect dosages, order was received to	11/25/2014	

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	<p>1. The clinical record of Resident #18 was reviewed on 11/7/14 at 11:38 a.m. The resident's diagnoses included, but were not limited to, history of subdural hematomas, ischemic cerebrovascular accident, dementia, anxiety, recurrent major depression, benign prostatic hyperplasia and insomnia.</p> <p>During an observation on 11/7/14 at 2:08 p.m., Resident #18's wheelchair was observed with an incontinent pad placed on the seat and no Dycem (used to prevent slipping) in the wheelchair seat.</p> <p>During an observation with the Director of Nursing (DON) present on 11/7/14 at 2:15 p.m., Resident #18's wheelchair was observed with an incontinent pad on the seat and no Dycem in the wheelchair seat.</p> <p>During an observation on 11/7/14 at 2:35 p.m., Resident #18's bathroom floor was observed with no non-skid strips in front of the toilet.</p> <p>During an observation and interview with the DON on 11/7/14 at 2:45 p.m., Resident #18's bathroom floor was observed with no non-skid strips in front of the toilet. The DON indicated the following care plan interventions were to</p>		<p>discontinue ½ dose coverage at HS with no further orders at this time, Care plan updated as necessary. 2. Chart reviews completed for all residents' at risk for falls and residents with sliding scale blood glucose monitoring, to assure interventions are current and have been implemented to reduce fall risk and assure sliding scale glucose monitoring is complete, accurate and physicians are notified. Care plans updated as needed. Staff re-educated concerning following interventions for fall risk, proper procedure for sliding scale blood glucose monitoring and physician notification.3. In an effort to assure ongoing compliance with updating care plans with current interventions for falls and sliding scale blood glucose monitoring and physician notification, the DON and/or her designee will review all residents with falls daily on scheduled work days to assure new interventions are implemented and interventions that are no longer effective are discontinued per care plan, and records of residents who receive sliding scale insulin, to assure proper dosage given, notification of physician for blood sugars outside of set parameters and care plans are updated, 5 xs per week on scheduled work days x 1 month, 3 xs per week x 1 month, then weekly thereafter, should concerns be noted, corrective action shall be taken.4. As a</p>	

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	<p>be in place for fall prevention for Resident #18:</p> <p>a. Non-skid strips were to be on the floor in front of the toilet in the resident's bathroom.</p> <p>b. A Dycem pad was to be placed on the seat of the wheelchair.</p> <p>c. No incontinence pads were to be in the wheelchair.</p> <p>The DON indicated Resident #18 had a room transfer 9/3/14 and the non-skid strips in front of the resident's toilet must not have been applied in the bathroom of the new room.</p> <p>Review of Resident #18's current care plans, last reviewed on 10/6/14, indicated the following:</p> <p>"...The resident has multiple risk factors for falls...hx [history] of falls, impaired balance [with] transitions, hospice services, medication use, pain, hx [history] of CVA [cerebrovascular accident], incontinence, severely impaired cognition, poor safety awareness, depression, anxiety..."</p> <p>Interventions included but were not limited to: "Implement intervention to reduce risk of falls...No pads in w/c</p>		<p>means of quality assurance, The DON and/or designee will report findings of above monitoring and any corrective actions taken to the QA committee monthly x 3 months then quarterly thereafter, and revisions made to the plan, if warranted.5. 11-25-14</p>				

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	<p>[wheelchair] dated 11/22/12...Non-skid strips replaced in front of toilet dated 7/5/13...Dycem in w/c [wheelchair] dated 11/21/13...non skid strips reapplied undated..."</p> <p>2. The clinical record for Resident #14 was reviewed on 11/6/14 at 10:53 a.m. The resident's diagnoses included, but were not limited to, spinal canal stenosis, severe osteoarthritis of the back and dementia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 7/11/14, indicated the resident was cognitively intact.</p> <p>On 11/6/14 at 1:30 p.m., Resident #14 was observed in her room sitting in her recliner watching TV. Safety strips were not observed on the floor in front of her recliner.</p> <p>Review of a current care plan for "Falls", dated 11/5/14, indicated an intervention to be provided to prevent Resident #14 from falling was "safety strips in front of recliner" with a date of implementation of 4/19/13.</p> <p>During an interview with the Director of Nursing (DON) on 11/7/14 at 2:55 p.m., Resident #14's care plan for falls was reviewed with the DON and then the</p>						

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	<p>room was inspected with the DON and no safety strips were found on the floor in front of the recliner. The DON indicated the safety strips should have been on the floor in front of the recliner or discontinued from the care plan if they were no longer needed.</p> <p>3. The clinical record for Resident #29 was reviewed on 11/6/14 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus type II, congestive heart failure, obesity, renal insufficiency and anemia.</p> <p>Resident #29 had the following physician orders, dated 5/10/14, for sliding scale insulin coverage: "Humalog (insulin) 100 units/mL, inject three times daily according to the following scale: 141-180 (milligrams per deciliter) =1 unit, 181-220=2 units, 221-260=4 units, 261-300=6 units, 301-340=7 units, 341-380=8 units, 381-420=9 units, 421-460=10 units, > [greater than] 460=12 units. Call MD if blood sugar below 50 or greater than 460." The order indicated the 8:00 p.m. dose of Humalog to be given half the amount and rounded up to the nearest whole unit.</p> <p>Review of the Blood Glucose Monitoring/Sliding Scale Insulin Record indicated, on August 3 at 8:00 p.m.,</p>						

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	<p>Resident #29 had a blood glucose level of 220 mg/dl and received 2 units of Humalog. Review of the current order, indicated the Humalog dose should have been 1 unit. On August 18, Resident #29 had a blood glucose level of 153 mg/dl at 8:00 p.m. and received 1 unit of insulin. No insulin dose should have been given for the current blood sugar. On August 21 at 8:00 p.m., the blood glucose level was 389 mg/dl and the resident received 4 units of insulin. The resident should have received 5 units per current physician order.</p> <p>On September 8 at 8:00 p.m., Resident #29 had a blood glucose level of 194 and received 2 units of insulin. The resident should have received 1 unit of insulin.</p> <p>On October 1 at 4:00 p.m., Resident #29 had a blood glucose level of 335 mg/dl and received 8 units of insulin. The resident should have received 7 units. On October 18 at 8:00 p.m., Resident #29 had a blood glucose level of 173 and received 1 unit of insulin. The resident should have not received any insulin coverage. On October 20 at 8:00 p.m., Resident #29 had a blood glucose level of 215 mg/dl and received no insulin coverage. The resident should have received 1 unit of insulin. On October 28 at 8:00 p.m., Resident #29 had a blood</p>				

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	<p>glucose level of 335 and received 3 units of insulin. The resident should have received 4 units of insulin coverage. On October 29 at 8:00 p.m., Resident #29 had a blood glucose level of 304 mg/dl and received 3 units of insulin. The resident should have received 4 units of insulin.</p> <p>On November 1 at 8:00 p.m., Resident #29 had a blood glucose level of 325 mg/dl and received 7 units of insulin. The resident should have been 4 units of insulin. On November 2 at 8:00 p.m., Resident #29 had a blood glucose level of 217 and received 2 units of insulin. The resident should have received 1 unit of insulin. On November 3 at 8:00 p.m., Resident had a blood glucose level of 334 and received 7 units of insulin. The resident should have received 4 units of insulin.</p> <p>A current health care plan, dated 10/23/14, indicated the resident had a problem related to diabetes mellitus and was at risk for experiencing hypoglycemia and hyperglycemia episodes. Interventions for the problem included, but were not limited to, "monitor blood sugar as ordered and more frequently as indicated, notify physician per call parameters, administer meds [medication] per MD orders and</p>			

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	<p>call MD for BS [blood sugar] <50 or >460."</p> <p>4. Review of a current facility policy dated 10/2014, titled "CARE PLAN DEVELOPMENT AND REVIEW", which was provided by the Administrator on 11/7/14 at 3:15 p.m., indicated the following:</p> <p>"PURPOSE:</p> <p>-To ensure an interdisciplinary approach to plan for and meet resident's needs.</p> <p>POLICY:</p> <p>-Facility personnel will ensure development of a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents medical, nursing and mental and psychosocial needs.</p> <p>PROCEDURE:...</p> <p>...4. The comprehensive care plan is designed to:...</p> <p>...-Incorporate risk factors associated with identified problems and ways to manage said risk factors...</p> <p>...COMMUNICATION TO</p>			

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	<p>PERSONNEL...</p> <p>...2. Care plan interventions specific to direct care personal will be included on the direct care giver's assignment sheet, or similar tool in use..."</p> <p>5. Review of a current facility policy, dated 10/2014, titled "FALL PREVENTION PROGRAM", which was provided by the DON on 11/7/14 at 3:00 p.m., indicated the following:</p> <p>"PURPOSE</p> <p>-To identify residents who are at risk for falls and subsequently implement appropriate, individualized fall prevention interventions...</p> <p>...PROCEDURE:</p> <p>...7. The resident's plan of care should be updated/revised to reflect fall prevention review, interventions implemented, or to denote if current interventions remain appropriate after each fall...</p> <p>...11. Unit Managers/Charge Nurses are responsible to ensure interventions are implemented as discussed."</p> <p>6. Review of a current facility policy, dated 10/20/14, titled "NOTIFICATION</p>			
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F000323 SS=D	<p>OF CHANGE", which was provided by the Corporate Nurse on 11/7/14 at 2:45 p.m., indicated the following:</p> <p>"POLICY:</p> <p>Facility personnel shall immediately inform resident, consult with resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is:</p> <p>An accident involving...</p> <p>A significant change in the resident's...</p> <p>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)...</p> <p>Any response from the physician must be documented in the clinical record (e.g., new orders received, no new orders received, etc.)"</p> <p>3.1-35(g)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>			

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	<p>assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure non-skid strips were in place to prevent potential falls for 1 of 3 residents reviewed for accidents from a total sample of 26 residents (Resident #18).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #18 was reviewed on 11/7/14 at 11:38 a.m. The record indicated the resident's diagnoses included, but were not limited to, history of subdural hematomas, ischemic cerebrovascular accident, dementia, anxiety, recurrent major depression, benign prostatic hyperplasia and insomnia.</p> <p>During an observation on 11/7/14 at 2:35 p.m., Resident #18's bathroom floor was observed with no non-skid strips in front of the toilet.</p> <p>During an observation and interview with the DON on 11/7/14 at 2:45 p.m., Resident #18's bathroom floor was observed with no non-skid strips in front of the toilet. The DON indicated the care plan interventions were to be in place for fall prevention for Resident #18.</p> <p>The DON indicated Resident #18 had a</p>	F000323	F3231. Resident 18's fall interventions were initiated per POC including but not limited to non skid strips on floor in front of toilet. The staff were re-educated on the importance of following fall interventions. Care plans and C.N.A. assignment sheets are updated with individual fall interventions to ensure each resident receives adequate supervision and assistive devices to prevent accidents.2. Chart reviews completed for all residents at risk for falls to assure each resident receives adequate supervision and assistance devices to prevent accidents. The staff were re-educated on the importance of following fall interventions per plan of care. Care plans and C.N.A. assignment sheets are updated with individual fall interventions to ensure each resident receives adequate supervision and assistive devices to prevent accidents.3. As a means of ongoing compliance to assure each resident receives adequate supervision and assistance devices to prevent accidents, the staff were re-educated on the importance of following fall interventions per plan of care. Following education, the DON and/or her designee will review all residents with falls daily on scheduled work days to assure new interventions are implemented and interventions	11/25/2014			

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	<p>room transfer 9/3/14 and the non-skid strips in front of the resident's toilet must not have been applied in the room the resident was transferred to.</p> <p>A review of a nursing note, dated 10/15/14, provided by the AIT (Administrator In Training) on 11/10/14 at 9:40 a.m. indicated the following:</p> <p>"Res [Resident] yelling for "help" entered rm [room] res [resident] sitting on bath rm [bathroom] floor legs extended forward [with] feet against toilet leaning on w/c [wheelchair]...all previous planned interventions in place..."</p> <p>A review of Resident #18's current care plans indicated the following:</p> <p>a. "...The resident has multiple risk factors for falls...hx [history] of falls, impaired balance [with] transitions, hospice services, medication use, pain, hx [history] of CVA [cerebrovascular accident], incontinence, severely impaired cognition, poor safety awareness, depression, anxiety..."</p> <p>Interventions included but were not limited to: "Implement intervention to reduce risk of falls...Non-skid strips replaced in front of toilet dated 7/5/13...non skid strips reapplied</p>		<p>that are no longer effective are discontinued per care plan, C.N.A. assignment sheets are updated as needed. 4. As a means of quality assurance, The DON and/or designee will report findings of above reviews and any corrective actions taken to the QA committee monthly x 3 months then quarterly thereafter, and revisions made to the plan, if warranted.5. 11-25-14</p>		

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	<p>undated..."</p> <p>b. A review of a care plan titled "ADL [Activities of Daily Living] Assist Required", last updated/reviewed on 10/6/14, indicated the following:</p> <p>"...The resident requires up to 1-2 [person] assist in performing ADL's due to: decline, Hospice services, @ [at] risk for delirium, dementia, fall risk,...impaired balance, incontinence,...hx [history] of CVA [cerebrovascular accident]..."</p> <p>c. A review of a care plan titled "Cognitive Loss", last updated/reviewed on 10/6/14, indicated the following:</p> <p>"...The resident suffers from cognitive loss as evidenced by: [decreased] BIMS[Brief Interview for Mental Status] score [and] confusion...BIMS score = [equals] severely impaired cognition, requires ADL assist..."</p> <p>A review of the Minimum Data Set Quarterly Review, dated 10/4/14, indicated the following: Resident #18 was cognitively impaired, required extensive assist and two plus person physical assist with toilet use, transfers and bed mobility.</p>						

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F000431 SS=D	<p>2. A review of the policy titled "FALL PREVENTION PROGRAM" provided by DON on 11/7/14 at 3:00 p.m. indicated the following:</p> <p>"PURPOSE: To identify residents who are at risk for falls and subsequently implement appropriate individualized fall prevention interventions.</p> <p>...PROCEDURE:</p> <p>...7. The resident's plan of care should be updated/revised to reflect fall prevention review, interventions implemented, or to denote if current interventions remain appropriate after each fall...</p> <p>...11. Unit Managers/Charge Nurses are responsible to ensure interventions are implemented as discussed."</p> <p>3.1-45(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and</p>			

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	<p>periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to properly ensure medication carts had pills properly stored in regard to loose pills for 4 of 5 carts observed during medication storage (Hall 200, 300, 400 and 500). The facility also failed to ensure the narcotic drawer inside a medication cart was double locked for 1 of 5 carts observed. (Hall 200)</p> <p>Findings include:</p>	F000431	<p>F431</p> <p>1. No residents were affected by the loose pills found in the bottom of the medication cart, or the narcotic drawer that was not double locked inside the locked medication cart. The licensed nursing staff were re-educated on the proper storage of medications, (medication carts with double locked narcotic drawer, and loose pills in bottom of medication cart to be properly destroyed when found). The maintenance supervisor has covered the manufactured holes in the</p>	11/25/2014

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	<p>1. During observation on 11/10/14 at 9:53 a.m., the 300 Hall cart was found to have had 2 unidentified pills in the medication cart. The pills were loose inside the cart. The medication cart had 4 visible manufactured holes in each drawer which would have allowed loose pills to fall out of the cart.</p> <p>During observation of the 400 Hall cart, 1 unidentified pill was found in the medication cart. The pill was loose inside the cart. The medication cart had 4 visible manufactured holes in each drawer.</p> <p>During observation of the 500 Hall cart, 4 and 1/2 unidentified pills were found in the medication cart. The pills were loose inside the cart. The medication cart had 4 visible manufactured holes in each drawer.</p> <p>During observation of the 200 Hall cart, the narcotic drawer was found unlocked. 1 loose, unidentified pill was found in the medication cart. The medication cart had 4 visible manufactured holes in each drawer.</p> <p>During an interview on 11/10/14 at 9:53 a.m., LPN #1 indicated the medication carts had been checked on the previous Friday. She indicated the older staff did a</p>		<p>bottom of the drawers of all medication carts.</p> <p>2. All residents have the potential to be affected. The licensed nursing staff were re-educated on the proper storage of medications, (medication carts with double locked narcotic drawer, and loose pills in bottom of medication cart to be properly destroyed when found). The maintenance supervisor has covered the manufactured holes in the bottom of the drawers of all medication carts.</p> <p>3. As a means of ongoing compliance, licensed nursing staff were re-educated on the proper storage of medications, (medication carts with double locked narcotic drawer, and loose pills in bottom of medication cart to be properly destroyed when found). Following education, the DON and /or designee will monitor medication carts 5 x per week on scheduled work days x 1 month, then 3 days per week x 1 month, then weekly thereafter. Should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, The DON and/or designee will report findings of above monitoring and any corrective actions taken to the QA committee monthly x 3 months then quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 11-25-14</p>		

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	<p>pretty good job of keeping the medication carts free of loose pills.</p> <p>A current undated facility policy, titled "STORING DRUGS", which was provided by the Administrator in Training (AIT) on 11/10/14 at 10:53 a.m., indicated the following:</p> <p>"Policy Drugs and biologicals will be stored in a safe, secured, and orderly manner at proper temperatures and accessible only to licensed nursing and pharmacy personnel or staff member lawfully authorized to administer medications.</p> <p>PROCEDURES 1. The pharmacy supplier must dispense...</p> <p>...8. Controlled drugs in Schedule II (C-II) are subject to special storage. They may be accessible only to authorized licensed nursing and pharmacy personnel. C-II drugs must be stored under double-lock in a separate drawer or compartment...</p> <p>...12. Any outdated, contaminated, or deteriorated drugs, or those in containers</p>			

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	<p>which are cracked, soiled, or without secure closures must be removed from stock and destroyed according to procedures for drug destructions.</p> <p>3.1-25(n) 3.1-25(o)</p>				