STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND SKILLED NURSING AND REHABILITATION	500 N WILLIAMS ST ANGOLA, IN 46703

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 22-26, 2013 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Survey team: Diane Nilson, RN, TC Carol Miller, RN Tim Long, RN Rick Blain, RN Census bed type: SNF: 2 SNF/NF: 64 Total: 66 Census payor type: Medicare: 17 Medicaid: 33 Other: 16 Total: 66 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 2, 2013, by Brenda Meredith, R.N.	F000000	**This Plan of Correction is the center's credible allegation of compliance.** **Preparation and /or execution of this plan of correction does not constitues admission or agreement by the provider of the truth of the facts al-leged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **We respectfully request that this Plan of Corretion be given a desk review.**	

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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F000279 SS=D	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. 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. 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).			
	Based on observation, record review, and interview, the facility failed to ensure care plans were developed and revised to reflect the current resident status, for 1 of 2 residents reviewed for fluid restrictions, Resident #77. Findings include: The record for Resident #77 was reviewed at 10:00 a.m. on 7/25/13, and indicated the resident was admitted to the facility on 5/11/13. Diagnoses included, but were not	F000279	F279 It is the policy of this facility to develop and revise care plans to reflect the current resident status. Resident #77's care plan was review- ed and revised 7-25-13 so that all plan of care reflect physician orders and follow the facility's policy and procedure for fluid restrictions. An audit of all fluid restricted resi- dents was completed 7-25-13 to review physicians orders and if needed update care plan to reflect the current resident status. Nursing staff was in serviced on the fluid restriction policy on 7-25 and 8-13-13.(see Exhibit A) A chart audit on all Fluid restricted	08/25/2013

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	limited to: diverticulitis, atrial fibrillation, congestive heart failure, renal insufficiency, anxiety, and depression. A physician's order, dated and signed by the physician on 5/14/13, indicated the resident was to be on a 1200 cc (cubic centimeter) fluid restriction in 24 hours. A physician's order, dated 5/29/13, indicated a clarification order on fluid restrictions which indicated dietary was to provide 360 cc at breakfast, 240 cc at lunch, and 240 cc at dinner, and nursing was to provide 120 cc per shift with the medication pass. A physician's order, dated 6/4/13, indicated to increase the fluid restriction to 2500 Cubic Centimeters (cc's) daily. Review of care plans indicated the following: A care plan, dated 5/18/13, indicated a potential alteration in elimination related to constipation, with interventions including, but not limited to: encourage fluids with and between meals, and document intake at meals; A care plan, dated 5/18/13, indicated the resident was at high risk		residents will be conducted by the DNS, or her designee bi-weekly for one month, to review that care plans reflect any change of status or new physicians orders. If no issues are found the audits will be conducted on a monthly basis for 6 months. (see Exhibit B) Results of the audits will be report- ed by the DNS to the Business Lead- ership Team on a monthly basis. The Business Leadership team will submit a report to the Quality Assurance Com- mittee for review. The Quality Assur- ance Committee, responsible to the Administrator will monitor the resultsfor continued compliance	

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	for dehydration; fluid volume deficit , related to a chronic illness, hypertension, was on diuretic therapy, with interventions including, but not limited to: keep fresh fluids at the bedside unless contraindicated by restrictions, remind and/or assist to consume fluids regularly between meals and during routine care interactions, RD (Registered Dietician) to regularly evaluate and plan diet to provide required fluids needed, monitor resident intake patterns of food and fluids, report poor meal and/or poor fluid consumption, encourage compliance with the fluid restriction 1.2 Liters in 24 hours. A care plan, dated 5/25/13, indicated altered nutrition and hydration due to Congestive Heart Failure, Diabetes, Depression, and Diverticulitis, and indicated the resident was on a fluid restriction. The care plans thus indicated "encourage fluids with and between meals" while the resident was on a 1200 cc fluid restriction, and were not updated to reflect the increase in fluids beginning on 6/4/13. At 1:20 p.m., on 7/25/13, and accompanied by the Director of Nursing Services (DNS), a water			

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	pitcher with 450 cc of fluid was observed on the resident's bedside table in her room. The DNS indicated there were no other residents in this room. The Fluid Restriction Policy, dated 2008, and provided by the Director of Nursing Services (DNS), at 2:10 p.m., on 7/25/13, indicated fluid restrictions would be followed per physician orders and monitored by nursing staff for resident compliance. The policy indicated licensed nursing staff would notify the dietary department of the written physician orders for fluid restriction. The licensed nursing staff and dietary staff would collaboratively determine the amount of fluid restriction to be used by nursing on each shift, and the dietary department would determine the amount of fluid served during the daily meals. "Fluid Restriction" would be documented on the Medication Administration Record (MAR) and care plan, identifying fluids provided by dietary and nursing services. Nursing would record the fluids on the Input and Output Record (I and 0) every shift and calculate the 24 hour totals. If fluid totals exceeded the specific amount, the process was reassessed, and the physician should be notified of resident			

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	non-compliance or abnormal assessment findings. If fluids were restricted, water pitchers should not be available at the bedside unless evaluated as appropriate. 3.1-35(a)			

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F000282 SS=D	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. Based on observation, record review and interview, the facility failed to ensure physician orders for a fluid restriction were implemented as per facility policy for 1 of 2 residents (Resident #77) reviewed for fluid restrictions. The facility also failed to ensure physician's orders were followed for 1 of 1 residents (Resident #70) reviewed for urinary tract infections. Findings include: 1. The record for Resident #77 was reviewed at 10:00 a.m., on 7/25/13, and indicated the resident was admitted to the facility on 5/11/13. Diagnoses included, but were not limited to: diverticulitis, atrial fibrillation, congestive heart failure, renal insufficiency, anxiety, and depression. A physician's order, dated and signed by the physician on 5/14/13, indicated the resident was to be on a 1200 cc (cubic centimeter) fluid restriction in 24 hours.	F000282	F282 It is the policy of this facility to implement and follow all physi-cians orders. Resident #77's physicians orders, care plans and MAR's were reviewed and updated on 7-25-13, according to the physicians orders and the fluid restriction policy and procedure. An audit of all fluid restricted residents charts was completed on 7-25-13 to review and update if needed care plans and MARs to reflect physician orders. Nursing staff was in serviced on the Fluid Restriction policy and proced- ure and documentation of intake and output on 7-25-13 and 8-13-13. (see Exhibit A) DNS will conduct audits of fluid restrict-	08/25/2013

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	A physician's order, dated 5/29/13, indicated a clarification order on fluid restrictions which indicated dietary was to provide 360 cc at breakfast, 240 cc at lunch, and 240 cc at dinner, and nursing was to provide 120 cc per shift with the medication pass. A physician's order, dated 6/4/13, indicated to increase the fluid restriction to 2500 cc daily. Review of care plans indicated the following: A care plan, dated 5/18/13, indicated a potential alteration in elimination related to constipation, with interventions including, but not limited to: encourage fluids with and between meals, and document intake at meals; A care plan, dated 5/18/13, indicated the resident was at high risk for dehydration; fluid volume deficit , related to a chronic illness, hypertension, was on diuretic therapy, with interventions including, but not limited to: keep fresh fluids at the bedside unless contraindicated by restrictions, remind and/or assist to consume fluids regularly between meals and during routine care interactions, RD (Registered		ed residents bi-weekly for one month for compliance with physician orders and that physician orders are carried out through the care plan. If no issues after one month, audits will be done monthly thereafter for 6 months DNS will report findings of the audits to the Business Leadership Team. Business Leadership team will report the findings to the Quality Assurance Commit- tee who is responsible to the Administrator for monitoring continued compliance.	

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	Dietician) to regularly evaluate and plan diet to provide required fluids needed, monitor resident intake patterns of food and fluids, report poor meal and/or poor fluid consumption, encourage compliance with the fluid restriction 1.2 Liters in 24 hours. A care plan, dated 5/25/13, indicated altered nutrition and hydration due to Congestive Heart Failure, Diabetes, Depression, and Diverticulitis, and indicated the resident was on a fluid restriction. Review of a Nutrition Screening and Assessment progress note, dated 5/25/13, indicated the resident was on a 1.2 Liter fluid restriction, and "will suggest clarifying fluid restriction," 360 cc at breakfast, 240 cc at lunch, and 240 cc at dinner for dietary department, and nursing to provide 360 cc throughout the day with medication pass. Review of the Medication Administration Record (MAR) for May, 2013, indicated a fluid restriction 120 cc per shift from nursing with the medication pass, but there was no documentation recorded as to how much the resident was actually taking. The MAR also indicated dietary was to provide 360 cc at breakfast, 240 cc			

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	at lunch, and 240 cc at dinner, but there was no documentation how much fluid the resident was actually receiving. Review of the MAR for June, 2013, indicated starting June 4, 2013, the fluid restriction was increased to 2500 cc's, and nursing would provide 210 cc per shift, and dietary 1870 daily. There were staff initials documented on the MAR, but no documentation as to how much fluid the resident was actually receiving. Review of the MAR for July, 2013, indicated the resident was on a 2500 cc fluid restriction, and staff initials were documented on the MAR, but no documentation as to how much fluid the resident was receiving. The Director of Nursing (DNS) was interviewed, at 1:00 p.m., on 7/25/13 regarding the documentation for the fluid restriction. She indicated the fluid restriction and what amount the resident was to receive was written on the Medication Administration Record (MAR), but nursing was not documenting the amount of fluids the resident was receiving on each shift, so there was no way to tell how much the resident was actually receiving.			

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	At 1:20 p.m., on 7/25/13, and accompanied by the DNS, a water pitcher with 450 cc of fluid was observed on the resident's bedside table in her room. The DNS indicated there were no other residents in this room. The Dietary Manager was interviewed at 1:23 p.m., on 7/25/13, and indicated she had been employed at the facility since 6/7/13. She indicated if a resident was on a fluid restriction, nursing would send the order to dietary, and the information would be placed on the resident's tray card. She indicated nursing would inform dietary how many cc's of fluid were allowed for meals and this would be written on the resident's tray card. She indicated the dietary department did not keep track of the resident's consumption as this was a nursing responsibility. She indicated she was not working when the resident was on a 1200 cc fluid restriction and did not keep old records. Review of the current tray card for Resident #77, provided by the Dietary manager during this interview, indicated the following fluid restrictions: "Only 1-8 oz(240 cc) and 1-4 oz(120			

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	cc) to drink for breakfast Only 1-8 oz(240 cc) to drink for lunch Only 1-8 oz(240 cc) to drink for dinner. " The Dietary Manager indicated this would remain the same unless changed by nursing. The Fluid Restriction Policy, dated 2008, and provided by the Director of Nursing Services (DNS), at 2:10 p.m. on 7/25/13, indicated fluid restrictions would be followed per physician orders and monitored by nursing staff for resident compliance. The policy indicated licensed nursing staff would notify the dietary department of the written physician orders for fluid restriction. The licensed nursing staff and dietary staff would collaboratively determine the amount of fluid restriction to be used by nursing on each shift, and the dietary department would determine the amount of fluid served during the daily meals. "Fluid Restriction" would be documented on the Medication Administration Record (MAR) and care plan, identifying fluids provided by dietary and nursing services. Nursing would record the fluids on the Input and Output Record (I and 0) every shift and calculate the 24 hour totals. If fluid totals exceeded the specific amount, the process was			

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	reassessed, and the physician should be notified of resident non-compliance or abnormal assessment findings. If fluids were restricted, water pitchers should not be available at the bedside unless evaluated as appropriate. 2. Resident #70's clinical record was reviewed on 7/24/13 at 9:00 A.M. The record indicated on 6/24/13 a physician's order was received Ceftine (an antibiotic) 1 gram twice daily for 10 days for a diagnosis of a Urinary Tract Infection (UTI) and to repeat the Urinalysis (UA) with a Culture and Sensitivity (C&S) when the antibiotic is completed. Review of the laboratory results indicated no follow up UA with a C&S was performed following completion of Ceftine 1 gram twice daily on 7/4/13. An interview with the Director of Nursing (DN) on 7/25/13 at 11:02. A.M. indicated the follow up UA with a C&S was not completed as ordered by the physician. 3.1-35(g)(2)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interviews and record reviews, the facility failed to ensure a Physician's Order was written from a Medication Regimen Recommendation in a timely manner for 1 of 1 resident in a sample of 25 reviewed for Medication Regimen Recommendation (Resident #73). Also, the facility failed to ensure behavior monitoring and non-pharmacological interventions were done for 2 residents on psychotropic medications for 2 of 2	F000329	F329It is the policy of this facility for each resident's drug regimen tobe free from unnecessary drugs.1.The gradual dose reduction forresident # 73 was completed on in April 2013. Pharmacy recommendations for the last three months were reviewed formissed gradual drug reductions.All nursing staff were re-educatedOn 7-25 and 8-13-13 concerning theMedication Regimen Review form and physician orders resulting fromthe recommendations. (see Exhibit A)All recommendations will be	08/25/2013

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	residents reviewed for unnecessary medication in a sample of 10 (Residents # 42, # 108). Findings include: 1. The clinical record of Resident #73 was reviewed on 7/24/13 at 8:30 a.m. indicated diagnosis included, but were not limited to, insomnia. The Medication Regimen Review form dated 1/22/13 indicated "see report for any noted ...recommendations." The Medication Regimen Review form provided by the Director Nursing Service (DNS), dated 1/22/13, indicated the resident had an order for Melatonin (medication for sleep) 5 milligrams (mg) daily. The Medication Regimen Review form indicated to consider a gradual dose reduction for the medication melatonin from 5 mg to 3 mg daily. The Physician's Order, dated 4/26/13, indicated the resident's Melatonin 5 mg was decreased to 3 mg. During an interview on 7/24/13 at 2:00 p.m., the DNS indicated the Medication Regimen Review form dated 1/22/13 to reduce Melatonin 5		copiedand placed in a folder to be kept in the DNS's office. The original will be presented to the physician for reviewand recommendation.Once reviewed by the physician, the completed recommendation will becopied. The copy will go in the folderand the original will go to theresidents chart.Audits of the Medication Regimen Review will be completed monthly by the ADNS or her designee for sixmonths. (see Exhibit C)DNS is responsible to present the re-sults of the audits to the BusinessLeadership Team on a monthly basis.The Business Leadership Team willpresent the results to the QualityAssurance Committee. The Quality Assurance Committee, responsible to the Administrator, will monitor for continues com-pliance.2.Resident #42 and #108's careplans were reviewed and updated as needed. The nurses forthose two residents were re-edu-cated on the need to attempt in-terventions and document thoseinterventions prior to the admin-istration of medication on 7-25- and8-13-13. Both residents will be monitored weekly in addition to the10 randomly picked residents. A one time audit of the MAR's for PRN psychotropic drug use willbe completed by the DNS or herdesignee prior to 8-25-13. If any issues are discovered they will be addressed with the ran-dom audits and further	

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	mg to 3 mg did not get done until the second Medication Regimen Review form, dated 4/26/13, was reviewed by the Physician. The DNS indicated the Medication Regimen form, dated 1/22/13, to reduce the Melatonin 5 mg to 3 mg daily got missed. The DNS indicated the Assistant Director Nursing Services (ADNS) was responsible to present the Medication Regimen Review form to the Physician for review. During an interview on 7/26/13 at 11:00 a.m., the ADNS indicated the Medication Regimen Review forms were reviewed by the Physician and then the ADNS wrote the orders for the Physician. The ADNS indicated If all the Physician's orders were not done the ADNS left them for the nurses to finish writing the orders. 2. The clinical record of Resident #42 was reviewed on 7/25/13 at 1:00 p.m. The record of Resident #42 diagnosis included, but were not limited to, anxiety. The Medication Administration Record (MAR) for July 2013 indicated the resident had received xanax (medication for anxiety) 1 milligram (mg) on 7/2 at 4:00 p.m., 7/3 at 6:00 p.m., 7/4 at 7:00 a.m., 7/8 at 7:15		re-educa-tion of staff as needed.Nursing staff was re-educated on7-25-and 8-13-13 concerning the need to attempt non-pharmacologicalinterventions before administration ofmedication and to document those attempts.An audit will be completed by theDNS or her designee weeklyon ten (10) randomly picked resi-dents for four weeks. If there areno further issues the audit will be conducted on a monthly basis forsix months. (see exhibit F)DNS will present the results of the audits to the Business LeadershipTeam on a weekly/monthly basis.The Business Leadership Team willpresent the results to the Quality Assurance committee. The QualityAssurance committee, responsible tothe administrator, will monitor theresults for continued compliance.	

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	p.m., 7/9 at 7:00 p.m. 7/11 at 7:00 p.m., 7/12 at 3:15 p.m., 7/18 at 5:00 p.m., and 7/20 at 8:00 a.m. The Behavior logs, Nurses Notes and Behavior Monitoring Record, dated July 2013, indicated there was no documentation what behaviors the resident had on 7/2 at 4:00 p.m., 7/3 at 6:00 p.m., 7/4 at 7:00 a.m., 7/8 at 7:15 p.m., 7/9 at 7:00 p.m. 7/11 at 7:00 p.m., 7/12 at 3:15 p.m., 7/18 at 5:00 p.m., and 7/20 at 8:00 a.m. or that non-pharmacological interventions were tried prior to the administration of the xanax 1 mg. The Physician Order Sheet, dated July 2013, indicated Resident #42 had an order for xanax 1 mg three times a day as needed for anxiety. The resident's Care Plan for Anxiety, dated 1/9/11, indicated for interventions to try to redirect and provide diversions to the resident. During an interview on 7/26/13 at 9:45 a.m., QMA #1 indicated if Resident #42 became anxious QMA #1 would try non-pharmacological interventions first and if that failed would medicate the resident with xanax and document the interventions and effect in the			

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	resident's chart. 3. Resident # 108's clinical record was reviewed on 7/24/13 at 1:30 P.M. The record indicated the resident was admitted to the facility on 5/17/13. Review of the resident's most recent physician's orders of 7/1/13, indicated the resident had a order for Xanax (an antianxiety medication) 0.5 milligrams (mg) twice daily as needed. The medication order does not indicate what the medication is needed for. Review of Resident #108's medication administration record (MAR) for May, June and July of 2013 indicated the resident received Xanax 0.5 mg as needed for anxiety on; (5/19/13 at 9:15 A.M.; 5/10/13 at 9:00 A.M.; 5/13/13 at 11:05 P.M.; 5/14/13 at 12:45 P.M.; 5/14/13 at 6:20 P.M.; 5/16/13 at 6:20 P.M.; 5/17/13 at 12:20 P.M.; 5/18/13 at 11:15 A.M.; 5/19/13 at 8:40 P.M.; 5/21/13 at 4:45 P.M.; 5/22/13 at 1:00 P.M.; 5/23/13 at 9:40 P.M.; 5/24/13 at 11:00 P.M.; 5/27/13 at 7:45 A.M.; 5/28/13 at 8:35 P.M.; 5/31/13 at 12:25 P.M.; 6/22/13 at 11:10 P.M.; 6/23/13 at 11:00 P.M.; 6/25/13 at 1:15 A.M.; 7/7/13 at 11:00 A.M.. Review of the MAR's the resident's			

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	progress notes and the behavior monitoring form indicated no documentation of why the resident received the Xanax 0.5 mg as needed and did not indicated if any non-pharmacological interventions for anxiety were attempted before administration of the medication. Review of an "Anxiety Care Plan," dated 5/14/13, indicated the problem as generalized anxiety manifested by anxious complaints. The interventions were listed as: monitor for signs of behavior disturbance; provide reassurance; provide redirection or diversion; provide a structured and familiar daily routine; provide explanations prior to implementing care or procedures; encourage to participate and discuss personal care; provide calm, quiet environment and approach; anti-anxiety medication, Xanax as directed. An interview with LPN # 8 on 7/25/13 at 10:28 A.M., indicated resident #108's Xanax was given as needed for anxiety. LPN did not indicate any non-pharmacological interventions were attempted before administering Xanax 0.5 mg as needed. An interview with the Director of Nursing (DN) on 7/25/13 at 10:39			

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	A.M., indicated nurse's are to attempt non-pharmacological interventions before giving Xanax as needed and are to document the interventions on the behavior flow sheets. Review of the policy provided by the DN on 7/24/13 at 2:00 P.M. titled "General Dose Preparation and Medication Administration" date May, 2010, did not indicate any policy for administration of as needed medications. The DN indicated they had no policy for as needed medications. 3.1-48(a)(4)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, facility failed to ensure	F000441	F441It is the policy of this facility toprevent contamination of the	08/25/2013

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	nursing staff disinfected a potentially contaminated glucose meter after use during 1 of 3 observations of glucose meter use. Findings include: On 7/24/13 at 11:05 A.M., LPN #2 was observed to use a glucose meter (device used to measure blood sugar levels) to check the blood sugar of Resident #23. The nurse was observed to obtain a sample of blood on the glucose meter test strip and insert the strip into the glucose meter. After obtaining the blood sugar levels and discarding the test strip, LPN #2 was observed to return to the medication cart in the hallway, remove a wipe from a container labeled "Bleach Germicidal Wipes" and briefly wipe the outside of the glucose meter with the bleach wipe. LPN #2 was then observed to immediately wipe the glucose meter with a dry tissue. LPN #2 was then observed to carry the glucose meter into the room of Resident #104 to check the resident's blood sugar level. The nurse was observed to obtain a sample of blood on the glucose meter test strip and insert the strip into the glucose meter. After obtaining the blood sugar levels		glucose meter by following theGlucose Meter policy and procedure.Nursing staff was re-educated on the Glucose Meter policy and proced-ure on 7-25 and 8-13-13.(see Exhibit A)Performance tests for the nursingstaff will be conducted by the Director of Staff Development during the weeks of 8-12-13 and8-19-13 . (see Exhibit D)At least 5 Random observations of Glucose meter cleaning will be con-ducted by the Director of Staff De-velopment or her designee on a weekly basis, on all shifts, for four weeks.If there are no issues then the ran-dom observations will be con-ducted monthly for six months.The results of the performance tests and observations will be presentedto the Business Leadership Team ona weekly/monthly basis. The BusinessLeadership Team will present the re-sults to the Quality Assurance Com-mittee. The QA Committee, respon-sible to the Administrator, will mon-itor for continued compliance.	

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	and discarding the test strip, LPN #2 was observed to return to the medication cart in the hallway, remove a wipe from the container labeled "Bleach Germicidal Wipes" and then briefly wipe the outside of the glucose meter with the bleach wipe. LPN #2 was then observed to immediately wipe the glucose meter with a dry tissue and place the glucose meter into the medication cart. The label on the container labeled "Bleach Germicidal Wipes" indicated the wipes could be used for disinfecting medical equipment surfaces and was effective against bloodborne viruses, including, but not limited to, HIV, hepatitis B, and hepatitis C. The label indicated the contact time required to inactivate viruses was one minute. The label further indicated " Wipe hard, nonporous surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for the contact time listed on the label. Let air dry." The facility Assistant Director of Nursing (ADON) was interviewed on 7/25/13 at 1:05 P.M. During the interview, the ADON indicated nurses were to disinfect glucose meters following each use with the bleach			

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	wipes and were to follow the instructions on the container of wipes. LPN #3 was interviewed on 7/25/13 at 1:15 PM. During the interview, LPN #3 indicated glucose meters were to be disinfected with bleach wipes and were to air dry to ensure the glucose meters were properly disinfected. A policy dated 4/2012, entitled "Glucose Meter Cleaning/Disinfecting," indicated "When using a a disposable professional grade wipe, follow package instructions for use to ensure device/surface is wet covered for proper length of time to kill pathogens." 3.1-18(b)(1)			

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F000502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			
	Based on record review and interview, the facility failed to obtain a physician's ordered laboratory test for 1 of 1 residents (Resident #70) reviewed for laboratory services. Finding includes: Resident #70's clinical record was reviewed on 7/24/13 at 9:00 A.M.. The record indicated on 6/24/13, a physician's order was received Ceftine (an antibiotic) 1 gram twice daily for 10 days for a diagnosis of a Urinary Tract Infection (UTI) and to repeat the Urinalysis (UA) with a Culture and Sensitivity (C&S) when the antibiotic is completed. Review of the laboratory results indicated no follow up UA with a C&S was performed following completion of Ceftine 1 gram twice daily on 7/4/13. An interview with the Director of Nursing (DN) on 7/25/13 at 11:02. A.M. indicated the follow up UA with a C&S was not completed as ordered by the physician.	F000502	F502 It is the policy of this facility to provide or obtain laboratory services as ordered by a physician. Physician was contacted on 7-24-13 and UA order was discontinued. An audit was conducted by ADNS on 7-26-13all labs for current residents to make sure no further labs were missed. An audit will be conducted by ADNS each week for four weeks on all labs throughout the facility. (see exhibit E) If there are no further issues with labs, the audits will be conducted on a month- ly basis for six months DNS is responsible for reporting the results of the audits on a weekly/monthly basis to the Business Leadership Team. The Business Leadership Team will review and report finding to the	08/25/2013

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	3.1-49(a)		Quality Assurance Committee. The Quality Assurance Committee, responsible to the Administrator will review and monitor for continued compliance.	

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F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview the facility failed to ensure a physician was notified in a timely manner of abnormal laboratory results for 1 of 1 residents (Resident #70) reviewed for urinary tract infections (UTI). Findings include: Resident #70's clinical record was reviewed on 7/24/13 at 9:00 A.M. The record indicated a physician's order was received, on 6/5/13, for a urinalysis (UA) with a culture and sensitivity (C&S). The initial UA results were received on 6/6/13 and a physician's order for Amoxil (an antibiotic) 500 milligrams three times daily x 7 days was received for an urinary tract infection (UTI). On 6/8/13 until 6/19/13 the resident was out of the facility. On 6/21/13 the C&S results were received from the UA on 6/6/13 at 12:29 P.M. The C&S results were faxed to the physician by the Assistant Director of Nursing (ADN) and indicated "you treated with Amoxil on 6/6/13 x 7 days. I called today for the C&S. It doesn't have amoxicillin on it. It's showing greater than 100,000 CFU's [colony forming	F000505	F505 It is the policy of this facility to notify the attending physician of findings in a prompt manner. Nursing staff were re-educated to promptly fax abnormal lab results to the physician's office during business hours. If there is no response prior to end of shift the nurse is responsible to call the physician for a response. If the lab results are within normal limits, the results will be given to the ADNS for review with the physician. All critical labs must be telephoned to the doctor immediately. All lab results that are faxed to the physician and the reply will be kept in a lab fax binder on each nurses station. Each binder will be audited weekly for one month by nursing manage- ment staff for compliance. If there are no issues, the audits will be completed monthly for 6 months. (see exhibit E) DNS is responsible for reporting	08/25/2013

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	units]," "the bug is Pseudomonas. NKA's [no known allergies]." "How do you want to treat." A physician's order did not respond until 6/24/13, and ordered Cefepime 1 gram twice daily x 10 days for a diagnoses of pseudomonas aeruguinosa/UTI. Review of resident #70's progress notes from 6/21/13, indicated no follow up attempts were make to contact the physician to obtain treatment after the fax was sent to the physician on 6/21/13, until the physician's order was obtained on 6/24/13. An interview with the Director of Nursing (DN) on 7/24/13 at 12:50 P.M., indicated a nurse faxed the lab results of the C&S from 6/6/13, to the doctor on 6/21/13. The DN indicated she had no knowledge of why the physician did not respond to the fax until 6/24/13. An interview with the DN on 7/25/13 at 1:50 P.M., indicated after faxing abnormal lab results to the physician the nurse should watch for the response and follow up if no response is received. Review of a policy provided by the DN on 7/24/13 at 2:00 P.M., titled, "Policy		the results of the audits on a weekly/month- ly basis to the Business Leadership Team. The Business Leadership Team will review and report the results to the Quality Assurance Committee. The Quality Assurance Committee, respon- sible to the Administrator, will re- view and monitor for continued com- liance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/26/2013

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	Regarding Physician Notification," dated 3/15/12, indicated the physician is to be notified via fax for non-emergent situations including, but not limited to, abnormal labs (non-critical levels). 3.1-49(f)(2)			