

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00202349.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00203995.</p> <p>Complaint IN00202349 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 27, 28, 29, 30, July 1, 5, and 6, 2016.</p> <p>Facility number: 011149 Provider number: 155757 AIM number: 200829340</p> <p>Census bed type: SNF/NF: 117 SNF: 24 Total: 141</p> <p>Census payor type: Medicare: 27 Medicaid: 81 Other: 33 Total: 141</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	Rosegate Village respectfully requests desk review in lieu of an on-site revisit	

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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F 0242 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Q.R. completed by 14466 on July 12, 2016.</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 ensure a resident was given the right to choose and/or make choices about a resident's bathing preference for 1 of 2 residents reviewed for choices. (Resident # 287)</p> <p>Findings include:</p> <p>During an interview with Resident #287 on 06/28/2016 at 3:37 P.M., Resident</p>	F 0242	<p>F- 242-Self-Determination –Right to Make Choices</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#287 has chosen to have her shower 3 times per week on Tuesday, Thursday, and Saturday during day shift. Care Plan and shower schedule has been updated to reflect this change as of July 2016.</p>	08/05/2016	

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	<p>#287 indicated she was admitted to the facility on 06/20/16, and had not had a shower. This was going on 15 days since she had a shower, but she had received several partial baths which are not the same as a shower. Staff came in on the first day and ask if resident wanted baths or showers, how often and when. Resident #287 indicated she answered the questions and would really like to have a shower.</p> <p>The clinical record review for Resident #287 was completed on 07/05/16 at 11:00 A.M. Diagnoses included, but were not limited to, abscess right elbow, rheumatoid arthritis, acute kidney failure, overactive bladder, atrial fib, anemia, obesity, heart disease, cardiomegaly, hypotension, asthma, and cutaneous abscess of abdominal wall.</p> <p>Preference for Customary Routine and Activities completed 6/21, indicated, "Section: Do you have a preference as to what time or how often you bathe: two per week in the A.M. ... Section: What type of bathing are you use to? Shower."</p> <p>In an interview with the Activities Director at 4:00 P.M., on July 6, 2016, she indicated she had completed the ASC preference for customary routine</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive a shower have the potential to be affected by this alleged deficient practice. ·All resident shower preferences will be audited by DNS and/or Designee to ensure resident's shower preferences are being honored. ·Care plans, profiles, and shower sheets will be updated to reflect residents shower preference. ·All residents who receive showers will be identified in a daily audit by DNS and/or Designee to ensure showers are being conducted per daily preference. <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Activity Director or designee will complete the Preferences for Daily Customary Routines worksheet upon admission of a new resident, quarterly and upon significant change of a resident. The interview will be conducted with the resident unless they are not able to be understood. If the resident is not able to be understood, the worksheet is completed with the family/significant other, as available. The information from the worksheet will be shared 	

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	<p>and activities for resident #287 on 6/20/16. In the case of a resident having any special requests she texts the Unit Manager with them and that if there are no special requests then she simply enters the information into the computer. She indicated that Resident #287 hadn't given any special requests so she hadn't texted the unit manager.</p> <p>Per Point of Care history: The resident received partial baths on the following dates June 20, 25, 26, 27, 30, July 1 and 2, 2016 on second shift. The resident received partial baths on the following days June 28, 29, and on July 4, 2016 on day shift. Resident received other bath on June 25, 2016, and a shower on July 5, 2016, on second shift.</p> <p>Interview with Unit Manager on July 5, 2015 at 2:50 P.M., indicated she was not aware Resident #287 had a concern about her showers. She will investigate and resolve the issue.</p> <p>Interview with Unit Manager on July 5, 2015 at 4:00 P.M., indicated she had talked with Resident #287 and thought she had resolved concerns about her shower. The Certified Nursing Assistant was taking resident to get a shower now. Resident indicated to the Unit Manager that she would like 3 showers a week in</p>		<p>with the interdisciplinary team so that each department can address the resident's preferences and update the residents profile and CP as needed. Prior to bathing a resident the facility staff will review the residents CP or profile to ensure the residents preference is being followed.</p> <ul style="list-style-type: none"> An in-service will be completed by the Director of Nursing and/or Designee by August 5, 2016 for nursing staff on following residents shower preferences by reviewing resident profiles and/or shower schedule. The Director of Nursing Service and/or Designee will complete a daily audit of residents who receive showers to ensure showers are being given per the plan of care. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> A CQI audit tool "Accommodation of Needs", will be utilized by the Director of Nursing and/or designee to monitor the daily monitoring tool. Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. Results of Audit tool will be presented to the CQI Committee monthly to review for compliance and follow-up. 		

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F 0282 SS=D Bldg. 00	<p>the A.M.</p> <p>On July 6, 2016 at 3:30 P.M., Interview with Social Worker indicated she spoke with Resident #287 and had updated the care plan today to reflect the resident's preference on shower schedule.</p> <p>Interview with the Unit Manager on July 6,2016 at 4:15 P.M. indicated that in her unit it is standard procedure that, unless specifically requested otherwise, Residents in A beds are offered showers in the morning and residents in B beds are offered showers in the evening.</p> <p>3.1-3(u)(3)</p> <p>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. Based on record review and interview, the facility failed to provide services in</p>	F 0282	<p>Identifiednoncompliance may result in staff re-education and/or disciplinary action.</p> <p>·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up.</p> <p>Date Compliance: 8/5/2016</p> <p>F- 282-Services by Qualified Persons/per Care Plan</p>	08/05/2016	

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	<p>accordance with a resident's written plan of care for a resident who required blood pressure monitoring prior to administering medications. (Resident #40)</p> <p>Findings include:</p> <p>The clinical record review for Resident #40 was completed on 7/6/16 at 10:26 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure).</p> <p>a. A physician's order dated 12/3/15 and current through 7/6/16, indicated Resident #40 was to receive furosemide (a medication used to eliminate extra water) twice a day. The order indicated to withhold the medication if Resident #40's systolic blood pressure (top number/the amount of pressure in your arteries during contraction of the heart muscle) was less than 110.</p> <p>b. A physician's order dated 12/3/15 and current through 7/6/16, indicated Resident #40 was to receive potassium chloride (a medication used as a potassium supplement) every day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 110.</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #40 the Director of Nursing checked resident's Blood Pressure and in-serviced nurses working that assignment. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All Residents receiving medication requiring Blood Pressure monitoring prior to medication have the potential by the alleged deficient practice. ·An audit by DNS and/or Designee has been completed to ensure all residents with orders for vitals prior to medication administration have received blood pressure appropriately. ·An in-service will be completed by the Director of Nursing and/or designee by August 5, 2016 to licensed nurses on Blood Pressure monitoring and documentation. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·When a nurse administers medications she will review the order prior to administration. If vitals are required prior to administration the nurse will assess and document the vital 	

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	<p>c. A physician's order dated 1/21/16 and current through 7/6/16, indicated Resident #40 was to receive diltiazem (a medication used to treat high blood pressure) three times a day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 100.</p> <p>d. A physician's order dated 1/25/16 and current through 7/6/16, indicated Resident #40 was to receive metoprolol tartrate (a medication used to treat high blood pressure) twice a day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 100.</p> <p>A review of Resident #40's clinical record, lacked documentation indicating the blood pressure had been assessed prior to administering the above medications.</p> <p>A careplan started 4/8/14 and last revised on 4/5/16, indicated Resident #40 is at risk for fluid imbalance due to hypertension. An intervention indicated to administer medications as ordered.</p> <p>A careplan started 4/8/16 and last revised on 4/5/16, indicated Resident #40 has ineffective tissue perfusion related to hypertension.</p>		<p>signs inmatrix and act accordingly to the MD order.</p> <ul style="list-style-type: none"> An in-service will be completed by the Director of Nursing and/or designee by August 5, 2016 to licensed nurses on Blood Pressure monitoring and documentation. Noncompliance with physician orders and documentation related to Blood Pressure monitoring may result in reeducation and/or disciplinary action. The Director of Nursing Services and/or designee will complete a daily audit tool of eMAR for Blood Pressure monitoring for all residents with orders to monitor Blood Pressure to ensure nurses are performing and documenting per physician orders. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> CQI audit tool "Obtaining Blood Pressure Prior to Medication" will be utilized by the Director of Nursing and/or designee to monitor compliance with Blood Pressure documentation. Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. 	

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F 0315 SS=D Bldg. 00	<p>On 7/6/16 at 2:14 p.m., the Director of Nursing (DON) indicated no blood pressures were found in the clinical record that correlated with the medication administration times. The DON indicated the electronic order would be updated with a line added to document the blood pressure obtained prior to administering the medications.</p> <p>On 7/6/16 at 4:03 p.m., the DON indicated no policy and procedure was found relating to blood pressure documentation with medication administration.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review, observation, and interview, the facility failed to ensure</p>	F 0315	<p>Identified noncompliance may result in staff re-education and/or disciplinary action.</p> <p>If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p> <p>Compliance Date:08/05/2016</p> <p>F-315 No Catheter, Prevent UTI, Restore Bladder</p>	08/05/2016

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	<p>urinary catheter drainage tubes were maintained in a manner to prevent urinary tract infections for 2 of 2 residents observed for urinary catheter drainage tubes. (Resident's #284 & 52)</p> <p>Findings include:</p> <p>1. A clinical record review was completed for Resident #284 on 7/6/16 at 11:20 a.m. Diagnoses included, but were not limited to, obstructive uropathy (flow of urine is blocked).</p> <p>A recapitulated physician's order for July, 2016, with an original order date of 6/28/16, indicated Resident #284 had a urinary catheter (a tube which drains urine from the bladder).</p> <p>A care plan dated 6/22/16 and current through 7/6/16, indicated a problem of, "Resident requires an indwelling urinary catheter." Approaches included, "Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>During initial tour on 6/27/16 at 10:55 a.m., Resident #284's urinary catheter tubing was observed resting on the floor in resident's room.</p> <p>2. A clinical record review was completed for Resident #52 on 7/6/16 at</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #284 Foley catheter tubing was immediately secured to his leg. Residents care plans were updated to reflect these needs. Resident #52 Foley catheter tubing was immediately secured to his leg. Residents care plans were updated to reflect these needs. Immediate training was completed to educate nursing staff on not allowing tubing or any part of the drainage system to touch the floor. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents identified with Foley catheters have the potential to be affected by the alleged deficient practice. An audit was performed by the DNS/Designee on all catheters to ensure the tubing is not touching the floor. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> All residents identified with Foley catheters will not have tubing or any part of the drainage system touch the floor. When providing care staff will ensure 	

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	<p>11:38 a.m., Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder (a person lacks control of the urine flow) and obstructive uropathy (flow of urine is blocked).</p> <p>A recapitulated physician's order for July, 2016, with an original order date of 4/28/16, indicated Resident #52 had an indwelling catheter (a tube which drains urine from the bladder).</p> <p>A care plan dated 7/13/15, last revised on 6/2/16, and current through 7/6/16, indicated a problem of, "Resident is at risk for infection d/t [due to] requires an indwelling urinary catheter." Approaches included, "Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>During initial tour on 6/27/16 at 11:34 a.m., Resident #52's urinary catheter tubing was observed resting on the floor in the activity room.</p> <p>On 7/6/16 at 4:05 p.m., the Director of Nursing (DON) indicated indwelling catheter tubing is not supposed to touch the floor at any time. The DON also indicated there was no policy found relating to catheter tubing touching the floor.</p>		<p>thatcatheter bags and tubing are positioned appropriately and ensure the tubing andbag are secured so that the tubing and/or bag do not touch the ground.</p> <ul style="list-style-type: none"> ·An in-service will be completed by the Directorof Nursing and/or Designee on August 5, 2016 for nursing staff on not allowingtubing or any part of the drainage system to touch the floor. ·Noncompliance in care of residents with Foleycatheters may result in re-education and/or disciplinary action. ·The Director of Nursing Services and/or Designee will conduct a daily audit by completing the monitoring tool on every shift toensure that no tubing or any part of the drainage system is touching the floor. <p>How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·A CQI "Catheter Drainage System" tool will beutilized by Director of Nursing and/or Designee to monitor compliance with notallowing tubing or any part of the drainage system to touch the floor for residentswith Foley catheters weekly x 4 weeks, monthly x 6 months, then quarterlythereafter for at least 2 Quarters. ·Results of the audit will be presented to theCQI Committee 		

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F 0323 SS=D Bldg. 00	<p>3.1-41(a)(2)</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 assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure potentially hazardous chemicals and disinfecting wipes were secured on 2 of 6 hallways.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 6/27/16 at 11:00 a.m. to 11:40 a.m., the following observations were made:</p> <p>1. An unlocked drawer in the dining area of the secured unit (32 residents residing), contained 2 butcher knives, both approximately 8 and 1/2 inches long.</p>	F 0323	<p>monthly to ensure compliance and follow-up. Identified non-compliance may result in staff re-education and/or disciplinary action.</p> <p>·If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. Compliance Date: 8/5/2016</p> <p>F- 323 – Accidents</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·The butcher knives in the dining room in the secured unit were immediately removed and placed in a secured area.</p> <p>·The 160 count container of Micro Kill wipes, two 28 (oz) Glade Air Freshener Arysol Cans, one 11(oz) can of hair spray, one 32 z Bleach Germicidal Cleaner, one 32(oz) Array Citrus Spray, one 16 (oz) Stainless Steel Polish, One 32 (oz) Clorox Cleaner + Bleach, One 750 Milliliter Neutral Quat, and seven disposable razor all located in the</p>	08/05/2016

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	<p>2. The shower room on the secured unit was unlocked. The following were observed in the unlocked shower room:</p> <p>a. One, 160 count container of Micro Kill wipes, with a labeling indicating, "Hazardous to humans. Call a doctor for treatment advice."</p> <p>b. Two, 28 ounce (oz) Glade Air Freshener Arysol cans, with labeling indicating, "Inhaling can be harmful and even fatal to humans."</p> <p>c. One, 11 oz can of hairspray, with labeling indicating, "Inhaling can be harmful and even fatal to humans."</p> <p>d. One, 32oz Bleach Germicidal Cleaner, with labeling indicating, "Hazardous to humans."</p> <p>e. One, 32oz Array Citrus Spray, with labeling indicating, "Causes eye irritation."</p> <p>f. One, 16oz Stainless Steel Polish, with labeling indicating, "Causes eye irritation."</p> <p>g. One, 32oz Clorox Cleaner + Bleach, with labeling indicating, "If swallowed, call doctor immediately, contains bleach."</p>		<p>shower room on the secured were immediately secured.</p> <ul style="list-style-type: none"> The 750 Milliliter Neutral Quat, one 32 (oz) Bleach Germicidal Cleaner all located in the 400 hall shower room were immediately secured. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. Safety assessments of all resident dining areas and shower rooms have been completed. All potential hazards have been removed from areas accessible to residents. An in-service will be provided to all staff to ensure that all hazardous materials and chemicals are secured by the DNS or designee on or before August 5, 2016. <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> All hazardous items will be locked and stored out of the reach of the residents and all shower doors will remain locked with unsupervised. An in-service will be provided to all staff to ensure that all hazardous materials and chemicals are secured by the DNS or designee on or before August 5, 2016. An audit will be conducted daily on each shift by Director of 	

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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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	<p>h. One, 750 millimeter Neutral Quat, with labeling indicating, "Incase of contact with eyes, flush immediately."</p> <p>i. Seven disposable razors.</p> <p>3. The 400 hall shower room door on was unlocked and ajar. One, 750 milliliter Neutral Quat was observed, with labeling indicating, "Incase of contact with eyes, flush immediately." One, 32oz Bleach Germicidal Cleaner was observed, with labeling indicating, "Hazardous to humans."</p> <p>During an interview on 6/27/16 at 11:15 a.m., Licensed Practical Nurse (LPN) #1 indicated the drawer containing knives in the dining area was supposed to be locked and the shower room doors should be locked as well.</p> <p>On 7/6/16 at 4:25 p.m., the Director of Nursing (DON) indicated no policy was found relating to potentially hazardous items, unlocked drawers, and unlocked doors.</p> <p>3.1-45(a)(1)</p>		<p>Nursing Servicesand/or Designee using the monitoring tool to ensure potential hazardousmaterials are secured.</p> <ul style="list-style-type: none"> ·Noncompliancein storage of hazardous materials and chemicals may result in re-educationand/or disciplinary action <p>How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·ACQI "Safety and Hazardous CQI Tool" audit tool will be utilized to monitorcompliance with proper usage of mechanical lifts. Resident transfers usingmechanical lifts will be observed weekly X 4 weeks, monthly X 6 months, andquarterly thereafter for at least 2 Quarters. ·Results of these evaluation processeswill be presented to the CQI Committee monthly to review for compliance andfollow-up. Identified noncompliance may result in staff re-education and/ordisciplinary action. ·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. <p>Compliance Date: 8/5/2016</p>	

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F 0329 SS=D Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a blood pressure was monitored as indicated by physician prior to medication administration for 1 of 5 residents reviewed for unnecessary medication use. (Resident #40)</p> <p>Findings include:</p> <p>The clinical record review for Resident #40 was completed on 7/6/16 at 10:26 a.m. Diagnoses included, but were not</p>	F 0329	<p>F- 329-Drug regimen is free from unnecessary drugs</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Resident #40 the Director of Nursing checked resident's Blood Pressure and in-serviced nurses working that assignment.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action</p>	08/05/2016
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	<p>limited to, hypertension (high blood pressure).</p> <p>a. A physician's order dated 12/3/15 and current through 7/6/16, indicated Resident #40 was to receive furosemide (a medication used to eliminate extra water) twice a day. The order indicated to withhold the medication if Resident #40's systolic (top number/the amount of pressure in your arteries during contraction of the heart muscle) blood pressure was less than 110.</p> <p>b. A physician's order dated 12/3/15 and current through 7/6/16, indicated Resident #40 was to receive potassium chloride (a medication used as a potassium supplement) every day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 110.</p> <p>c. A physician's order dated 1/21/16 and current through 7/6/16, indicated Resident #40 was to receive diltiazem (a medication used to treat high blood pressure) three times a day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 100.</p> <p>d. A physician's order dated 1/25/16 and current through 7/6/16, indicated</p>		<p>will be taken?</p> <ul style="list-style-type: none"> ·All Residents receiving medicationrequiring Blood Pressure monitoring prior to medication have the potential bythe alleged deficient practice. ·An audit by DNS and/or Designee has beencompleted to ensure all residents with orders for vitals prior to medicationadministration have received blood pressure appropriately ·A daily audit by DNS and/or Designee hasbeen initiated to ensure nurses are obtaining Blood Pressure per physicianorders. <p>What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?</p> <ul style="list-style-type: none"> ·Whena nurse administers medications she will review the order prior toadministration. If vitals are requiredprior to administration the nurse will assess and document the vital signs inmatrix and act accordingly to the MD order. ·An in-service will be completed by theDirector of Nursing and/or designee by August 5, 2016 to licensed nurses on BloodPressure monitoring and documentation. ·Noncompliance with physician orders anddocumentation related to Blood Pressure monitoring may result in reeducation and/ordisciplinary action. ·The Director of Nursing 	

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F 0505	<p>Resident #40 was to receive metoprolol tartrate (a medication used to treat high blood pressure) twice a day. The order indicated to withhold the medication if Resident #40's systolic blood pressure was less than 100.</p> <p>A review of Resident #40's clinical record, lacked documentation indicating the blood pressure had been assessed prior to administering the above medications.</p> <p>On 7/6/16 at 2:14 p.m., the Director of Nursing (DON) indicated no blood pressures were found in the clinical record that correlated with the medication administration times. The DON indicated the electronic order would be updated with a line added to document the blood pressure obtained prior to administering the medications.</p> <p>On 7/6/16 at 4:03 p.m., the DON indicated no policy and procedure was found relating to blood pressure documentation with medication administration.</p> <p>3.1-48(a)(3)</p> <p>483.75(j)(2)(ii)</p>		<p>Services and/or designee will complete a daily audit tool of eMAR for Blood Pressure monitoring for all residents with orders to monitor Blood Pressure to ensure nurses are performing and documenting per physician orders.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · CQI audit tool "Obtaining Blood Pressure Prior to Medication" will be utilized by the Director of Nursing and/or designee to monitor compliance with Blood Pressure documentation. Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. · If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. <p>Compliance Date: 8/5/2016</p>	

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SS=D Bldg. 00	<p>PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure a resident's physician was notified of a laboratory value outside of the reference range for 1 of 5 residents reviewed for unnecessary medication use. (Resident #117)</p> <p>Findings include:</p> <p>The clinical record of Resident #117 was reviewed on 7/1/16 at 12:43 p.m. Diagnoses for Resident #117 included, but were not limited to, paranoid schizophrenia, major depressive disorder, dementia with behaviors, and bipolar disorder.</p> <p>Recapitulated orders for July, 2016, indicated Resident #117 was to receive divalproex, 250 mg (milligrams) twice a day. The original order date was 6/15/15. Divalproex (valproic acid-VPA) is a medication used to treat manic episodes in bipolar disorder.</p> <p>A physician's order dated 9/21/15, indicated Resident #117 was to have a VPA laboratory blood test on the third Monday of January, 2016, to check the level of divalproex in her bloodstream.</p>	F 0505	<p>F-505-Promptly Notified Physician of Lab of Results</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #117 the Director of Nursing immediately notified physician of lab values and in-serviced nurses working that assignment. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> An audit was performed on all residents who received labs in the last 60 days by the DNS and/or Designee to ensure the physician was notified of lab values. All residents requiring labs have been identified and a daily audit by DNS and/or Designee has been initiated to ensure nurses notifying Physician of lab values. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> When a lab result is obtained from the lab. The responsible nurse will review the lab and notify the physician of the lab values. The MD will sign the lab order or the nurse will initial that the MD was notified and the 	08/05/2016			

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	<p>Results of the VPA level blood test, drawn 1/18/16, indicated Resident #117's level was 23. The laboratory report indicated the reference range for this medication was 50 -100, and the resident's level for this medication was below the reference range.</p> <p>No documentation was found in Resident #117's record which indicated the physician was aware of the results of the VPA blood test drawn 1/18/16.</p> <p>On 7/5/16 at 3:15 p.m., the Director of Nursing indicated she was unable to find any documentation which indicated the physician was notified of Resident #117's VPA lab result.</p> <p>The Nursing 2014 Drug Handbook indicates the drug level should be monitored, "Therapeutic level is commonly considered to be 50 - 100."</p> <p>3.1-49(f)(2)</p>		<p>date of notification. The lab will then be filed in the chart under the lab section. A nurse manager or designee will review the lab report daily to ensure all order labs are obtained and the physician was notified and that the lab was filed in the medical record.</p> <ul style="list-style-type: none"> · An in-service will be completed by the Director of Nursing and/or designee by August 5, 2016 to licensed nurses on physician notification of lab values. · Noncompliance with physician notification related to lab values may result in reeducation and/or disciplinary action. · The Director of Nursing Services and/or designee will complete a daily lab monitoring tool for all residents with lab orders to ensure nurses notifying physician. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · CQI audit tool "MD Notification of Lab Values" will be utilized by the Director of Nursing and/or designee to monitor compliance with physician notification. Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review 	

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			<p>for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p> <p>If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p> <p>Compliance Date: 8/5/2016</p>		