

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 25, 26, 27, 30 and 31, 2015</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Survey team: Julie Ferguson, RN-TC Caitlyn Doyle, RN Heather Hite, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 13 SNF/NF: 82 Total: 95</p> <p>Census payor type: Medicare: 17 Medicaid: 54 Other: 24 Total: 95</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after April 17, 2015</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 221 SS=D Bldg. 00	<p>Quality review completed on April 5, 2015, by Janelyn Kulik, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident was free from a physical restraint related to a seatbelt restraint not being released at meal service and a Physical Restraint Order flow sheet not being completed for 1 of 2 residents reviewed for physical restraints out of the 2 who met the criteria for physical restraints. (Resident #98)</p> <p>Finding includes:</p> <p>On 3/27/15 at 10:56 a.m., Resident #98 was observed sitting in a Broda chair in the 1 West Dining Room. The resident was sitting upright with his eyes closed and wearing headphones over his ears.</p>	F 221	<p>F 221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS It is the practice of this provider to ensure that each resident is free from a physical restraint related to a seatbelt restraint not being released at meal service and a Physical Restraint Order Flowsheet being completed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #98's seatbelt restraint is being released per the physician's order and a Physical Restraint Order Flowsheet is being completed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with a seatbelt</p>	04/17/2015

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	<p>The resident had a seatbelt connected to the chair and clipped around the side of the resident. The residents arms were folded and laying over the seatbelt.</p> <p>On 3/27/15 from 12:00 p.m. to 12:40 p.m., Resident #98 was observed continuously sitting in a Broda chair at a dining table in the Main Dining Room. The resident was sitting upright with headphones over his ears and eyes open. The resident had a seatbelt connected to the chair and clipped around the side of the resident. At 12:03 p.m., the resident received food covered from the Dietary Manager and placed on the table, she then placed a clothing protector on the resident and walked away. The residents seatbelt was still clipped around the resident. At 12:14 p.m., LPN #5 sat down at the table to assist Resident #98 with eating. The resident's seatbelt was still clipped around the side of the resident. At 12:40 p.m., the resident finished eating, the LPN removed the residents clothing protector and the seatbelt was still clipped around the side of the resident.</p> <p>Record review for Resident #98 was completed on 3/27/15 at 11:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and dementia.</p>		<p>restraint have the potential to be affected by the alleged deficient practice. All residents with a seatbelt restraint were checked by the Director of Nursing or her designee to ensure residents were released per plan of care and physician order. Nursing staff are responsible to release the seatbelt restraint per the physician's order every shift. CNAs are responsible to document on the Physical Restraint Order Flowsheet every shift. Each resident with a seatbelt restraint is being checked each shift by the Charge Nurse to ensure compliance with physician orders related to releasing the seatbelt. The Charge Nurse is responsible to check the Physical Restraint Order Flowsheet every shift to ensure compliance with documentation. Each resident with a Physical Restraint Order Flowsheet is being checked daily by the Unit Manager or her designee to ensure compliance with documentation. Nursing staff have been re-educated related to the facility restraint policy and procedure and Physical Restraint Order Flowsheet documentation by the Director of Nursing Service or her designee by April 17, 2015.</p> <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>	

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	<p>The Annual MDS (Minimum Data Set) assessment completed on 2/15/15, indicated the resident was severely cognitively impaired. The resident used a trunk restraint less than daily.</p> <p>The March 2015 Physician Order Summary indicated an order was started on 9/3/14 for: May use alarming seat belt in rocking Broda chair PRN (as needed) visual check every 30 minutes, release every 2 hours for ROM (range of motion) due to increased fall risk, poor safety awareness secondary to dementia, check every hour and reposition and release every 2 hours on every shift.</p> <p>A Restrictive Device Review assessment completed on 3/3/15 indicated the current reduction plan included to remove the restraint at meal times, direct care, supervised activities and visits from family and friends.</p> <p>A Physical Restraint Order flow sheet for March 2015 was left blank up to March 27 at 3:00 p.m.</p> <p>Interview with LPN #1 on 3/27/15 at 11:04 a.m., indicated a restraint flow sheet where the restraint was checked and released every 2 hours was completed by the CNAs. She further indicated she was</p>		<p>Nursing staff are responsible to release the seatbelt restraint per the physician's order every shift. CNAs are responsible to document on the Physical Restraint Order Flowsheet every shift. Each resident with a seatbelt restraint is being checked each shift by the Charge Nurse to ensure compliance with physician orders related to releasing the seatbelt. The Charge Nurse is responsible to check the Physical Restraint Order Flowsheet every shift to ensure compliance with documentation. Each resident with a Physical Restraint Order Flowsheet is being checked daily by the Unit Manager or her designee to ensure compliance with documentation. The Director of Nursing Services or her designee will make rounds each shift to ensure that seatbelts are being released per plan of care and physician order. Nursing staff have been re-educated related to the facility restraint policy and procedure and documentation on the Physical Restraint Order Flowsheet by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	

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	<p>unable to find the flow sheet.</p> <p>Interview with LPN #5 on 3/27/15 at 12:41 p.m., indicated she did not release the residents seatbelt while he was eating and was unsure if he was supposed to have it released while he was eating.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/27/15 at 2:54 p.m., indicated the resident was supposed to have the seatbelt released while he was eating and the nurse should have released it.</p> <p>Interview with CNA #2 and CNA #3 on 3/30/15 at 4:10 p.m., indicated the residents restraint was supposed to be removed every 2 hours when he was toileted, also at bedtime, and at meals and activities when someone was with him. The CNA's further indicated they document on a flow sheet when the restraint was removed.</p> <p>Interview with the DNS on 3/30/15 at 4:16 p.m., indicated she was unable to find the March 2015 restraint release flow sheet. She further indicated a new flow sheet was started on 3/27/15.</p> <p>A policy titled Restrictive Devices and received from the DNS as current indicated..."8. A restraint release record</p>		<p>program will be put into place?</p> <p>The CQI form titled "Physical Restraints" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>	

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F 279 SS=D Bldg. 00	<p>will be initiated to document that the resident is checked every hour and released or repositioned every two hours..."</p> <p>3.1-3(w) 3.1-26(f)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure each resident had a comprehensive care plan related to</p>	F 279	<p>F279 DEVELOP COMPREHENSIVE CARE PLANS It is the practice of this provider to ensure that each resident has a</p>	04/17/2015

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	<p>a seat belt restraint for 1 of 2 residents reviewed for restraints of the 2 residents who met the criteria for restraints and for a psychoactive medication for 1 of 5 residents reviewed for unnecessary medications of the 5 residents who met the criteria for unnecessary medications. (Residents #98 and #29)</p> <p>Findings include:</p> <p>1. Record review for Resident #98 was completed on 3/27/15 at 11:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and dementia.</p> <p>The Annual MDS (Minimum Data Set) assessment completed on 2/15/15, indicated the resident was severely cognitively impaired. The resident used a trunk restraint less than daily.</p> <p>The March 2015 Physician Order Summary indicated an order was started on 9/3/14 for: May use alarming seat belt in rocking Broda chair PRN (when necessary) visual check every 30 minutes, release every 2 hours for ROM (range of motion) due to increased fall risk, poor safety awareness secondary to dementia, check every hour and reposition and release every 2 hours on every shift.</p>		<p>comprehensive care plan related to a seatbelt restraint and psychoactive medication.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #98 has a comprehensive care plan related to a seatbelt restraint. Resident #29 has a comprehensive care plan related to psychoactive medication.</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> <p>All residents with a seatbelt restraint and psychoactive medication have the potential to be affected by the alleged deficient practice. The MDS coordinator or her designee has reviewed the physician orders of all residents with a seatbelt restraint to ensure there is a corresponding care plan. The MDS coordinator or her designee has reviewed the physician orders of all residents with a psychoactive medication to ensure there is a corresponding care plan. The Interdisciplinary team has been re-educated related to ensuring a resident has a corresponding care plan when they receive a physician order for a seatbelt restraint or a</p>				

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	<p>Review of Resident #98's record lacked a care plan for the restraint.</p> <p>Interview with the MDS Coordinator on 3/30/15 at 4:28 p.m., indicated when she was asked about the resident's restraint on 3/27/15 she realized the resident did not have a care plan for the restraint. She further indicated a care plan should have been put into place before 3/27/15.</p> <p>2. The record for Resident #29 was reviewed on 3/27/15 at 2:15 p.m. Diagnoses included, but were not limited to, depression, anxiety, congestive heart failure, chronic kidney disease, and diabetes mellitus.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 2/18/15 indicated Resident #29 received an antidepressant medication during 7 of the last 7 days and an anti-anxiety medication during 7 of the last 7 days.</p> <p>Review of Physician's Orders from admission on 8/28/14 until present indicated the following orders for psychoactive medications: - 11/13/14 Xanax (anti-anxiety medication) 0.5 mg (milligram) tablet oral at bedtime . Indication: anxiety. - 11/13/14 Prozac (antidepressant medication) 20 mg oral once a day.</p>		<p>psychoactive medication by the Director of Nursing Service or her designee by April 17, 2015.</p> <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> <p>When a resident receives an order for a seatbelt restraint, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. When a resident receives an order for a psychoactive medication, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The MDS Coordinator or her designee is responsible to check all orders the next day and to develop a corresponding care plan. The Interdisciplinary team reviews care plans quarterly and as needed to ensure each resident has a corresponding care plan for seatbelt restraints and psychoactive medication when they have a physician order for them. The Interdisciplinary team has been re-educated related to ensuring a resident has a corresponding care plan when they receive a physician order for a seatbelt restraint or a psychoactive medication by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in</p>		

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	<p>Indication: tearfulness, s/s (signs/symptoms) of depression. - 12/10/14 Prozac 40 mg oral once a day. Indication: depression. - 1/6/15 Xanax 0.5 mg tablet oral three times a day. Indication: anxiety. - 1/22/15 Xanax 0.5 mg tablet oral twice a day. Indication: anxiety. - 1/30/15 Psych (psychiatric services) referral</p> <p>Review of the February and March 2015 MARs (Medication Administration Records) indicated Resident #29 received the medications Xanax and Prozac as ordered.</p> <p>Review of Behavior Flow sheets for Resident #29 from October 2014 through February 2015 indicated the behavior of Repetitive verbalizations, dx. anxiety was being documented and monitored every shift.</p> <p>Review of Resident #29's care plans indicated a Behavioral Symptom care plan for Repetitive verbalizations, dx. (diagnosis) anxiety. Interventions included, talk with resident, pain mgt (management), and reposition resident as needed. No intervention for medications was noted. The record also lacked care plans for depression and the psychoactive medication use of Xanax and Prozac.</p>		<p>employee re-education and/or disciplinary action.</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? The CQI form titled "Care Plan Updating" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>		

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F 282 SS=E Bldg. 00	<p>Interview with the MDS Coordinator on 3/31/15 at 9:15 a.m., indicated the anti-anxiety and antidepressant medication use was documented on Resident #29's MDS assessment and should have been carried over on to a permanent care plan for psychoactive medication use. She further indicated she was in charge of doing the care plans for medications and the Social Services Director (SSD) was in charge of care plans for behaviors and moods.</p> <p>Interview with the SSD on 3/31/15 at 9:30 a.m., indicated Resident #29 should have had a mood care plan in place for depression since the resident received the medication Prozac and one had just been entered into the computer.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</p>			
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	<p>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the current plan of care was followed as written related to the release of a seat belt restraint at meal service for 1 of 2 residents reviewed for restraints out of the 2 who met the criteria for restraints and for fall interventions not in place for 1 of 3 residents reviewed for accidents of the 3 who met the criteria for accidents and dialysis site assessment for 1 of 1 residents reviewed for dialysis of the 3 who met the criteria for dialysis. The facility also failed to ensure the current plan of care was followed as written related to non-pharmacological interventions prior to PRN (when necessary) pain medication and insulin administration completed as ordered for 2 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Residents #98, #40, #134, #118 and #32)</p> <p>Findings include:</p> <p>1. On 3/27/15 at 10:56 a.m., Resident #98 was observed sitting in a Broda chair in the 1 West Dining Room. The resident was sitting upright with his eyes closed</p>	F 282	<p>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is the practice of this provider to ensure that the current plan of care is followed as written related to the release of a seat belt restraint at meal service, for fall interventions, for dialysis site assessment, and as related to non-pharmacological interventions prior to PRN pain medication and insulin administration.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The care plan for resident #98's seatbelt restraint is being followed. The care plan for resident #40's fall interventions is being followed. The care plan for resident #134's dialysis access site assessment is being followed. The care plan for resident #118's non-pharmacological interventions prior to PRN medication administration is being followed. The care plan for resident #32's insulin administration is being followed.</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>	04/17/2015

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	<p>and wearing headphones over his ears. The resident had a seatbelt connected to the chair and clipped around the side of the resident. The residents arms were folded and laying over the seatbelt.</p> <p>On 3/27/15 from 12:00 p.m. to 12:40 p.m., Resident #98 was observed continuously sitting in a Broda chair at a dining table in the Main Dining Room. The resident was sitting upright with headphones over his ears and eyes open. The resident had a seatbelt connected to the chair and clipped around the side of the resident. At 12:03 p.m., the resident received food covered from the Dietary Manager and placed on the table, she then placed a clothing protector on the resident and walked away. The residents seatbelt was still clipped around the resident. At 12:14 p.m., LPN #5 sat down at the table to assist Resident #98 with eating. The resident's seatbelt was still clipped around the side of the resident. At 12:40 p.m., the resident finished eating, the LPN removed the residents clothing protector and the seatbelt was still clipped around the side of the resident.</p> <p>Record review for Resident #98 was completed on 3/27/15 at 11:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease,</p>		<p>All residents that have care plans related to a seatbelt restraint, fall interventions, a dialysis access site, PRN medication and insulin have the potential to be affected by the alleged deficient practice.</p> <p>All residents with a seatbelt restraint have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. The profiles of all residents with a seatbelt restraint have been reviewed by the MDS coordinator or her designee to ensure they show the interventions from the corresponding care plan. Nursing staff have been re-educated related to following a resident care plan for releasing a seatbelt restraint at mealtimes by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>All residents with fall interventions have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. The profiles of all residents with fall interventions have been reviewed by the MDS coordinator or her designee to ensure they show the interventions from the corresponding care plan. Nursing staff have been re-educated related to following the care plans and profiles for having fall interventions in place by the Director of Nursing Service or her designee by April 17, 2015.</p>	

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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
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	<p>anxiety, and dementia.</p> <p>The March 2015 Physician Order Summary indicated an order was started on 9/3/14 for: May use alarming seat belt in rocking Broda chair PRN (when necessary) visual check every 30 minutes, release every 2 hours for ROM (range of motion) due to increased fall risk, poor safety awareness secondary to dementia, check every hour and reposition and release every 2 hours on every shift.</p> <p>A Restrictive Device Review assessment completed on 3/3/15 indicated the current reduction plan included to remove the restraint at meal times, direct care, supervised activities and visits from family and friends.</p> <p>Interview with LPN #5 on 3/27/15 at 12:41 p.m., indicated she did not release the residents seatbelt while he was eating and was unsure if he was supposed to have it released while he was eating.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/27/15 at 2:54 p.m., indicated the resident was supposed to have the seatbelt released while he was eating and the nurse should have released it.</p> <p>Interview with CNA #2 and CNA #3 on</p>		<p>All residents with a dialysis access site have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. The physician orders for all residents with a dialysis access site have been reviewed by the Director of Nursing Services or her designee.</p> <p>All residents with a dialysis access site are being assessed per physician order.</p> <p>Nursing staff have been re-educated related to assessing a dialysis access site by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>All residents with prn pain medication have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan.</p> <p>Nursing staff have been re-educated related to offering non-pharmacological interventions per the care plan before giving prn pain medication by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>All residents with sliding scale insulin administration have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan.</p> <p>All residents with a sliding scale have been reviewed by their physician.</p> <p>Nursing staff have been re-educated related to following physician orders for sliding scale insulin</p>		

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	<p>3/30/15 at 4:10 p.m., indicated the residents restraint was supposed to be removed every 2 hours when he was toileted, also at bedtime, and at meals and activities when someone was with him. The CNA's further indicated they document on a flow sheet when the restraint was removed.</p> <p>2. Record review for Resident #32 was completed on 3/30/15 at 10:47 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and dementia.</p> <p>A care plan dated 8/13/14 indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included: medications as ordered.</p> <p>The March 2015 Physician Order Summary indicated an order for Humalog (insulin) solution per sliding scale TID (three times a day). The units to be given were as followed:</p> <p>0-150=give 0 units 151-200=give 3 units 201-250=give 5 units greater than 250=give 8 units</p>		<p>administration by the Director of Nursing Service or her designee by April 17, 2015.</p> <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> <p>When a resident receives an order for a seatbelt restraint, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The MDS Coordinator or her designee is responsible to check all orders the next day and to develop a corresponding care plan and update the profile related to releasing the seatbelt restraint at mealtimes. The Unit Manager or her designee is responsible to make a Physical Restraint Order Flowsheet related to releasing the seatbelt restraint at mealtimes. Nursing staff are responsible to ensure the seatbelt restraint is released at mealtimes. The CNA's check the profile each shift. The CNA's are responsible to document on the Physical Restraint Order Flowsheet. The Charge Nurse is responsible to audit the Physical Restraint Order Flowsheet each shift to ensure compliance. The Unit Manager is responsible to audit the Physical Restraint Order Flowsheet each day to ensure compliance. The Director of Nursing Services or</p>	

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	<p>Review of the February 2015 MAR (Medication Administration Record) indicated the following:</p> <p>On February 14, at 4:00 p.m., the resident's blood sugar was 137 and he received 3 units of insulin. The resident should have received 0 units of insulin.</p> <p>On February 23, at 4:00 p.m., the resident's blood sugar was 192 and he received 0 units of insulin. The resident should have received 3 units of insulin.</p> <p>Interview with the DNS on 3/30/14 at 1:48 p.m., indicated according to the sliding scale insulin order the resident received the wrong amounts of insulin on the above dates.</p> <p>3. The record for Resident #134 was reviewed on 3/27/15 at 3:00 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease stage IV and diabetes mellitus type II.</p> <p>Review of the Dialysis Appointment Assessments for March 2015, indicated the resident's dialysis access site had only been monitored upon return from dialysis on Mondays Wednesdays and Fridays.</p> <p>Review of the March 2015 Treatment Administration Record (TAR) and Medication Administration Record</p>		<p>her designee will make rounds each shift to ensure that seatbelts are being released per plan of care and physician order.</p> <p>Nursing staff have been re-educated related to following a resident care plan for releasing a seatbelt restraint at mealtimes by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>When a resident has a fall or is assessed for the potential of a fall, the Charge nurse is responsible to put an immediate fall intervention into place.</p> <p>The Nursing staff are responsible to pass new resident specific fall interventions through shift to shift report.</p> <p>The Interdisciplinary team is responsible to review the fall the next day to ensure the fall intervention is appropriate and to update the care plan and profile to reflect the new intervention.</p> <p>The CNA's check the profile each shift.</p> <p>Nursing staff are responsible to ensure resident specific fall interventions are in place each shift.</p> <p>The Unit Manager or her designee is responsible to check all resident specific fall interventions each day to ensure compliance.</p> <p>The Director of Nursing Services or her designee will make rounds each shift to ensure that fall interventions are in place per plan of care and physician order.</p> <p>The Customer Care Representatives</p>	

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	<p>(MAR), lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Resident Progress Notes for March 2015, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Resident #134 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth, bruit/thrill. Document findings, report abnormals to MD and dialysis..."</p> <p>Interview with LPN #4 on 3/31/15 at 9:12 a.m., indicated she assessed the resident's access site daily. She indicated there was no current treatment order to assess the site and she could not find assessment of the dialysis site documented anywhere.</p> <p>Interview with the Director of Nursing Services (DNS) on 3/31/15 at 8:55 a.m., indicated she was unsure if the assessment of the dialysis access was documented every shift.</p> <p>4. On 3/31/15 at 9:24 a.m. Resident #40 was observed lying in bed with her eyes</p>		<p>are responsible to check their designated residents and rooms each business day to ensure fall interventions are in place. They are responsible to report to the Nursing staff any issues with fall interventions.</p> <p>Nursing staff have been re-educated related to following the care plans and profiles for having resident specific fall interventions in place by the Director of Nursing Service or her designee by April 17, 2015. The Customer Care Representatives have been re-education related to Customer Care Rounds by the Executive Director by April 17, 2015.</p> <p>When a resident receives an order for dialysis, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The Charge Nurse is responsible to ensure there is a corresponding order to assess the dialysis access site each shift.</p> <p>The Charge Nurse is responsible to assess the dialysis access site per the physician's order.</p> <p>The Unit Manager is responsible to review the ETAR daily to ensure the dialysis access site is being assessed per the plan of care and physician order.</p>	

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	<p>closed. The bed was in low position and a mat was on the floor next to the bed. A mattress was leaning up against the dresser on the other side of the room. The resident was wearing white cotton socks on her feet.</p> <p>On 3/31/15 at 12:26 p.m. Resident #40 was observed seated in her wheelchair in the 1 West Dining Room. The resident's lunch meal had been served and was on the table in front of her.</p> <p>The record for Resident #40 was reviewed on 3/26/15 at 2:59 p.m. The resident's diagnoses included, but were not limited to, muscle weakness, dementia with delusions, and depressive disorder.</p> <p>Review of the March 2015 Physician Order Summary indicated an order for low bed, place another mattress on the floor by her low bed, then a mat next to it.</p> <p>Review of the "Care Profile", received from the Assistant Director of Nursing (ADNS) as current, indicated place resident in stationary dining room chair at meals, low bed with mattress and mat on floor.</p> <p>Resident #40 had a care plan for risk for</p>		<p>The Interdisciplinary Team is responsible to check all orders the next business day and to develop a corresponding care plan. It is their responsibility to ensure there a corresponding order to assess the dialysis access site each shift. Nursing staff have been re-educated related to assessing a dialysis access site by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>When a resident receives an order for a prn pain medication, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The MDS Coordinator or her designee is responsible to check all orders the next day and to develop a corresponding care plan. When a resident complains of pain, it is the responsibility of the Charge nurse to offer non-pharmacological interventions prior to administration and to document the attempt on the PRN Pain Management Intervention flowsheet in the Narcotic book. It is the responsibility of the Unit Manager or her designee to review the prn medication report daily to ensure non-pharmacological interventions are were attempted prior to dispensing pain medication per plan of care. Nursing staff have been re-educated related to offering non-pharmacological interventions per the care plan before giving prn</p>	

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	<p>falls. The nursing interventions included "...low bed with mattress and mat on floor...non skid footwear...place resident in stationary dining room chair at meals..."</p> <p>Interview with the West Unit Manager on 3/31/15 at 9:45 a.m., indicated the resident's fall interventions were not in place as ordered. She further indicated CNAs have access to information in care profile to indicate what fall interventions should be in place.</p> <p>5. Resident #118's record was reviewed on 3/27/15 at 11:46 a.m. The resident's diagnoses included, but were not limited to, colon cancer, congestive heart failure, and dementia with behavioral disturbance.</p> <p>Review of the March 2015 Physician Order Summary, indicated an order for hydrocodone-acetaminophen (a narcotic pain medication) 5/325 milligrams (mg), every 4 hours PRN (as needed) for severe pain.</p> <p>Review of the Medication Administration Record (MAR), dated 3/2015, indicated there was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen on</p>		<p>pain medication by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>When a resident receives an order for sliding scale insulin administration, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The MDS Coordinator or her designee is responsible to check all orders the next day and to develop a corresponding care plan. The Charge nurse is responsible to administer insulin per the physician's order. The Unit Manager or her designee will review sliding scale insulin administration each day to ensure compliance with each resident's plan of care. Nursing staff have been e re-educated related to following physician orders for sliding scale insulin administration by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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? The CQI forms titled " Physical Restraint", "Care Plan Updating",</p>		

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	<p>3/13/15, 3/15/14, 3/15/15, 3/17/15, 3/18/15, 3/19/15, 3/23/15, 3/24/15, and 3/25/15.</p> <p>Review of the MAR, dated 2/2015, indicated there was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen on 2/1/15, 2/8/15, 2/22/15, and 2/28/15.</p> <p>Review of the Resident Progress Notes for February 2015 and March 2015 lacked documentation of any non pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen medication.</p> <p>Resident #118 had a care plan for pain. The nursing interventions included, "...Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition..."</p> <p>Interview with the Director of Nursing Services (DNS) on 3/30/15 at 11:11 a.m., indicated nurses should be attempting interventions prior to administering PRN medications. She further indicated the interventions should be charted in the PRN medication note on the MAR or in the progress notes.</p>		<p>"Fall Management", "Customer Care Rounds", "Insulin Administration Monitoring", "Dialysis Care" and PRN Pain Management Interventions" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance.</p> <p>The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance.</p> <p>The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>	

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F 309 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to assessment of the dialysis access site for 1 of 1 residents reviewed for dialysis of the 3 residents who met the criteria for dialysis. (Resident #134)</p> <p>Finding includes:</p> <p>The record for Resident #134 was reviewed on 3/27/15 at 3:00 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease stage IV and diabetes mellitus type II.</p> <p>Review of the Dialysis Appointment Assessments for March 2015, indicated the resident's dialysis access site had only been monitored upon return from dialysis</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is the practice of this provider to ensure that each resident receives the necessary treatment and services related to assessment of a dialysis access site.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The dialysis access site for resident #134 is being assessed per physician order.</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> <p>All residents with a dialysis access site have the potential to be affected</p>	04/17/2015
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	<p>on Mondays Wednesdays and Fridays.</p> <p>Review of the March 2015 Treatment Administration Record (TAR) and Medication Administration Record (MAR), lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Resident Progress Notes for March 2015, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Resident #134 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth, bruit/thrill. Document findings, report abnormals to MD and dialysis..."</p> <p>Interview with LPN #4 on 3/31/15 at 9:12 a.m., indicated she assessed the resident's access site daily. She indicated there was no current treatment order to assess the site and she could not find assessment of the dialysis site documented anywhere.</p> <p>Interview with the Director of Nursing Services (DNS) on 3/31/15 at 8:55 a.m., indicated she was unsure if the</p>		<p>by the alleged deficient practice. All residents with a dialysis access site have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. The physician orders for all residents with a dialysis access site have been reviewed by the Director of Nursing Services or her designee. All residents with a dialysis access site are being assessed per physician order. Nursing staff have been re-educated related to assessing a dialysis access site by the Director of Nursing Service or her designee by April 17, 2015.</p> <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> <p>When a resident receives an order for dialysis, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The Charge Nurse is responsible to ensure there is a corresponding order to assess the dialysis access site each shift. The Unit Manager is responsible to review the ETAR daily to ensure the dialysis access site is being assessed per the plan of care and physician order. The Interdisciplinary Team is responsible to check all orders the next day and to develop a corresponding care plan.</p>				

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F 323 SS=D Bldg. 00	<p>assessment of the dialysis access was documented every shift.</p> <p>A facility policy, titled Dialysis Care, dated 1/2015, and received from the Minimum Data Set (MDS) Coordinator as current on 3/30/15, indicated "...4. An assessment of the resident's dialysis access site will be completed every shift to include bruit and thrill (if applicable), condition of skin at site, drainage, pain, warmth, redness, and recorded on the Medication Administration Record (MAR) and/or dialysis flow sheet..."</p> <p>3.1-37(a)</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</p>		<p>It is their responsibility to ensure there a corresponding order to assess the dialysis access site each shift. Nursing staff have been re-educated related to assessing a dialysis access site by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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? The CQI form titled "Dialysis Care" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>		

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	<p>receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 1 of 3 residents reviewed for accidents of the 3 who met the criteria for accidents. (Resident #40)</p> <p>Finding includes:</p> <p>On 3/31/15 at 9:24 a.m. Resident #40 was observed lying in bed with her eyes closed. The bed was in low position and a mat was on the floor next to the bed. A mattress was leaning up against the dresser on the other side of the room. The resident was wearing white cotton socks on her feet.</p> <p>On 3/31/15 at 9:42 a.m. Resident #40 was observed lying in bed with her eyes closed. The bed was in low position and a mat was on the floor next to the bed. A mattress was leaning up against the dresser on the other side of the room. The resident was wearing white cotton socks on her feet.</p> <p>On 3/31/15 at 12:26 p.m. Resident #40 was observed seated in her wheelchair in the 1 West Dining Room. The resident's lunch meal had been served and was on the table in front of her.</p>	F 323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is the practice of this provider to ensure that fall interventions are in place.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident specific fall interventions are in place for resident #40.</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> <p>All residents with resident specific fall interventions have the potential to be affected by the alleged deficient practice. All residents with resident specific fall interventions have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. The profiles of all residents with resident specific fall interventions have been reviewed by the MDS coordinator or her designee to ensure they show the interventions from the corresponding care plan. Nursing staff have been re-educated related to following the care plans and profiles for having resident</p>	04/17/2015

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	<p>On 3/31/15 at 12:42 p.m. Resident #40 Resident #40 was observed seated in her wheelchair in the 1 West Dining Room. The resident's lunch meal was on the table in front of her and her eyes were closed. CNA #1 entered the dining room, woke the resident up, and encouraged the resident to eat her peaches.</p> <p>The record for Resident #40 was reviewed on 3/26/15 at 2:59 p.m. The resident's diagnoses included, but were not limited to, muscle weakness, dementia with delusions, and depressive disorder.</p> <p>Review of the March 2015 Physician Order Summary indicated an order for low bed, place another mattress on the floor by her low bed, then a mat next to it.</p> <p>Review of the "Care Profile", received from the Assistant Director of Nursing (ADNS) as current, indicated place resident in stationary dining room chair at meals, low bed with mattress and mat on floor.</p> <p>Resident #40 had a care plan for risk for falls. The nursing interventions included "...low bed with mattress and mat on floor...non skid footwear...place resident</p>		<p>specific fall interventions in place by the Director of Nursing Service or her designee by April 17, 2015.</p> <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> <p>When a resident has a fall or is assessed for the potential of a fall, the Charge nurse is responsible to put an immediate fall intervention into place. The Nursing staff are responsible to pass new resident specific fall interventions through shift to shift report. The Interdisciplinary team is responsible to review the fall the next business day to ensure the resident specific fall intervention is appropriate and to update the care plan and profile to reflect the new intervention. The CNA's check the profile book for any changes each shift. Nursing staff are responsible to ensure resident specific fall interventions are in place each shift. The Unit Manager or her designee is responsible to check all resident specific fall interventions each business day to ensure compliance. The Director of Nursing Services or her designee will make rounds each shift to ensure that fall interventions are in place per plan of care and physician order. The Customer Care Representatives are responsible to check their</p>	

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	<p>in stationary dining room chair at meals..."</p> <p>Interview with the West Unit Manager on 3/31/15 at 9:45 a.m., indicated the resident's fall interventions were not in place as ordered. She further indicated CNAs have access to information in care profile to indicate what fall interventions should be in place.</p> <p>Interview with CNA #1 on 3/31/15 at 12:45 p.m., indicated she was unsure what the resident's usual routine was during dining. She further indicated the resident usually ate in the Main Dining Room.</p> <p>Interview with LPN #6 on 3/31/15 at 12:45 p.m., indicated she was not sure if the resident should have been seated in her wheelchair or a dining room chair for meals. She further indicated she was unable to find any orders to indicate if the resident was supposed to be transferred to another chair for dining.</p> <p>Interview with the West Unit Manager on 3/31/15 at 12:46 p.m., indicated the resident was new to the unit and had just been transferred from another unit within the last week. She further indicated the resident should have been transferred to a stationary chair for dining.</p>		<p>designated residents and rooms each business day to ensure resident specific fall interventions are in place. They are responsible to report to the Nursing staff any issues with resident specific fall interventions. Nursing staff have been re-educated related to following the care plans and profiles for having resident specific fall interventions in place by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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? The CQI form titled "Fall Management", "Customer Care Rounds" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>		

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F 329 SS=D Bldg. 00	<p>3.1-45(a)(2)</p> <p>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.</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 each resident was free from unnecessary medications related to insulin administration completed as ordered and non-pharmacological interventions prior</p>	F 329	<p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS It is the practice of this provider to ensure that each resident is free from unnecessary medications related to insulin administration completed as ordered and non-pharmacological interventions prior to PRN pain</p>	04/17/2015

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	<p>to PRN (when necessary) pain medication for 2 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Residents #32 and #118)</p> <p>Findings include:</p> <p>1. Record review for Resident #32 was completed on 3/30/15 at 10:47 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, depression, and dementia.</p> <p>A care plan dated 8/13/14 indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included: medications as ordered.</p> <p>The March 2015 Physician Order Summary indicated an order for Humalog (insulin) solution per sliding scale TID (three times a day). The units to be given were as followed:</p> <p>0-150=give 0 units 151-200=give 3 units 201-250=give 5 units greater than 250=give 8 units</p> <p>Review of the February 2015 MAR</p>		<p>medication.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #32 is receiving insulin per the physician's order. Resident #118 is receiving PRN pain medication after non-pharmacological interventions have been attempted with no success.</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> <p>All residents receiving sliding scale insulin and PRN pain medication have the potential to be affected by the alleged deficient practice. All residents with prn pain medication have been reviewed by the MDS coordinator or her designee to ensure they have a corresponding care plan. Nursing staff have been re-educated related to offering non-pharmacological interventions per the care plan before giving prn pain medication by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>All residents with sliding scale insulin administration have been reviewed by the MDS coordinator or her designee to ensure they have a</p>	

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	<p>(Medication Administration Record) indicated the following:</p> <p>On February 14, at 4:00 p.m., the resident's blood sugar was 137 and he received 3 units of insulin. The resident should have received 0 units of insulin.</p> <p>On February 23, at 4:00 p.m., the resident's blood sugar was 192 and he received 0 units of insulin. The resident should have received 3 units of insulin.</p> <p>Interview with the DNS on 3/30/14 at 1:48 p.m., indicated according to the sliding scale insulin order the resident received the wrong amounts of insulin on the above dates.</p> <p>2. Resident #118's record was reviewed on 3/27/15 at 11:46 a.m. The resident's diagnoses included, but were not limited to, colon cancer, congestive heart failure, and dementia with behavioral disturbance.</p> <p>Review of the March 2015 Physician Order Summary, indicated an order for hydrocodone-acetaminophen (a narcotic pain medication) 5/325 milligrams (mg), every 4 hours PRN (as needed) for severe pain.</p> <p>Review of the Medication Administration</p>		<p>corresponding care plan.</p> <p>All residents with a sliding scale have been reviewed by their physician.</p> <p>Nursing staff have been re-educated related to following physician orders for sliding scale insulin administration by the Director of Nursing Service or her designee by April 17, 2015.</p> <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> <p>When a resident receives an order for a prn pain medication, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan.</p> <p>The MDS Coordinator or her designee is responsible to check all orders the next day and to develop a corresponding care plan.</p> <p>When a resident complains of pain, it is the responsibility of the Charge nurse to offer non-pharmacological interventions prior to administration and to document the attempt on the PRN Pain Management Intervention flowsheet in the Narcotic book.</p> <p>It is the responsibility of the Unit Manager or her designee to review the prn medication report daily to ensure non-pharmacological interventions are were attempted prior to dispensing pain medication per plan of care.</p>	

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	<p>Record (MAR), dated 3/2015, indicated there was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen on 3/13/15, 3/15/14, 3/15/15, 3/17/15, 3/18/15, 3/19/15, 3/23/15, 3/24/15, and 3/25/15.</p> <p>Review of the MAR, dated 2/2015, indicated there was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen on 2/1/15, 2/8/15, 2/22/15, and 2/28/15.</p> <p>Review of the Resident Progress Notes for February 2015 and March 2015 lacked documentation of any non pharmacological interventions attempted prior to the administration of the hydrocodone-acetaminophen medication.</p> <p>Resident #118 had a care plan for pain. The nursing interventions included, "...Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition..."</p> <p>Interview with the Director of Nursing Services (DNS) on 3/30/15 at 11:11 a.m., indicated nurses should be attempting interventions prior to administering PRN</p>		<p>Nursing staff have been re-educated related to offering non-pharmacological interventions per the care plan before giving prn pain medication by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>When a resident receives an order for sliding scale insulin administration, the Charge nurse is responsible to enter the order into the EMAR system and to initiate a corresponding Temporary Care Plan. The MDS Coordinator or her designee is responsible to check all orders the next business day and to develop a corresponding care plan. The Charge nurse is responsible to administer insulin per the physician's order.</p> <p>The Unit Manager or her designee will review sliding scale insulin administration each day to ensure compliance.</p> <p>Nursing staff have been re-educated related to following physician orders for sliding scale insulin administration by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>				

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F 332 SS=D Bldg. 00	<p>medications. She further indicated the interventions should be charted in the PRN medication note on the MAR or in the progress notes.</p> <p>A facility policy, titled Pain Management, dated 2/2015, and received from the Minimum Data Set (MDS) Coordinator as current on 3/30/15, indicated "...7. Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet. 8. A plan of care will be written with the initiation of pain medication and individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain techniques..."</p> <p>3.1-48(a)(6)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or</p>		<p>i.e., what quality assurance program will be put into place? The CQI forms titled "Insulin Administration Monitoring" and "PRN Pain Management Interventions" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>		

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	<p>greater.</p> <p>Based on observation, record review, and interview the facility failed to ensure a medication error rate of less than 5%, related to administering three crushed medications mixed together into a Percutaneous Endoscopic Gastrostomy (PEG) tube and the facility also failed to allow proper time between puffs for an inhaler observed during the medication pass for 2 of 10 residents. Two errors were observed during 26 opportunities resulting in an error rate of 7.69%. (Resident #2 and Resident #174)</p> <p>Findings include:</p> <p>1. During a preparation of a medication pass observed on 3/27/15 at 8:00 a.m., LPN #1 punched out each of the following tablet medication for Resident #2's into a cup: atenolol (medication to treat high blood pressure), simethicone (to decrease gas), vimpat (medication to help prevent seizures). LPN #1 placed each of the medications into a pouch and crushed the medications, then placed them in a medication cup for administration. LPN #1 went to Resident #2's room, checked the placement of the resident's PEG tube and added 10 cc (cubic centimeters) of water into the crushed medication cup and set it aside. LPN #1 administered the crushed</p>	F 332	<p>F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>It is the practice of this provider to ensure that it is free of medication error rates of 5% or greater.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #2 is receiving medication per physician's order. Resident #174 is receiving medication per physician's order.</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> <p>All residents have the potential to be affected by the alleged deficient practice. Nurse staff have received skills validation related to g-tube medication administration and nebulizer inhaler administration by the Director of Nursing Services or her designee by April 17, 2015. Nurse staff have received a second skills validation by the Clinical Education Consultant by April 17, 2015.</p> <p>What measures will be put into place or what systemic changes</p>	04/17/2015

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	<p>dissolved tablet mixture, then added 5 cc of water into the syringe to flush the medication.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/27/15 at 12:28 p.m., indicated the medications should have been administered separately and flushed in between with water.</p> <p>The policy titled, "Enteral tube-Medication Administration," was provided by the DNS on 3/27/15 at 11:22 a.m. as current and indicated, "...Procedure Steps:...2. Prepare medications:...Dissolve each crushed medication in at least 10-30 cc of water...."</p> <p>The policy titled, "Medication Pass Procedure," was provided by the DNS on 3/27/15 at 11:22 a.m. as current and indicated, "...Procedure Steps:...21...Flush tubing with 5 cc water between each medication...."</p> <p>2. During another medication pass observation on 3/30/15 at 3:57 p.m., LPN #2 administered 2 puffs of Ventolin HFA (an inhaled medication to help the resident breath easier) to Resident #174 with only waiting 10 seconds in between puffs.</p>		<p>you will make to ensure that the deficient practice does not recur? All Nurse staff have received skills validation by the Director of Nursing Services or her designee related to G-tube medication administration and nebulizer inhaler administration by April 17, 2015. Nurse staff have received a second skills validation by the Clinical Education Consultant related to G-tube medication administration and nebulizer inhaler administration by April 17, 2015. Nurse staff will received skills validations upon hire by the Clinical Education Coordinator or her designee related to G-tube medication administration and nebulizer inhaler administration. Nurse staff will received skills validations annually and prn by the Clinical Education Coordinator or her designee related to G-tube medication administration and nebulizer inhaler administration. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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? The CQI forms titled "Enteral Tube - Medication Administration" and "Metered Dose Inhaler" will be utilized by the Interdisciplinary team weekly times four, monthly times six</p>	

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F 431 SS=E	<p>The resident's record was reviewed 3/30/15 at 4:15 p.m.</p> <p>The Physician's Order Summary 2015 indicated Ventolin HFA 2 puffs every four hours.</p> <p>Interview on 3/30/15 at 4:44 p.m. with LPN #2, indicated she should have waited 1-2 minutes between the puffs of the inhaler.</p> <p>The policy titled, " Metered Dose Inhaler," was provided by the DNS on 3/30/15 at 4:55 p.m. as current and indicated, "...Procedure Steps:...12. If taking more than one puff, wait at least 1 minute before dispensing second...."</p> <p>3.1-48(c)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS</p>		<p>and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>		

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Bldg. 00	<p>& BIOLOGICALS</p> <p>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 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, record review and interview, the facility failed to ensure to correctly label a medication punch card for change in directions for 1 of 10 resident's observed during medication pass. The facility also failed to put an</p>	F 431	<p>F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>It is the practice of this provider to ensure to correctly label a medication punch card for change in directions and to put an open date on a house</p>	04/17/2015			

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	<p>open date on a house Mantoux Tuberculin solution (TB) multi use vial for 1 of 3 medication storage rooms observed. (Resident #2 and Moving Forward Medication storage room)</p> <p>Findings include:</p> <p>1. During a medication pass observed on 3/27/15 at 8:00 a.m., Resident #2 ' s punch card labeled Potassium Chloride indicated 20 meq (milliequivalents)/15 ml (milliliters) by mouth once daily.</p> <p>The resident's record was reviewed 3/27/15 at 9:30 a.m.</p> <p>The Physician's Order dated 11/24/14 indicated to administer Potassium Chloride 20 meq per G-tube once daily.</p> <p>The Physician's Order Summary 2015 indicated NPO (Nothing by mouth).</p> <p>Interview with LPN #1 on 3/27/15 at 8:20 a.m., indicated the resident had not taken anything by mouth for at least four years.</p> <p>2. During an observation on 3/27/15 at 3:15 p.m. in the Moving Forward medication storage room's refrigerator, a house multi dose vial of TB solution was open and lacked an open date.</p>		<p>Mantoux Tuberculin solution multi use vial.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The medications for resident #2 are labeled correctly. The house Mantoux Tuberculin solution is dated correctly.</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> <p>All residents have the potential to be affected by the alleged deficient practice. The Nurse Management Team has reviewed all medications and compared them to the physician's order to ensure the medications are correctly labeled. The Nurse Management Team has checked all open house medications to ensure they are correctly dated. Nurse Management will review all orders during clinical meeting. The Nurse Manager will review any medication order change to ensure the label has been corrected. Nursing staff have been re-educated related to the related to medication labeling and dating by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in</p>	

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	<p>Interview with LPN #3 at that time, indicated there should have been an open date on the vial. The solution can only be used for 30 days after opening.</p> <p>The policy titled, "Medication Administration," was provided by the MDS Coordinator on 3/30/15 as current and indicated, "...Procedure:...1.4 Route and times(s) the medication is to be given...1.12. All multi-dose medication vials or devices should be labeled with a date open...."</p> <p>3.1-25(j)(k)(l)</p>		<p>employee re-education and/or disciplinary action.</p> <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> <p>When a medication order is changed, the Charge Nurse is responsible to place a change of direction label "LABEL CHANGE-CHECK MED SHEET" on the medication card. The Charge Nurse is responsible to match the physician medication order to the instructions on the medication card before administering any medications. The nurse management team is responsible to review all medication order changes daily for accuracy comparing the order to the medication card.</p> <p>The 11-7 Charge Nurse is responsible to review all open house medications daily to ensure they are correctly labeled. The Unit Manager or her designee is responsible to review all open house medication weekly to ensure they are correctly labeled. Nursing staff have been re-educated related to the related to medication labeling and dating by the Director of Nursing Service or her designee by April 17, 2015. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p>	

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F 441 SS=D Bldg. 00	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		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? The CQI form titled "Medication Storage Review" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance. The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Service or her designee is responsible to monitor for compliance. Compliance Date: April 17, 2015	
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	<p>corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to a toothbrush left out on top of a countertop in the bathroom and improper disposal of a glucometer test strip (a test strip used to test blood sugars). This had the potential to affect 1 of 7 residents that received glucometer testing (testing of blood for blood sugars) on the West Hall. (Resident # 165 and BCD Hallway)</p> <p>Findings include:</p> <p>1. During initial tour on 3/25/15 at 3:35 p.m., a toothbrush was observed</p>	F 441	<p>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the practice of this provider to ensure that infections control practices and standards are maintained related to storage of toothbrushes and disposal of glucometer test strips.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The toothbrushes in room #137 are properly stored when not in use. All glucometer test strips are disposed of properly per facility policy and procedure.</p> <p>How will you identify other</p>	04/17/2015

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	<p>uncovered and on top on the countertop in Room #137's bathroom.</p> <p>The same toothbrush was observed again uncovered and on top of the countertop during the environmental tour on 3/31/15 at 9:45 a.m.</p> <p>2. During an observation of Resident #165 ' s glucometer testing on 3/27/15 at 10:49 a.m., LPN #1 donned gloves, cleansed the resident's finger, pricked the resident ' s finger with a lancet, placed a drop of blood onto a test strip, received a blood sugar reading, removed gloves with the test strip with the blood test strip remaining in the gloves, threw the gloves away into the resident's garbage can and left the room.</p> <p>Interview with LPN #1 at that time, indicated that was normal practice to throw the used test strip away in the resident ' s garbage wrapped in the gloves.</p> <p>Interview with the DNS (Director of Nursing Services) on 3/27/15 at 12:28 p.m., indicated the nurse should have placed the used test strip with the blood, into the sharps container on the medication cart.</p> <p>The policy titled, "Glucose Meter Cleaning & Testing," was provided by</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Nurse Management has checked all room for infection control issues. Unit manager or their designee will check their units each day to ensure there are no infection control issues. During Customer Service room rounds, the Customer Service Representative will note any infection control issues and report them to the Unit Manager or her designee.</p> <p>All Nurse staff have received skills validation by the Director of Nursing Services or her designee related to infection control and Glucose Meter Cleaning & Testing by April 17, 2015.</p> <p>Nurse staff have received a second skills validation by the Clinical Education Consultant designee related to infection control and designee related to infection control and Glucose Meter Cleaning & Testing by April 17, 2015.</p> <p>Nursing staff have been re-educated related to the infection control policy and designee related to infection control and Glucose Meter Cleaning & Testing by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>What measures will be put into</p>	

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	<p>the DNS on 3/27/15 at 11:22 a.m. as current and indicated, "...Obtaining blood sugar results:...28. Dispose of used lancet and reagent in sharps container...."</p> <p>3.1-18(b)(2)</p>		<p>place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>All Nurse staff have received skills validation by the Director of Nursing Services or her designee related to infection control and designee related to infection control and Glucose Meter Cleaning & Testing by April 17, 2015. Nurse staff have received a second skills validation by the Clinical Education Consultant related to infection control and designee related to infection control and Glucose Meter Cleaning & Testing by April 17, 2015. Nurse staff will received skills validations upon hire by the Clinical Education Coordinator or her designee. Nurse staff will received skills validations annually and prn by the Clinical Education Coordinator or her designee. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>Nursing staff are responsible to observe for infection control issues each shift. Unit manager or their designee will check their units each day to ensure there are no infection control issues. During Customer Service room rounds, the Customer Service Representative will note any infection control issues and report</p>	

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F 465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional,		<p>them to the Unit Manager or her designee.</p> <p>Nursing staff have been re-educated related to the infection control policy and Glucose Meter Cleaning & Testing by the Director of Nursing Service or her designee by April 17, 2015.</p> <p>Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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> <p>The CQI form titled "Glucose Meter Cleaning & Testing" "Customer Care Rounds" and "Resident Care Rounds" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance.</p> <p>The CQI committee reviews the audits monthly and action plans are developed if a threshold of 95% is not met to ensure continual compliance.</p> <p>The Director of Nursing Service or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 17, 2015</p>	

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	<p>sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the resident's environment was in good repair related to ripped wheelchair pad, cracked floor tile, toilet bowl caps missing, marred and stained floor and loose electrical outlet for 3 of the 4 units. (BCD Unit,1 North Unit, and 1 West Unit)</p> <p>Findings include:</p> <p>During the Environmental Tour on 3/31/15 from 9:45 a.m. until 10:15 a.m. with the Housekeeping and Laundry Supervisor, the Maintenance Assistant and the Maintenance Supervisor, the following was observed:</p> <p>1. BCD Unit</p> <p>a. In room #142's bathroom, the heater vent was dented. There were three residents who shared this bathroom.</p> <p>b. Room #136's wheelchair was observed again during the Environmental Tour to have rips in the back padding. The wheelchair was first observed on 3/26/15 at 9:55 a.m. with the ripped pad.</p> <p>c. In room #137's bathroom, the raised vinyl, padded toilet bar risers were</p>	F 465	<p>F465 SAFE/FUNCTIONAL/SANITARY /COMFORTABLE ENVIRONMENT</p> <p>It is the practice of this provider to ensure that the resident's environment is in good repair related to a ripped wheelchair pad, cracked floor tile, toilet bowl caps, marred and stained floor and a loose electrical outlet.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The heater vent in room #142's bathroom has been repaired. The wheelchair in room 136 has been repaired. The raised vinyl, padded toilet bar risers and the counter top in room #137's bathroom have been repaired. The bathroom floor tile in room #141's bathroom has been repaired. The toilet bowl flange caps have been replaced, the sink drain has been cleaned and the screw has been repaired in room #144's bathroom. The toilet bowl flange caps have been replaced and the wall has been repaired behind the sink in room #149's bathroom. The toilet bowl flange caps have been replaced in the bathrooms for rooms #153, #156 and #154. The electrical box in room #163, bed B has been repaired.</p>	04/17/2015

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	<p>cracked, and the countertop was chipped. There were two residents who shared this bathroom.</p> <p>d. Room # 141's bathroom floor tile was cracked. There were three residents that shared this bathroom.</p> <p>2. 1 North Unit</p> <p>a. In room #144 bathroom, the toilet bowl flange caps were missing, rust on the sink's drain, and a half exposed screw on the edge of the sink's caulk line. There were two residents who shared this bathroom.</p> <p>b. In room #149's bathroom, the toilet bowl flange caps were missing, and a hole in the wall behind the sink. There were two residents that shared this bathroom.</p> <p>c. In room #153's, and 156's bathroom, the toilet bowl flange caps were missing. There were two residents that shared this bathroom.</p> <p>d. In room #154's bathroom, the the toilet bowl flange caps were missing. There were two residents that shared this bathroom.</p> <p>e. In room #156's bathroom, the toilet</p>		<p>The bathroom door has been repaired in room #165.</p> <p>The ceiling tile, vent and cove base have been repaired in room #168's bathroom.</p> <p>The floor around the toilet and the caulk around the sink in room #171's bathroom have been repaired.</p> <p>The caulk around the sink in room #172's bathroom has been repaired.</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> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An inspection of all resident rooms and bathrooms was conducted by the Executive Director to identify and repair any heater vents, wheelchairs, vinyl, padded toilet bar risers, countertops, bathroom floor tile, toilet bowl flange caps, electrical boxes, bathroom doors, floors, ceiling tiles, vents and cove base and caulking around sinks.</p> <p>During Customer Service room rounds, the Customer Service Representative will note any needed repairs and report them to the Maintenance Supervisor.</p> <p>Customer Service Representatives were re-educated by the Executive Director related to noting any needed repairs and reporting them to the Maintenance Supervisor by April 17, 2015.</p>				

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	<p>bowl flange caps were missing. There were two residents that shared this bathroom.</p> <p>3. 1 West Unit</p> <p>a. In room #163, by bed B, there was a loose electrical box. There were two residents that resided in this room.</p> <p>b. Room #165's inner bathroom door had gouges. There were four resident who shared this bathroom.</p> <p>c. In room #168's bathroom, there was a displaced ceiling tile, loose ceiling vent, and loose cove base by the toilet. There were four residents that share this bathroom.</p> <p>d. In room #171's bathroom, the floor in front of the toilet was marred and stained yellow and the caulk around the sink was cracked. There were four residents that shared this bathroom.</p> <p>e. In room #172's bathroom, the caulk around the sink was cracked. There were four residents that shared this bathroom.</p> <p>Interview with Maintenance Supervisor on 3/31/15 at 10:15 a.m., indicated all of the above were in need of repair.</p>		<p>During daily cleaning, Housekeeping staff will note any needed repairs and report them to the Maintenance Supervisor.</p> <p>Housekeeping staff were re-educated by the Maintenance Supervisor related to noting any needed repairs and reporting them to the Maintenance Supervisor by April 17, 2015.</p> <p>The Maintenance Supervisor or his designee will be responsible to ensure that all repairs are completed within a reasonable time frame. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <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> <p>During Customer Service room rounds, the Customer Service Representative will note any needed repairs and report them to the Maintenance Supervisor. Customer Service Representatives were re-educated by the Executive Director related to noting any needed repairs and reporting them to the Maintenance Supervisor by April 17, 2015.</p> <p>During daily cleaning, Housekeeping staff will note any needed repairs and report them to the Maintenance Supervisor. Housekeeping staff were re-educated by the Maintenance Supervisor</p>	

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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(f)		<p>related to noting any needed repairs and reporting them to the Maintenance Supervisor by April 17, 2015.</p> <p>The Maintenance Supervisor or his designee will be responsible to ensure that all repairs are completed within a reasonable time frame. The Executive Director or her designee will review repair list weekly to ensure repairs on completed within a reasonable time frame.</p> <p>Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</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> <p>The CQI tools titled "Customer Care Rounds", "Environmental Safety-Resident Area" and "Quality Control Inspection Checklist Housekeeping" will be utilized by the Interdisciplinary team weekly times four, monthly times six and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures.</p> <p>The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance.</p> <p>Non-compliance with facility policy and procedure may result in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
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			employee re-education and/or disciplinary action. The Maintenance Supervisor or his designee is responsible to monitor for compliance. Compliance Date: April 17, 2015		