

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 20, 21, 22, 23, 26 and 27, 2015</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>Survey Team: Sharon Ewing, RN-TC Deb Kammeyer, RN Lora Swanson (1/26, 1/27, 2015) Julie Wagoner, RN</p> <p>Census Bed Type: SNF: 11 SNF/NF: 39 Total: 50</p> <p>Census Payor Type: Medicare: 8 Medicaid: 35 Other: 7 Total: 50</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on February 4,</p>	F000000	<p>Preparation or execution of this plan of correction by Lakeland Rehabilitation and Healthcare does not constitute an admission or agreement of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in response to the allegations of noncompliance cited during the Annual Recertification and State Licensure Survey on January 27, 2015. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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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F000156 SS=B	<p>2015, by Brenda Meredith, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>			

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	<p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to</p>			

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	<p>residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure that 2 of 3 residents reviewed for discharge from Medicare services received notification in a timely manner. (Resident #17 and Resident #6)</p> <p>Finding includes:</p> <p>On 1/26/15 at 10:00 A.M., the Notice of Medicare Non-Coverage (NOMNC) forms for three residents was received from the Business Office Manager and reviewed.</p> <p>The OMB (Office of Management and Budget) approval NO. 0938-0910 form entitled NOMNC for Resident #17 indicated, "The effective date coverage of your current physical and occupational therapy services will end: 8/12/14." The form was signed on 8/12/14.</p> <p>The OMB approval NO. 0938-0910 form entitled NOMNC for Resident #6 indicated, "The effective date coverage of your current therapy services will end: 3/5/14." The form was signed on 3/6/14.</p> <p>Review of the "SNF (Skilled Nursing</p>	F000156	<p>1) Resident #17 and #6 have been discharged. 2) All Medicare residents have the potential to be affected by this alleged deficient practice.3) Facility management staff to be inserviced regarding importance of notification of non-coverage being provided to residents and/or responsible party as required, no later than 2 days prior to discharge date. During discharge care planning Social Services director to discuss non-coverage with residents and/or family and have them sign letter if actual date of discharge is known at that time. Social Services Director and/or designee will review upcoming discharges 3 times per week times 4 weeks then weekly times 4 months to ensure notifications of non-coverage are completed 2 days prior to discharge. If notice not given in appropriat time frame, family to be notified immediately upon finding. 4) Audit tools to be utilized and filled out for discharging residents to include date of discharge and date notice signed. The Social Service Director/designee will forward results of the audits to the Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations.</p>	02/26/2015

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F000246 SS=D	<p>Facility) Notices of Non-Coverage Cheat Sheet" received from the Administrator on 1/26/15 at 12:30 P.M. indicated, "...What notice to give: Notice of Medicare Non-Coverage no later than 2 days before covered services end...."</p> <p>On 1/26/15 at 2:09 P.M., an interview with the Business Office Manager indicated Resident #17 and Resident #6 should have been given two days notice before their services ended.</p> <p>3.1-4(f)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observations and record review, the facility failed to ensure 4 of 50 residents observed had call light controls within their reach. (Resident #53, Resident #30, Resident #55 and Resident #24)</p> <p>Finding includes:</p> <p>On 1-20-15 at 2:46 P.M., Resident #53 was observed sitting in a chair facing his TV. The call light was clamped at the</p>	F000246	<p>1) Residents #53, #30, #55, and #24 call lights were placed within reach when made aware of concern. 2)All residents have the potential to be affected by this alleged deficient practice. All staff to monitor call lights for placement during rounds and place them within reach of residents if non-compliance found. 3) All staff inserviced regarding call lights and placement of call lights within reach of residents when they are not in bed. 4) DHS and/or</p>	02/26/2015			

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	<p>bedside, on the rail nearest to the resident, however the call light was not within the resident's reach.</p> <p>During an environmental tour on 1-27-15 from 9:50 A.M. thru 10:30 AM, with the Plant Operation Officer the following was observed:</p> <p>At 9:53 A.M., Resident #30 was observed sitting in her recliner beside her bed. The resident's call light was attached to the bed rail on the wall side of her bed. The resident indicated she could not reach the call light.</p> <p>At 10:01 A.M., Resident #55 was observed sitting in a recliner beside his bed. The resident's call light was attached to the bed and near the floor, out of reach for the resident.</p> <p>At 10:09 A.M., Resident #24 was observed sitting in a recliner. The resident's bedside table was between the recliner and the resident's bed. The call light was attached on the resident's bed rail, out of the resident's reach.</p> <p>On 1-27-15 at 10:55 A.M., the Director of Nursing provided a policy titled "Guidelines for Answering Call Lights" undated and indicated the policy was the one currently used by the facility. The</p>		<p>designee to audit call lights for placement 5 days a week, ongoing for 4 weeks then monthly times 5 months and record findings on audit tool. DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations</p>				

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F000272 SS=E	<p>policy indicated "...2. Ensure the call light is plugged in securely to the outlet and in reach of the resident...."</p> <p>3.1-3(v)(1)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p>			

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	<p>Documentation of participation in assessment.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 1 of 1 residents reviewed for a decline in bladder contingency was thoroughly assessed (Resident #11), and 3 of 5 residents reviewed for unnecessary medication had the need for psychoactive medications thoroughly assessed. (Residents #7, 15, and 20)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 01/23/15 at 10:48 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnoses, including but not limited, to hypertension and muscle weakness.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 09/15/14, indicated the resident required extensive staff assistance for transfers and toileting needs and was continent of her bowels and bladder.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained</p>	F000272	<p>1) Residents #11 bladder patterns assessed and reviewed for bladder continence. 2) Residents #7 and 15 assessed for needs of psychoactive medications. Resident #20 no information given regarding alleged non-compliance, will be incorporated in corrective action. 2) All residents have the potential to be affected by this alleged deficient practice. 3) Licensed nursing staff to be in-serviced on urinary continence status assessments. Documentation inservice with review of S/S of depression, S/S of Anxiety, identification of S/S of Delirium and Delusions for nursing staff. Behavior tracking logs to assist in documentation of behavioral concerns with individuals on psychoactive medications. 4) DHS and/or designee to audit elimination record schedule for new admissions for proper assessment 5 days a week, ongoing for 4 weeks then monthly times 5 months and record findings on audit tool. DHS and/or designee to audit residents on psychoactive medications for proper assessment and documentation 5 days a week, ongoing for 4 weeks then monthly times 5 months and record findings on audit tool DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and</p>	02/26/2015

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	<p>continent of her bowels.</p> <p>An elimination record was completed for Resident #11 on 09/07/14 through 09/10/14. The record indicated the resident did not have any incontinent episodes.</p> <p>The MDS coordinator provided an MDS assessment form, dated 01/22/15, which indicated the number of incontinent and continent episodes per day from 01/16/15 through 01/22/15, but there was no other assessment information provided.</p> <p>During an interview on 01/23/15 at 2:30 P.M., the Director of Nursing indicated he could not locate any other assessment form or documentation regarding bladder incontinence for Resident #11. He indicated the facility should have completed a "Change in Elimination" assessment form when the decline was noted.</p> <p>During an interview on 01/27/15 at 10:55 A.M., RN #25 (MDS Coordinator) indicated if only one decline was noted on the MDS assessments, she probably did not realize there had been a significant change in one area. She indicated the corporate policy as far as she knew was to only do a 7 day look back which indicated per shift how many</p>		trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations		

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	<p>times there had been incontinence. She did not know of any other form or assessment tool utilized to assess bladder incontinence. RN #25 indicated she was uncertain if the nurses on the floor had completed other nursing assessment documentation for Resident #11. In addition, RN #25 indicated all incontinent resident's care plans had interventions to ensure everyone was to checked every 2 hours for incontinence.</p> <p>The facility policy and procedure, titled, "Bowel and Bladder Continence Programming," dated October 2007, indicated the bladder incontinence assessments were to include the following: "MDS (assessment), History and Physical, Nurse's notes, Physician's Notes, Medications, History of continence, Current Cognitive status." In addition, potential factors contributing to the incontinence were: "UTI (urinary tract infections), Fecal Impaction, Dehydration, Diagnosis such as but not limited to: Delirium, Diabetes, CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), Parkinson's, CVA (cerebral vascular accident) , CA (cancer) of the bladder or spine, Spinal cord or head injury, and Alzheimer's (dementia), Edema, Diabetes, Pain related to urination, Atrophic vaginitis, Impaired mobility,</p>			

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	<p>Impaired cognition, Medications, Lack of sensation or ability to recognize the need to void/eliminate, urge or stress incontinence, and Behaviors contributing to noncompliance with a toileting program.</p> <p>The policy included the following instructions:</p> <p>"4. Identify potential causative factors, address with physician and implement appropriate interventions to reduce or eliminate cause(s) when possible.</p> <p>5. Analyze assessments to s, address with physician and implement appropriate interventions to reduce or eliminate cause(s) when possible.determine resident's ability to participate in a continence program. If a toileting plan may be beneficial initiate the Elimination Record and Schedule to record the resident's elimination pattern for a 3-day period."</p> <p>The facility's policy then described how to determine if a resident was able to be placed on a continence program and how to determine the resident's restorative potential as well as a toileting schedule.</p> <p>2. The clinical record of Resident #7 was reviewed on 1-26-15 at 10:02 A. M. The resident's diagnoses included, but were</p>			

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	<p>not limited to: diabetes, anemia, depression, hypertension, hypothyroid, osteoarthritis and coronary artery disease.</p> <p>A form titled, "Initial Psychosocial Assessment/MDS Supportive Documentation Tool & Progress Note," indicated on 12-4-14, the resident reported to the Social Service Director "feeling down nearly everyday, poor appetite/overeating, feeling tired/no energy and trouble staying asleep." The assessment did not address anxiety.</p> <p>The Medication Administration Record (MAR) indicated the resident was receiving clonazepam (klonopin) 0.25 milligrams (mg) at bedtime (HS) for anxiety. Nurses were monitoring the resident each shift for klonopin side effects such as, dry mouth, change in appetite, and excitation/sedation.</p> <p>The Physician's Progress Note, dated 1-7-15, the indicated the resident had a diagnosis of anxiety and was taking clonazepam 0.25 mg. at bedtime. The physician's Progress Note further indicated the resident was allergic to klonopin (clonazepam).</p> <p>The care plans indicated the resident had the following care plan titles: Activities</p>			

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	<p>of Interest, Acute Care Needs, ADL (Activities of Daily Living), Bowel and Bladder, Cognition, Height/Weights, Meals/Snacks/Fluids, Mood and Behaviors, Pain Management, Skin, and Vitals. Under the title of Vitals the care plan indicated the resident was taking daily "...psychotropic medications for depression and anxiety..." The care plan did not include interventions to monitor behaviors or manifestations of anxiety.</p> <p>The Psychiatric Progress Note dated 11-26-14 indicated the resident was seen on a regular basis for a chief complaint of "bipolar". The progress note indicated the resident was doing well. The Assessment/Treatment plan and Recommendations stated "Continue klonopin 0.25 mg at HS, cymbalta 30 mg daily, and namenda 14 mg daily." (Per physician order dated 9-30-14 namenda was changed to 5 mg BID.) The section of the form that assessed mood indicated the resident was euthymic [normal mood]. The assessment did not mention if the resident was anxious.</p> <p>The "Monthly Nursing Assessment & Data Collection" forms for August 2014 thru December 2014 indicated, under the Mood and Behavior section, the resident exhibits little interest in doing things. There were no other moods or behaviors</p>			

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	<p>listed or addressed on the form.</p> <p>The Minimum Data Set (MDS) Quarterly Review Assessment indicated the resident received anti-anxiety medication 4 of the 7 days of review and had an active diagnosis which included anxiety.</p> <p>A form titled "Gradual Dose Reduction Circumstance Assessment and Inter-", dated 3-10-14, indicated the resident was taking clonazepam for anxiety. There were no other Circumstance forms in regards to the resident's anxiety.</p> <p>During an interview on 1-26-15 at 1:45 P.M., the Director of Nursing (DON) indicated he was unable to locate an anti-anxiety care plan for Resident # 7. He further indicated the resident had been on the medication (Klonopin) since his admission in 2010. The DON confirmed the diagnosis of anxiety was not listed in the resident's diagnosis list nor on the MAR diagnosis list. However the MAR did indicate the Klonopin was being administered to the resident for anxiety.</p> <p>During an interview, on 1-27-15 at 1:45 P.M., the MDS Coordinator indicated she had pulled the diagnosis from the physician's last Progress Note. She further indicated she had documented incorrectly the number of days the</p>			

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	<p>resident received an ant-anxiety medication, as the resident received the medication 7 of 7 days.</p> <p>During an interview, on 1-27-15 at 2:00 P.M., the Social Service Director indicated if the resident was having, anxiety, it would be documented in the Monthly Nursing Assessment or on a Circumstance form. She further indicated she had not seen the resident for anxiety issues.</p> <p>On 1-26-15 at 3:29 P.M., the DON provided a policy titled " INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE" revised 1/2008 when asked for an assessment policy. The policy indicated "...c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 2.0)...i Problems areas should identify the relative concerns...ii. Goals should be measurable and attainable...iii Interventions should be reflective of the individual's needs and risk influence...."</p> <p>3. The clinical record of Resident #15 was reviewed, on 1-23-15 at 3:15 P.M. The resident's diagnoses, included but were not limited to: depression with psychotic features, mental disorder due to head trauma, seizure disorder,</p>						

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	<p>hemiplegia, heimparesis, osteopenia, and insomnia.</p> <p>The MAR (Medication Administration Record) indicated the resident was on the following medications: Zyprexa 1.25 mg (milligrams) every morning and 2.5 mg HS (at bedtime) for hallucinations. On 1-7-15, the dosage was changed to Zyprexa 2.5 every morning and at bedtime. Then on 1-9-15, the dose was changed again to Zyprexa 5 mg every morning and at bedtime.</p> <p>The Mental Health Wellness Circumstance forms indicated, on 1-7-15, the resident "...was upset and pinned CNA [Certified Nursing Assistant] between w/c [wheelchair] and bed..."</p> <p>The Prevention Update section indicated "...reassurance, anticipate needs, and evaluate medications...." The IDT (Interdisciplinary Team) review, dated 1-8-15, indicated Zyprexa was increased. On 1-14-15 the resident had a behavior of " thinking staff and physician were trying to kill her." She had also refused medications 4 of 7 days of the follow-up assessment after the initial incident.</p> <p>Another Mental Health Wellness Circumstance form, dated 1-19-14, indicated the resident was resistant to care and expressed unrealistic fears. The resident "feels nurses and doctor are</p>						

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	<p>trying to kill her." The Prevention Update section indicated staff were to anticipate needs, explain procedures and to engage the Social Service staff.</p> <p>During an interview on 1-27-15 at 2:20 P.M., the Social Service Director indicated all behaviors were documented on a "Mental Health Wellness Circumstance, Assessment and Intervention forms and on the Behavior Detail Report. The Social Service Director indicated she had spoke with the resident about refusing her medications.</p> <p>The care plan for "Mood and Behaviors," dated 12-8-14 to present, indicated "...currently prescribed medication for my history of hallucinations...In the past, I would hallucinate by having very vivid and disturbing dreams...I haven't had any behaviors or mood issues in quite a while, but I have a history of resisting care and being physically abusive... I also have a history of mood issues and currently have a diagnosis of depression with psychotic features, as well as insomnia...I am currently on prescribed an antidepressant and antipsychotic for these diagnosis...Please continue to monitor my moods and depression and if you notice any negative changes, please inform my doctor...Please ensure that I continue to see the psychologist from</p>			

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	<p>[name of psychiatric provider] on a regular basis...Please review this care plan by 3/2015 to make any necessary changes and to ensure that my needs are met...."</p> <p>A "Behavior Detail Report" form, received from the Social Service Director, indicated Resident #15 had an episode of "physical abuse" on 1-7-15 at 10:30 A.M. The form further indicated "none of the interventions apply" (which meant no interventions were documented as having been tried to address this behavior.) On 1-11-15 at 9:00 P.M. the report indicated the resident had an episode of resisting/rejecting care and the intervention was to toilet the resident, but was ineffective.</p> <p>A Nursing Note dated 1-7-15 at 10:45 P.M. indicated a CNA was pinned by resident between Resident #15's wheelchair and bed. The resident was told the behavior was "inappropriate." The physician was in the building and was notified of the incident. The physician referred the resident to the psychiatric services. The nurse left a message for the Nurse Practitioner (NP) at the psychiatric services. At 4:00 P.M. on 1-7-15, the NP returned the call and ordered an increase in Zyprexa (2.5 mg) in A.M.</p>				

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	<p>A Nursing Note, dated 1-11-15 at 8:00 P.M., indicated the resident was refusing all night medications. At 10:15 P.M., the nurse reproached resident with night medications. The resident agreed to take the medications and "took meds [medications] without arguing or complaining." The nurse reassured her and helped to assist the resident into bed with an aide.</p> <p>A Nursing Note, dated 1-14-15 at 12:00 P.M., indicated the resident did not refuse her seizure medication with her parents present.</p> <p>A Nursing Note, dated 1-14-15 at 5:30 P.M., indicated if the resident refused medications and/or had increased behaviors, facility was to send the resident to psychiatric hospital for evaluation and treatment.</p> <p>A Nursing Note, dated 1-16-15 at 12:45 P.M., indicated the resident took the medications without resistance. No delusional behavior or thinking was noted and the resident was cooperative.</p> <p>A Nursing note dated 1-18-15 at 2:00 A.M., indicated, the resident was awake "wanting to talk" and indicated she wanted to stop all her medications. The</p>			

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	<p>resident was told, by the nurse, to discuss the issue in A.M. At 3:00 A.M., the resident was on her call light continuously, demanding to get up. The nurse encouraged resident to rest. At 3:45 A.M., the Nursing Note indicated the resident was gotten up for the day and "continuously after the nurse about her medications." At 6:45 A.M., the physician was called and the Ambien medication was discontinued.</p> <p>The Physician Orders indicated, on 1-7-15, the Zyprexa morning dose was increased to 2.5 mg. On 1-15-15 a Physician Order indicated the staff were to monitor the resident's behaviors for 1-3 days, if resident's behaviors escalated or resident continued to refuse medications, staff were to send there resident to the psychiatric hospital, and obtain a urine dipstick or urine specimen. On 1-18-15 Ambien was discontinued. On 1-19-15 a Lamictal level was ordered. On 1-19-15 an order was received to discontinue Zyprexa 2.5 mg BID (twice a day) and an order to give Zyprexa 5 mg bid and further indicated the staff may give IM (intramuscular) if refuses po (oral). On 1-20-15 the order for IM dose was discontinued.</p> <p>The Social Service notes for 1/13, 1/14, 1/5, and 1/16/2015 indicated the Social</p>						

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	<p>Service Director had explained the importance of taking medications to the resident. The resident would express understanding and type on Ipad "ok" and smile.</p> <p>A form titled "Psychiatric Progress Note", dated 12-19-14, indicated the chief complaint was depression, resident was cooperative and thought process was progressively organized. There were no notes on the form indicating the resident had been having delusions or hallucinations.</p> <p>On 1-27-15 at 4:29 P.M., the DON provided a current policy titled " INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE," revised 1/2008. The policy indicated " PURPOSE: to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 2.0)...i Problems areas should identify the relative concerns...ii. Goals should be measurable and attainable...iii Interventions should be reflective of the individual's needs and risk influence...."</p>						

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F000279 SS=D	<p>3.1-31(c)(1) 3.1-31(c)(3)</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 interviews, the facility failed to ensure a care plan was initiated with targeted medical symptoms and interventions regarding the use of an antipsychotic medication for 1 of 5 residents reviewed for medication use. (Resident #22) The facility also failed to ensure a care plan was initiated for hypothroidism and anemia for 1 of 5 residents reviewed for medication use. (Resident #7)</p>	F000279	<p>1) Resident #22 comprehensive care plans have been revised to reflect the symptoms and interventions for use of antipsychotics. Resident #7 comprehensive care plans have been initiated regarding hypothroidism and anemia. 2) All residents have the potential to be affected by this alleged deficient practice. Audit of all admissions in last 30 days to ensure proper care plans are in</p>	02/26/2015			

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	<p>Findings include:</p> <p>1. The clinical record for Resident #22 was reviewed on 01/26/15 at 9:27 A.M. Resident #22 was admitted to the facility on 01/07/14 and readmitted on 07/23/14 with diagnoses, including but not limited to: cellulitis, peripheral vascular disease, hypertension, renal insufficiency, osteoarthritis, history of pneumonia, history of kidney stones, and diabetes mellitus.</p> <p>The current physician's orders for medications included an order for the antipsychotic medication, Risperidone 0.25 mg 1/2 tab (0.125 mg once a day).</p> <p>The current care plans for Resident #22 included a care plan to monitor the resident for signs and symptoms of depression and antidepressant medication use. The care plan mentioned the resident's antipsychotic medication use and the need for a gradual dose reduction, but the plan did not mention the medical symptoms for which the medication had been prescribed. In addition, except for the need to possibly gradually reduce the medication, there was no plan to address any behavior issues in the care plan. The care plans had last been reviewed on 11/24/14.</p>		<p>place and appropriate. 3) Licensed nursing staff were re-educated regarding the campus guidelines for interdisciplinary care plans and on monitoring medical symptoms of individuals on antipsychotics and appropriate intervention. 4) Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms, and change in condition forms and telephone orders in the daily clinical meeting 5 days a week, ongoing. The review is to ensure the care plan have been initiated/updated as necessary. The Daily Clinical Report will be completed to document the review of the above stated reports/forms. Audits and/or observations related to care plans will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations</p>				

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	<p>Interview on 01/26/15 at 2:00 P.M. with CNA #26, indicated the care tracker (electronic charting system) instructed staff to track Resident #22 for depression, crying, and sadness. She indicated she had never had to chart this mood issue for the resident. She indicated there was no behavior symptoms noted on the care tracker "I care plan" to be monitoring for Resident #22.</p> <p>Interview with the Social Service Designee, on 01/27/15 at 10:15 A.M., indicated there was no behavior tracking except what was in the Kiosk for Resident #22, which was for signs and symptoms of depression. She indicated a medical symptom for antipsychotic medication use needed to be care planned with interventions.</p> <p>2. The clinical record of Resident #7 was reviewed on 1-26-15 at 10:02 A.M. The resident's diagnoses included, but were not limited to: anemia and hypothyroid.</p> <p>The Medication Administration Record (MAR) indicated the resident was receiving ferrous sulfate 325 mg twice a day (BID) for anemia and synthroid 75 micrograms (mcg) daily for hypothyroidism.</p> <p>A Physician's Progress Note, dated</p>						

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	<p>1-7-15, indicated the resident had a thyroid test (TSH) on 12-5-11.</p> <p>The care plans indicated the resident had the following care plan titles: Activities of Interest, Acute Care Needs, ADL (Activities of Daily Living), Bowel and Bladder, Cognition, Height/Weights, Meals/Snacks/Fluids, Mood and Behaviors, Pain Management, Skin, and Vitals. There was no care plan to address anemia nor hypothyroidism.</p> <p>During an interview on 1-26-15 at 1:45 P.M., the Director of Nursing (DON) indicated he was unable to locate a hypothyroidism or anemia care plan for Resident # 7.</p> <p>On 1-26-15 at 3:29 P.M., the DON provided a policy titled "INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE" revised 1/2008. The policy indicated "...c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 2.0)...i Problems areas should identify the relative concerns...ii. Goals should be measurable and attainable...iii Interventions should be reflective of the individual's needs and risk influence...."</p> <p>3.1-35(a)</p>						

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F000280 SS=D	<p>3.1-35(b)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interviews, the facility failed to ensure the nutritional care plan was revised to address a significant weight loss for 1 of 3 residents reviewed for significant weight loss (Resident #43), and a fall care plan was revised after a fall for 1 of 3 residents reviewed for accidents (Resident #42)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #43 was reviewed on 01/26/15 at 10:23 A.M.</p>	F000280	<p>1) On 2/13/15 the MDS coordinator updated the care plan for Residents #43 and #42. 2) All residents have the potential to be affected by this alleged deficient practice. Review of weights for past 60 days and fall for last 30 days reviewed and care plans updated/implemented as appropriate. 3)The facility's Interdisciplinary Team will attend an in-service on care planning. Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms, and</p>	02/26/2015
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	<p>Resident #43 was admitted to the facility on 11/25/14 with diagnoses, including but not limited to, status post urinary tract infection, dementia, hypertension, chronic airway obstruction, benign prostatic hyperplasia, hydrocephalus, and dysphagia.</p> <p>The initial nursing assessment, completed on 11/26/14, indicated the resident weighed 110 pounds, had broken and/or loose fitting dentures, and had no natural teeth present.</p> <p>The initial nutritional assessment, completed by the registered dietician, on 12/01/14, indicated the resident's BMI (Body Max Index) was 19.5 percent. The resident was assessed to be independent with eating, on a regular no added salt diet, and had some confusion. The recommendations were to change the resident's diet to regular, no supplements were recommended, and the goal was for the resident to maintain and/or increase his weight 1-3 pounds per month.</p> <p>A 30 day Minimum Data Set (MDS) assessment, completed on 12/09/14, indicated the resident's weight was 103 pounds, but did not assess the 7 pound weight loss as a significant (greater than 5 percent in 30 days) weight loss.</p>		<p>accident/incident forms in the daily clinical meeting 5 days a week, ongoing. Weights will be reviewed monthly and/or as weights are ordered by physician. The review is to ensure the care plan have been initiated/updated as necessary with new dietary orders and interventions for falls. The Daily Clinical Report will be completed to document the review of the above stated reports/forms 4) Audits and/or observations related falls and interventions will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations</p>		

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	<p>The care plan related to heights and weights, initiated on 12/04/14, indicated the resident was to be weighed monthly and his weight monitored. The goal was for the resident to maintain his current weight of 110 pounds or gradually gain weight. There was also a care plan, initiated on 12/04/14 regarding the resident's meals which indicated he enjoyed food and routinely ate 90 - 100 percent of a no added salt diet. The plan had an intervention to ask the doctor to liberalize his diet, monitor his intakes, labs, and physical parameters. There was no revised plan to address the resident' significant weight loss or the liberalized diet.</p> <p>During an interview on 01/27/15 at 2:00 P.M., the Director of Nursing (DON) indicated he had no further information or documentation regarding the weight loss for Resident #43.</p> <p>Review of the policy and procedure, titled "Interdisciplinary Team Care Plan Guidelines", revised on 01/08, included the following: "...f. The comprehensive care plan should be revised to reflect change in condition updates with each MDS assessment...."</p> <p>2. On 1/26/15 at 8:50 A.M., the clinical record for Resident # 42 was reviewed. The clinical record indicated the resident</p>						

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	<p>was admitted to the facility on 7/13/12 with diagnoses that included but were not limited to the following: hypothyroidism, chronic kidney disease and unspecified essential hypertension.</p> <p>The quarterly Minimum Data Set assessment, dated 10/21/14, indicated a Brief Interview for Mental Status (BIMS) score was 3, indicating severe cognitive impairment.</p> <p>The Fall Circumstance Assessment and Intervention form, provided by Medical Records and dated 1/17/15 was reviewed. The Fall Circumstance Assessment and Intervention form included but was not limited to the following: "...Date of Fall: 1/17/15...Time of Fall: 1630...Location of fall: N. E. Dining Room...Witnessed: N...Found on floor: indicated by an X...Activity at time of fall: leaned over and slipped out of w/c [wheelchair]...Fall Risk Re-Assessment: Resident has cognitive or memory impairment that effects safety and judgement? Y [circled to indicate yes] Resident has difficulty understanding and following directions? Y [circled to indicate yes]...Care Plan: I had a recent fall because I slipped out of my w/c. My goal is to not fall and not be injured by fall. Please help me by using/doing the following things: Orient to environment... IDT Review: 1/19/15.</p>			

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	<p>Root Cause: Increased confusion, poor safety awareness...."</p> <p>On 1/26/15 at 9:51 A.M., an interview was conducted with the Director of Health Services. The Director of Health Services indicated the nurse at the time of the fall initiates an intervention and that they (nurse at time of fall) should have gotten a dycem [a non-slip pad] because the fall was not witnessed and it is not known if the resident was transferring herself or not.</p> <p>On 1/26/15 at 10:00 A.M., a current policy titled "... Falls Management Program Guidelines....", provided by the Clinical Consultant on 1/22/15 at 4:00 P.M., was reviewed. The policy included but was not limited to the following: "... Procedure...3. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form" The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions...."</p>						

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F000282 SS=E	<p>3.1-35 (d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interviews, the facility failed to follow the physician's orders and care plans for 1 of 1 residents regarding pressure ulcer interventions (Resident #14), 2 of 5 residents regarding medication administration (Residents #20 and #60) and 1 of 1 residents reviewed for incontinence regarding toileting needs (Resident #11).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #60 was reviewed on 01/22/15 at 2:38 P.M. Resident #60 was admitted to the facility on 10/06/14 with diagnosis, including but not limited to, pneumonia, urinary tract infection, weakness, acute cerebrovascular disease, chronic kidney disease stage III, neurogenic bladder, anemia, depressive disorder, hypertension, coronary athrelosclerosis, aortic valve disorder, atrial fibrillation, congestive heart failure, and aphasia.</p>	F000282	<p>1)Resident #60, 14, 11 and 20, did not have any negative effects related to practice and medical records have been reviewed/corrected 2)All resident residing at the campus have the potential to be affected by the alleged practice. 3)All newly written physician orders will be reviewed in the first Clinical Care Meeting held after the orders have been written, review and update of MARS/TARS and care plan will be completed at that time. Licensed Nursing staff and CRMA in serviced on proper medication administration pass and requirements of initialing MAR/TAR when medication/treatment provided or declined. 4) DHS and/or designee will monitor medication pass 3 times a week for 4 weeks; then weekly x 1months; then monthly x 4 months alternating staff so different staff will be monitored. DHS and/or designee will monitor newly written physician orders 5 times weekly for x 4 weeks; then weekly x 1months; then</p>	02/26/2015

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	<p>Her admission physician orders, dated 10/06/14, included orders to administer the medication, Amiodarone (a medication treat heart arrhythmias) 400 mg (milligrams) twice a day for 7 days then reduce to 200 mg twice a day for 14 days for wide-complex tachycardia.</p> <p>On 10/15/14 there was an order to send the resident to the acute care center emergency room for dyspnea and chest pain.</p> <p>Review of the acute care center's history and physical report, dated 10/17/14 for the 10/15/14 admission, indicated the resident had been taking the medication Amiodarone prior to admission but it was stopped after only one week and was stopped "reason unknown." Resident #60 was admitted to the acute care facility on 10/15/14, for acute congestive heart failure with symptoms, fluid overload with abdominal and lower extremity edema.</p> <p>Review of the Medication Administration Record (MAR) for October 2014 from the October 06 - October 15, 2014, indicated the Amiodarone 400 mg twice a day had been administered as ordered from October 6 through October 12, 2014. The Amiodarone 200 mg twice a day was written on the MAR, but the</p>		<p>monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Findings will be reviewed by campus QAA committee to determine future monitoring needs.</p>				

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	<p>medication was not documented as having been given on 10/13/15, 10/14/15, or 10/15/14 prior to the resident being sent to the acute care facility. The 200 mg dose of Amiodarone had been colored yellow with a highlighting marker, which indicated it had been discontinued.</p> <p>During an interview on 01/23/15 at 2:45 P.M., the Assistant Director of Nursing (ADON) and Registered Nurse #24 (Nurse Consultant) indicated they could not find any order or any documentation in the clinical record for Resident #60 to explain why the medication had not been administered as ordered.</p> <p>During an interview on 01/27/2015 2:34 P.M., the Director of Nursing (DON) indicated in November 2014 nurses were inserviced regarding all aspects of medication pass, including medication errors. He indicated he was unsure if anyone had noted the administration errors of the Amiodarone for Resident #60</p> <p>2. The clinical record for Resident #14 was reviewed on 01/23/15 at 10:05 A.M. Resident #14 was admitted to the facility on 03/17/2003 with diagnoses, including but not limited to, muscular atrophy, weakness, abnormal gait, difficulty in walking, lack of coordination,</p>			

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	<p>osteoarthritis, hypothyroidism. anxiety, atrial fibrillation, memory loss, and athrosclerosis.</p> <p>Monthly nursing assessments, completed on 10/18/14 and 11/17/14, indicated the resident did not have any impaired skin issues.</p> <p>A nursing monthly assessment form, completed on 01/17/15, indicated the resident had a skin impairment on the heel of the left foot. There was no specific documentation on the assessment to indicate what the impairment was on the resident's left foot.</p> <p>A Skin Impairment Circumstance Investigation form, completed on 01/08/15, indicated the resident had an unstageable pressure ulcer on her right heel.</p> <p>The physician was notified on 01/08/15 and a treatment for skin prep optifoam and mefix tape daily to the left heel was ordered. There was also an order, dated 01/08/15, to float the resident's heel on a pillow while in bed.</p> <p>The current health care plan for Resident #14, related to risk for impaired skin, initiated and reviewed as current on 12/03/14, included interventions to</p>						

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	<p>observe her skin, provide pressure redistribution products for her bed and chair, provide the resident with assistance for bed mobility, encourage the resident to eat 75 % of food and snacks, encourage the resident to drink fluids, provide the resident with nutritional supplements, use a draw sheet for turning and repositioning, and provide weekly nursing skin assessment.</p> <p>An acute care plan related to the pressure ulcer development, initiated on 01/09/15, indicated the resident had issues with her right heel. The interventions included providing treatment as ordered, monitoring for signs and/or symptoms of infection. There was no intervention to float the resident's heels on a pillow when she was lying in her bed.</p> <p>Resident #14 was observed, on 01/23/15 at 1:23 P.M. standing by her bed making her bed. She was noted to be wearing slip on tennis shoes with diamond shaped cut outs on the canvas part of the back of each heel.</p> <p>Resident #14 was observed, on 01/23/15 at 2:36 P.M. lying in her bed on her back underneath multiple layers of blankets. CNA #21 was noted to be passing ice water to Resident #14's room. CNA #21 pulled back the blankets to reveal</p>			

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	<p>resident #14's heels in panty hose lying directly on the mattress. There was a pillow on top of the blankets at the end of the bed. CNA #21 indicated she had to make sure her (Resident #14's) feet were cleaned really good in between her toes. She made no attempt to float the resident's heels on a pillow as was ordered by the physician.</p> <p>Resident #14 was observed on 01/26/15 at 9:10 A.M. lying in her bed asleep. The resident had nonslip grip socks on and her feet were against the mattress. She had two blankets over the rest of her body. CNA #22 was passing ice water in Resident #14's room. The CNA indicated Resident #14 used to wear diabetic hose but they were too tight with her with her edema so now she just wore nylons that were not as tight. CNA #22 was not aware of any other issue with the resident's skin or preventative measures except for some incontinence issues. A pillow was laying off to the side of the resident by her hip on top of the blankets. CNA #22 made no attempt to reposition the resident's legs and feet to float the heels on the pillow.</p> <p>On 01/26/15 at 10:00 A.M., RN #23 entered Resident #14's room to administer medication. She did not reposition the resident's feet to float her</p>						

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	<p>heels before she exited the room.</p> <p>Resident #14 was observed on 01/26/15 at 11:00 A.M., lying in her bed with her heels against the mattress.</p> <p>During an interview on 01/26/15 at 11:10 A.M., RN #24 indicated the intervention to float the resident's heels had been "missed" and not added to the resident's care plan.</p> <p>3. The clinical record for Resident #11 was reviewed on 01/23/15 at 10:48 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnosis, including but not limited to hypertension and muscle weakness.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 09/15/14, indicated the resident required extensive staff assistance for transfers and toileting needs and was continent of her bowels and bladder.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained continent of her bowels.</p>						

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	<p>The MDS coordinator provided a bowel and bladder MDS assessment form, dated 01/22/15, which the had number of incontinent and continent episodes per day for 01/16/15 - 01/22/15, but there was no other assessment information provided.</p> <p>The current health care plan for Resident #11, initiated on 12/15/14, indicated the following: "I am incontinent of bladder at times r/t [related to] decreased mobility and an injury to my right shoulder form childhood. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence every two hours and prn [as needed]. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinent care. Offer me toileting during incontinence checks. Provide me with incontinence products for dignity and control...."</p> <p>Resident #11 was observed on 01/26/15 at 9:10 A.M. seated in her recliner in her room, being administered medication by the licensed nurse.</p> <p>Resident #11 was observed on 01/26/15 at 9:25 A.M., seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed on 01/26/15</p>				

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	<p>at 10:00 A.M. seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed on 01/26/15 at 10:40 A.M. seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed on 01/26/15 at 11:07 A.M. seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed on 01/26/15 at 11:30 A.M., seated in her recliner awake. She had moved her legs some and her shoes were now showing out the end of the blanket over top her. She indicated she had not had a very long nap and was still tired. She indicated she could not get up by herself and staff were very busy.</p> <p>Resident #11 was observed on 01/26/15 at 11:38 A.M. telling a CNA she did not want to go to the dining room for lunch. The CNA indicated she would come back in about 15 minutes.</p> <p>At 12:10 P.M., Resident #11 was pushed into the dining room by CNA #22 indicated the resident was not toileted because she said she did not have to go to the bathroom. She indicated the resident would toilet herself at times and wore a pull up. CNA #22 was not sure of any</p>				

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	<p>specific toileting program or plan for Resident #11. CNA #22 indicated she had assisted Resident #11 to the bathroom when she had gotten her up in the morning before breakfast, over 4 hours earlier.</p> <p>4. On 1/27/15 at 12:00 P.M., the clinical record for Resident #20 was reviewed. Diagnosis included but were not limited to the following: congestive heart failure, chronic obstructive pulmonary disease, myocardial infarction, diabetes mellitus, coronary artery disease, defibrillation, ventricular tachycardia, deep vein thrombosis and hypertension.</p> <p>A physicians order written on 1/5/15 indicated the following: "... Flagyl [an antibiotic medication] 250 mg [milligrams] 2 [sic] po [by mouth] (500 mg) x [times]10 days TID [three times a day] for diarrhea...."</p> <p>A second physicians order written on 1/5/15 indicated the following: "...Vancomycin [an antibiotic medication] IVPB [intravenous piggy back, a way to administer the medication] 250 mg IVPICC [intravenous peripherally inserted central catheter, a form of intravenous access used to administer the medication] 250 ml [milliliters] q [every] 12 hours [sic] over 60 minutes...."</p>			

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	<p>The Medication Administration Record indicated a lack of documentation to indicate the antibiotics [Flagyl and Vancomycin] had been administered on 2 separate occasions. The following were indicated:</p> <p>1/7/15 the Medication Administration Record lacked documentation to support the Lunch dose of Flaygl had been administered.</p> <p>1/9/15 the Medication Administration Record lacked documentation to support the 9:00 P.M. dose of Vancomycin had been administered.</p> <p>On 1/27/15 at 3:30 P.M., an interview was conducted with the Director of Health Services. The Director of Health Services indicated the antibiotic medications had not been given on 1/7/15 at Lunch and 1/9/15 at 9:00 P.M. and that his expectation was that medications be administered as the physician prescribes them to be given.</p> <p>On 1/27/15 at 4:30 P.M., a current policy, provided by the Assistant Director of Nurses and titled "...Medication Administration-General Guidelines...." was reviewed. The policy, which had last been revised on 9/17/12, indicated but was not limited to the following: "...Policy... Medications are administered</p>			

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F000314 SS=D	<p>as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...Administration...b). Medications are administered in accordance with written orders of the attending physician...."</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interviews, the facility failed to implement interventions to promote healing for 1 of 3 residents with pressure ulcers reviewed. (Resident #14)</p> <p>Finding includes:</p> <p>The clinical record for Resident #14 was reviewed on 01/23/15 at 10:05 A.M. Resident #14 was admitted to the facility on 03/17/2003 with diagnoses, including but not limited to, muscular atrophy,</p>	F000314	<p>1) Resident #14 is a discharged resident 2)All residents with skin impairments have the potential to be affected by this alleged practice. 3) Nursing staff inserviced regarding wounds and interventions to promote healing. Audits will be conducted 2 times per week for 4 weeks then monthly times 5 months to ensure that interventions are in place to promote healing. 4) DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through</p>	02/26/2015			

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	<p>weakness, abnormal gait, difficulty in walking, lack of coordination, osteoarthritis, hypothyroidism. anxiety, atrial fibrillation, memory loss, and arteriosclerosis.</p> <p>Monthly nursing assessments, completed on 10/18/14 and 11/17/14, indicated the resident did not have any impaired skin issues.</p> <p>A nursing monthly assessment form, completed on 01/17/15, indicated the resident had a skin impairment on the heel of the left foot. There was no specific documentation on the assessment to indicate what the impairment was on the resident's left foot.</p> <p>A Skin Impairment Circumstance Investigation form, completed on 01/08/15, indicated the resident had an unstageable pressure sore (full thickness tissue loss in which the base of the ulcer is covered by slough and /or eschar in the ulcer bed) on her right heel.</p> <p>The physician was notified on 01/08/15 and a treatment for skin prep optifoam and mefix tape daily to the left heel was ordered. There was also an order, dated 01/08/15, to float the resident's heel on a pillow while in bed.</p>		the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance achieved, then randomly thereafter for further recommendations		

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	<p>Resident #14 was observed, on 01/23/15 at 1:23 P.M., standing by her bed making her bed. She was noted to be wearing slip on tennis shoes with diamond shaped cut outs on the canvas part of the back of each heel.</p> <p>During an observation of the resident's left heel, completed on 01/23/15 at 1:30 P.M., the following was noted: There was no open area noted on the left heel but the left heel was reddened and did not blanch. The Assistant Director of Nursing (ADON), who could not really visualize the area, indicated there must have been an open area on the heel. When questioned as to where the unstageable open area was located she indicated there must have been darker area or something. She placed skin prep, an epifoam 1 inch by 1 inch square on the heel and put an adhesive tape over all of the resident's left heel area. There was some lower extremity edema noted above the knee high panty hose band and there was some moistness noted on her shin. The resident's right heel observed and revealed a tear drop shaped superficial open area, pink in color, and a larger reddened area, which surrounded the open area, on the back of the resident's right heel. The ADON then went out, retrieved more supplies, and dressed the resident's right heel in the same manner</p>			

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	<p>as she had dressed the resident's left heel. The ADON was unaware of the most recent assessment of the resident's heel which indicated on 01/02/15, there was a 1.5 centimeter (cm) by 2 cm dry reddened area and on the inside was a 1 cm by 1 cm scabbed area on the resident's right heel.</p> <p>The current health care plan for Resident #14, related to risk for impaired skin, initiated and reviewed as current on 12/03/14, included interventions to observe her skin, provide pressure redistribution products for her bed and chair, provide the resident with assistance for bed mobility, encourage the resident to eat 75 % of food and snacks, encourage the resident to drink fluids, provide the resident with nutritional supplements, use a draw sheet for turning and repositioning, and provide weekly nursing skin assessment. An acute care plan related to the pressure ulcer development, initiated on 01/09/15, indicated the resident had issues with he right heel. The interventions included providing treatment as ordered, monitoring for signs and/or symptoms of infection.</p> <p>Resident #14 was observed, on 01/23/15 at 2:36 P.M., lying in her bed on her back underneath multiple layers of blankets.</p>			

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	<p>CNA #21 was noted to be passing ice water to Resident #14's room. CNA #21 pulled back the blankets to reveal resident #14's heels in panty hose lying directly on the mattress. There was a pillow on top of the blankets at the end of the bed. CNA #21 indicated she had to make sure her (Resident #14's) feet were cleaned really good in between her toes. She made no attempt to float the resident's heels on a pillow as was ordered by the physician.</p> <p>Resident #14 was observed on 01/26/15 at 9:10 A.M. lying in her bed asleep. The resident had nonskid grip socks on and her feet were against the mattress. She had two blankets over the rest of her body. CNA #22 was passing ice water in Resident #14's room. The CNA indicated Resident #14 used to wear diabetic hose but they were too tight with her with her edema so now she just wore nylons that were not as tight. CNA #22 was not aware of any other issue with the resident's skin or preventative measures except for some incontinence issues. A pillow was laying off to the side of the resident by her hip on top of the blankets.</p> <p>On 01/26/15 at 10:00 A.M., RN #23 entered Resident #14's room to administer medication. She did not reposition the resident's feet to float her</p>			

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F000315 SS=D	<p>heels before she exited the room.</p> <p>Resident #14 was observed on 01/26/15 at 11:00 A.M. still lying in her bed with her heels against the mattress.</p> <p>During an interview on 01/26/15 at 11:10 A.M., RN #24 indicated the intervention to float the resident's heels had been "missed" and not added to the resident's care plan.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interviews, the facility failed to ensure a decline in bladder continency for 1 of 1 residents review (Resident #11) was thoroughly assessed and individualized interventions implemented to restore as much bladder function as was possible.</p> <p>Finding includes:</p>	F000315	<p>1) Residents #11 bladder patterns assessed and reviewed for bladder continence 2) All residents have the potential to be affected by this alleged deficient practice. 3) Licensed nursing staff to be in-serviced on urinary continence status assessments. 4) DHS and/or designee to audit elimination record</p>	02/26/2015			

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	<p>The clinical record for Resident #11 was reviewed on 01/23/15 at 10:48 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnosis, including but not limited to hypertension and muscle weakness.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 09/15/14, indicated the resident required extensive staff assistance for transfers and toileting needs and was continent of her bowels and bladder.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained continent of her bowels.</p> <p>An elimination record was completed for Resident #11 on 09/07/14 - 09/10/14. The record indicated the resident did not have any incontinent episodes.</p> <p>The MDS coordinator provided an MDS assessment form dated 01/22/15, which indicated the number of incontinent and continent episodes per day from 01/16/15 - 01/22/15, but there was no other assessment information provided.</p>		<p>schedule for new admissions for proper assessment 5 days a week, ongoing for 4 weeks then monthly times 5 months and record findings on audit tool. DHS and or designee will forward the results of the audit and or observations to be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations</p>		

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	<p>During an interview on 01/23/15 at 2:30 P.M., the Director of Nursing indicated he could not locate any other assessment form or documentation regarding bladder incontinence for Resident #11. He indicated the facility should have completed a "Change in Elimination" assessment form when the decline was noted.</p> <p>During an interview on 01/27/15 at 10:55 A.M., RN #25 (MDS Coordinator), indicated if only one decline was noted on the MDS assessments, she probably did not realize there had been a significant change in one area. She indicated the corporate policy as far as she knew was to only do a 7 day look back which indicated per shift how many times there had been incontinence. She did not know of any other form or assessment tool utilized to assess bladder incontinence. RN #25 indicated she was uncertain if the nurses on the floor had completed other nursing assessment documentation for Resident #11. RN #25 indicated all incontinent resident's care plans had interventions to ensure everyone was to be checked every 2 hours for incontinence.</p> <p>Resident #11 was observed, on 01/26/15 at 9:10 A.M., seated in her recliner in her</p>				

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	<p>room, being administered medication by the licensed nurse.</p> <p>Resident #11 was observed, on 01/26/15 at 9:25 A.M., seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed, on 01/26/15 at 10:00 A.M., seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed, on 01/26/15 at 10:40 A.M., seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed, on 01/26/15 at 11:07 A.M., seated in her recliner in her room, asleep.</p> <p>Resident #11 was observed, on 01/26/15 at 11:30 A.M., seated in her recliner awake. She had moved her legs some and her shoes were now showing out the end of the blanket over top her. She indicated she had not had a very long nap and was still tired. She indicated she could not get up by herself and the nursing staff were very busy.</p> <p>Resident #11 was observed, on 01/26/15 at 11:38 A.M., telling a CNA she did not want to go to the dining room for lunch. The CNA indicated she would come back in about 15 minutes.</p>			

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	<p>On 1/26/15 at 12:10 P.M., Resident #11 was pushed into the dining room by CNA #22. CNA #22 indicated the resident was not toileted because she said she did not have to go to the bathroom. She indicated the resident would toilet herself at times and wore a pull up brief. CNA #22 indicated the last time she had assisted Resident #11 to go to the bathroom was first thing in the morning when she had assisted her to get dressed for the day. She indicated this toileting occurred over 4 hours previous.</p> <p>The facility policy and procedure, titled, "Bowel and Bladder Continence Programming", dated October 2007, indicated the bladder incontinence assessments were to include the following: "MDS (assessment), History and Physical, Nurse's notes, Physician's Notes, Medications, History of continence, Current Cognitive status." In addition, potential factors contributing to the incontinence were: "UTI (urinary tract infections), Fecal Impaction, Dehydration, Diagnosis such as but not limited to: Delirium, Diabetes, CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), Parkinson's, CVA (cerebral vascular accident) , CA (cancer) of the bladder or spine, Spinal cord or head injury, and</p>			

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F000325 SS=D	<p>Alzheimer's (dementia), Edema, Diabetes, Pain related to urination, Atrophic vaginitis, Impaired mobility, Impaired cognition, Medications, Lack of sensation or ability to recognize the need to void/eliminate, urge or stress incontinence, and Behaviors contributing to noncompliance with a toileting program." The policy included the following instructions:</p> <p>"4. Identify potential causative factors, address with physician and implement appropriate interventions to reduce or eliminate cause(s) when possible.</p> <p>5. Analyze assessments to s, address with physician and implement appropriate interventions to reduce or eliminate cause(s) when possible.determine resident's ability to participate in a continence program. If a toileting plan may be beneficial initiate the Elimination Record and Schedule to record the resident's elimination pattern for a 3-day period." The facility's policy then described how to determine if a resident was able to be placed on a continence program and how to determine the resident's restorative potential as well as a toileting schedule.</p> <p>3.1-41(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS</p>			

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	<p>UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interviews, the facility failed to ensure the nutritional status of 1 of 3 residents reviewed for significant weight loss was reassessed and interventions implemented to prevent further weight loss. (Resident #43)</p> <p>Finding includes:</p> <p>The clinical record for Resident #43 was reviewed on 01/26/15 at 10:23 A.M. Resident #43 was admitted to the facility on 11/25/14 with diagnoses, including but not limited to: status post urinary tract infection, dementia, hypertension, chronic airway obstruction, benign prostatic hyperplasia, hydrocephalus, and dysphagia.</p> <p>The initial nursing assessment, completed on 11/26/14, indicated the resident weighed 110 pounds, had broken and/or loose fitting dentures, and had no natural teeth present.</p>	F000325	<p>1) Resident #43 has been discharged. 2) All residents have the potential to be affected by the alleged deficient practice. The current weight history has been reviewed for any unplanned weight loss and referred to the Clinical Nutrition Support to assess and plan interventions to prevent further weight loss. 3) Admission weights to be verified by 2 staff members. Documented weights and admission chart will be reviewed in first Clinical Meeting following admission and audited to verify weight entered in clinical record. 4) Audit to be conducted in morning clinical meeting for weights conducted per admission. DHS and or designee will forward the results of the audits and/or observations to QAA and will monitor monthly for six months or until 100% compliance is achieved.</p>	02/26/2015			

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	<p>The initial nutritional assessment, completed by the Registered Dietician, on 12/01/14, indicated the resident's BMI (Body Mass Index) was only 19.5 percent. The resident was assessed to be independent with eating, on a regular no added salt diet, and had some confusion. The recommendations were to change the resident's diet to regular, no supplements were recommended, and the goal was for the resident to maintain and/or increase his weight 1-3 pounds per month.</p> <p>The resident's weight on 12/09/14 103 pounds and his weight on 01/06/15 was 100 pounds.</p> <p>An MDS (Minimum Data Set) 30 day assessment, completed on 12/23/14, noted weight of 103 pounds but did not indicate it was any significant weight change. The 7 pounds weight loss was over 5% weight loss in 30 days.</p> <p>During an interview on 01/26/15 at 10:55 A.M., the DON (Director of Nursing) indicated he would look for dietary recommendations. He concurred 7 pounds weight loss from 110 pounds was significant for Resident #43. He indicated he would have to ask the dietician why she did not recommend any nutritional supplements when the resident was first admitted.</p>						

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	<p>During an interview on 01/26/15 at 12:01 P.M., the DON indicated the only documentation he could locate was the hospital's discharge weight for Resident #43, which was 103.6 pounds. The DON indicated perhaps there was a documentation error on the admission assessment regarding Resident #43's weight.</p> <p>The care plan related to heights and weights, initiated on 12/04/14, indicated the resident was to be weighed monthly and his weight monitored. The goal was for the resident to maintain his current weight of 110 pounds or gradually gain weight. There was also a care plan, intimated on 12/04/14 regarding the resident's meals which indicated he enjoyed food and routinely ate 90 - 100 percent of a no added salt diet. The plan had an intervention to ask the doctor to liberalize his diet, monitor his intakes, labs, and physical parameters. There was no revised plan to address the resident' significant weight loss or the liberalized diet.</p> <p>During an interview on 01/27/15 at 2:00 P.M., the DON indicated he had no further information or documentation regarding the weight loss for Resident #43.</p>						

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	<p>Review of the facility policy, titled "Guidelines for Weight Tracking", dated 11/07 and updated on 05/14, included the following:</p> <p>"1. Residents will have their weight taken and recorded upon admission to establish a baseline.</p> <p>2. Unless otherwise indicated or ordered by the physician the resident have their weight taken and recorded monthly (sic).</p> <p>3. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement nutritional program when warranted...</p> <p>...6. The weight should be recorded in the individualized resident medical record utilizing the monthly tracking form and in the computerized system to provide an 'at a glance' report for the dietician.</p> <p>7. Residents who have a weight that seem out normal range shall be re-weighed to determine the accuracy of the original weight (sic) ...</p> <p>8. The physician, responsible party and dietician shall be notified of a weight variance of greater than 5 % (unless on a planned weight loss program)."</p> <p>3.1-45(a)(1)</p>						

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F000329 SS=E	<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 observation, record review and interviews, the facility failed to ensure there was adequate indications for the use of an antipsychotic medication for 1 of 5 residents reviewed for medications (Resident #22). The facility also failed to ensure there were adequate indications for the use of antianxiety medications for</p>	F000329	<p>1) Resident #7,15,20 &22 did not have any negative effects related to practice; each resident's chart has been reviewed and physician orders, consults have been obtained. Routine lab monitoring ordered for resident #7. 2) All residents who exhibit behaviors, s/s of depression or anxiety have the potential to be effected. 3)</p>	02/26/2015

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	<p>2 of 5 residents reviewed for medication use (Resident #7 and 20). The facility failed to ensure there was adequate indications to support an increased dose of an antipsychotic medication for 1 of 5 residents reviewed for medication use (Resident #15). In addition, the facility failed to ensure there was adequate monitoring for psychoactive medications for 4 of 5 residents reviewed for medication use. (Residents #7, 15, 20, and 22) Finally, the facility also failed to monitor a thyroid medication for 1 of 5 residents reviewed for monitoring of medications. (Resident #7)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #22 was reviewed on 01/26/15 at 9:27 A.M. Resident #22 was admitted to the facility on 01/07/14 and readmitted on 07/23/14 with diagnoses, including but not limited to: cellulitis, peripheral vascular disease, hypertension, renal insufficiency, osteoarthritis, history of pneumonia, history of kidney stones and diabetes mellitus.</p> <p>The current physician's orders for medications included an order for the antipsychotic medication, Risperidone 0.25 mg (milligrams) 1/2 tab (0.125 mg) once a day.</p>		<p>Documentation inservice with review of S/S of depression, S/S of Anxiety, identification of S/S of Delirium and Delusions for nursing staff. Behavior tracking logs to assist in documentation of behavioral concerns with individuals on psychoactive medications. Review of current residents on thyroid medications to ensure proper labs in place for monitoring. 4) Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, ADL tracking documentation related to behaviors, in the daily clinical meeting 5 days a week, ongoing. The review will also ensure the care plan have been initiated/updated as necessary. Audits and/or observations related to care plans will be conducted by the DHS or designee 5 times per week times 4 weeks; then weekly x 1months; then monthly x 4 months. DHS and/or designee to audit new admissions for thyriod mediations to ensure proper lab work ordered for monitoring 5 days a week, ongoing for 4 weeks then monthly times 5 months and record findings on audit tool. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved.</p>				

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	<p>The current care plans for Resident #22, with a review date of 11/24 /14, indicated the resident's antipsychotic medication use and the need for a gradual dose reduction, but the plan did not mention the medical symptoms for which the medication had been prescribed.</p> <p>During an interview, on 01/26/15 at 1:58 P.M., Registered Nurse (RN) #23, indicated the resident used to have attention seeking behaviors, such as saying she could not get up out of bed at times. She indicated the medication was being tapered. She indicated the need for Risperidone would be on the care plan and she thought the medication was being given due to the resident's dementia diagnosis.</p> <p>During an interview, on 01/26/15 at 2:00 P.M., Certified Nursing Aide (CNA) #26, indicated the care tracker (electronic charting system) indicated staff were to track Resident #22 for depression, crying, and sadness. She indicated she had never had to chart this mood issue for the resident. She indicated there was no behavior symptoms noted on the care tracker to be monitoring for Resident #22.</p> <p>During an interview, on 01/27/15 at</p>			

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	<p>10:15 A.M., the Social Service Designee, indicated there was no behavior tracking except what was in the Kiosk for Resident #22, which was for signs and symptoms of depression. She indicated a medical symptom for antipsychotic medication use needed to be care planned with interventions.</p> <p>On 01/27/14 at 2:00 P.M., the Assistant Director of Nursing was interviewed and review of an initial mental health assessment by a psychiatrist, dated 02/02/10, was conducted. The psychiatrist assessment indicated the resident had been admitted to the facility on the Risperdone medication. The psychiatrist completing the evaluation on 02/02/10 indicated he had reviewed documentation from a previous mental health inpatient stay but the resident had not displayed any psychotic behaviors during her inpatient psychiatric hospitalization. There was no definite determination of a medical symptom or active diagnosis which supported the use of the antipsychotic medication.</p> <p>The physician's progress notes from the psychiatric consultant, dated 2/18/14, indicated the resident was routinely assessed for her mental health needs, however, the notes were not specific regarding the use of the Risperdone</p>						

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	<p>medication and did not indicate a specific diagnosis with a medical symptom which had required the use of the medication for Resident #22.</p> <p>2. The clinical record of Resident #7 was reviewed on 1-26-15 at 10:02 A.M. The resident's diagnoses included, but were not limited to: diabetes, anemia, depression, hypertension, hypothyroid, osteoarthritis and coronary artery disease.</p> <p>A review of a form titled " Initial Psychosocial Assessment/MDS Supportive Documentation Tool & Progress Note" indicated on 12-4-14 resident reported to Social Service Director "feeling down nearly everyday, poor appetite/overeating, feeling tired/no energy and trouble staying asleep." The assessment did not address anxiety.</p> <p>The Medication Administration Record (MAR) indicated the resident was receiving clonazepam (klonopin) 0.25 milligrams (mg) at bedtime (HS) for anxiety, and synthroid 75 micrograms (mcg) daily for hypothyroidism.</p> <p>The completed lab results for 2014 indicated there were no lab tests obtained to monitor thyroid function.</p>				

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	<p>A Physician's Progress Note dated 1-7-15 indicated the resident had a diagnosis of anxiety and was taking clonazepam 0.25 mg. at bedtime. The physician's Progress Note further indicated the resident was allergic to klonopin (clonazepam). The Physician's Progress Note also indicated the resident had a thyroid test (TSH) on 12-5-11.</p> <p>The monthly pharmacist review did not suggest a thyroid test to monitor the use of the synthroid medication the resident was taking daily.</p> <p>The "Vitals" care plan indicated the resident was taking daily "...psychotropic medications for depression and anxiety...." The care plan did not include interventions to monitor behaviors or manifestations of anxiety.</p> <p>On 1-26-15 at 1:20 P.M., a review of the Psychiatric Progress Note, dated 11-26-14, indicated resident was seen on a regular basis for a chief complaint of "bipolar." The progress note indicated the resident was doing well. The Assessment/Treatment plan and Recommendations stated "Continue klonopin 0.25 mg at HS." The assessment did not mention the resident was anxious.</p> <p>The "Monthly Nursing Assessment &</p>			

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	<p>Data Collection" from August 2014 thru December 2014 indicated, under the Mood and Behavior section, the resident exhibits little interest in doing things. There were no other moods or behaviors listed or addressed on the form.</p> <p>During an interview, on 1-26-15 at 1:45 P.M., the Director of Nursing (DON)indicated he was unable to locate an anti-anxiety and hypothyroidism care plan for Resident # 7. He further indicated the resident had been on the medication (klonopin) since resident's admission in 2010. The DON indicated the diagnosis of anxiety was not listed in the resident's diagnosis list nor on the MAR diagnosis list, however the MAR did indicate the klonopin was being administered to the resident for anxiety.</p> <p>On 1-26-15 at 3:20 P.M., the DON provided a policy titled "GUIDELINES FOR: Psychotropic Medication Usage and Gradual Dose Reductions" dated 8/2013. The policy indicated "...PURPOSE: To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation, and monitoring by the interdisciplinary team... DEFINITION: Psychotropic medications include:</p>			

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	<p>anti-anxiety/hypnotic, anti-psychotic...PROCEDURE: 1. Residents shall receive psychotropic medication only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage...The medical necessity will be documented in the resident's medical record and in the care planning process...2. Regular review for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident.</p> <p>On 1-27-15 at 4:30 P.M., the DON provided a current policy titled "Guideline For: Psychotropic Medication Usage and Gradual Dose Reductions" dated 8/2013. The policy indicated "...Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of or in addition to, medications...a. Attempted non-pharmacological intervention will be documented on the PRN Medication Administration Form..."</p> <p>3. The clinical record of Resident #15 was reviewed on 1-23-15 at 3:15 P.M.</p>						

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	<p>The resident's diagnoses included but were not limited to: depression with psychotic features, mental disorder due to head trauma, seizure disorder, hemiplegia, heimparesis, osteopenia, and insomnia.</p> <p>The MAR (Medication Administration Record) indicated the resident was on the following medications: zyprexa 1.25 mg (milligrams) every morning and 2.5 mg HS (at bedtime) for hallucinations. On 1-7-15 the dosage was changed to zyprexa 2.5 every morning and at bedtime. Then on 1-9-15 the dose was changed again to zyprexa 5 mg every morning and at bedtime.</p> <p>On 1-27-15 at 2:00 P.M., a review of the Mental Health Wellness Circumstance forms indicated on 1-7-15 the resident "...was upset and pinned CNA [Certified Nursing Assistant] between w/c [wheelchair] and bed...." The Prevention Update section indicated "...reassurance, anticipate needs, and evaluate medications...." The IDT (Interdisciplinary Team) review, dated 1-8-15, indicated zyprexa was increased. On 1-14-15 the resident had behavior of "thinking staff and physician were trying to kill her." She refused medications 4 of 7 days of the follow-up assessment after the initial incident. Another Mental</p>			

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	<p>Health Wellness Circumstance form, dated 1-19-14, indicated the resident was resistant to care and expressed unrealistic fears. The resident "feels nurses and doctor are trying to kill her". The Prevention Update section indicated staff were to anticipate needs, explain procedures and to engage the Social Service staff.</p> <p>The care plan for "Mood and Behaviors," dated 12-8-14 to present, indicated "...currently prescribed medication for my history of hallucinations...In the past, I would hallucinate by having very vivid and disturbing dreams...I haven't had any behaviors or mood issues in quite a while, but I have a history of resisting care and being physically abusive... I also have a history of mood issues and currently have a diagnosis of depression with psychotic features, as well as insomnia...I am currently on prescribed an antidepressant and antipsychotic for these diagnosis...Please continue to monitor my moods and depression and if you notice any negative changes, please inform my doctor...Please ensure that I continue to see the psychologist from [name of psychiatric provider] on a regular basis...Please review this care plan by 3/2015 to make any necessary changes and to ensure that my needs are met...."</p>						

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	<p>A Nursing Note, dated 1-7-15 at 10:45 P.M., indicated a CNA was pinned by resident between the Resident #15's wheelchair and bed. The resident was told the behavior was "inappropriate". The physician was in building and was notified of the incident. The physician referred to the psychiatric services. The nurse left a message for the Nurse Practitioner (NP) at psychiatric services. At 4:00 P.M. on 1-7-15 the NP returned the call and ordered an increase in zyprexa (2.5 mg) in A.M.</p> <p>A Nursing Note, dated 1-11-15 at 8:00 P.M., indicated the resident was refusing all night medications. At 10:15 P.M., the nurse re-approached resident with the night medications. The resident agreed to take the medications and "took meds [medications] without arguing or complaining." The nurse reassured her and helped to assist the resident into bed with an aide.</p> <p>A Nursing Note, dated 1-14-15 at 5:30 P.M., indicated if resident refused medications and/or behaviors increase, facility was to send resident to psych. (psychiatric) hospital for evaluation and treatment.</p> <p>A Nursing Note, dated 1-16-15 at 12:45</p>			

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	<p>P.M., indicated the resident took the medications without resistance. No delusional behavior or thinking noted, resident cooperative.</p> <p>A Nursing Note, dated 1-18-14 at 2:00 A.M., indicated, resident awake "wanting to talk" (resident communicated with an Ipad) and indicated she wanted to stop all medications. Resident was told by the nurse to discuss issue in A.M. At 3:00 A.M., resident was on call light continuously demanding to get up. Nurse encouraged resident to rest. At 3:45 A.M., the Nursing Note indicated the resident was gotten up for the day and "continuously after nurse about medications." At 6:45 A.M., the physician on call was notified and new order was received to discontinue Ambien (sleep medication).</p> <p>The Physician Orders indicated, on 1-7-15, the zyprexa morning dose was increased to 2.5 mg. On 1-15-15, a Physician Order indicated the staff was to monitor resident's behaviors 1-3 days, if resident behaviors escalated or resident continued to refuse medications staff were to send resident to psychiatric hospital, and obtain a urine dipstick or urine specimen. On 1-19-15, a physician order was received to discontinue zyprexa 2.5 mg BID (twice a day) to</p>						

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	<p>zyprexa 5 mg bid, may give IM (intramuscular) if refuses po (oral). On 1-20-15, the order for IM dose was discontinued.</p> <p>The Social Service notes for 1/13, 1/14, 1/5 and 1/16/2015, indicated the Social Service Director had explained the importance of taking medications to the resident. The resident would express understanding and type on Ipad "ok" and smile.</p> <p>During an interview on 1-27-15 at 2:20 P.M., the Social Service Director indicated all behaviors are documented on a "Mental Health Wellness Circumstance, Assessment and Intervention forms and on the Behavior Detail Report. The Social Service Director indicated she had spoken with the resident about refusing her medications.</p> <p>On 1-27-15 at 4:30 P.M., a review of a policy titled " Guideline For: Psychotropic Medication Usage and Gradual Dose Reductions," dated 8/2013, indicated "...Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of or in addition to, medications...a. Attempted non-pharmacological intervention will be</p>			

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	<p>documented on the PRN Medication Administration Form...."</p> <p>4. On 1/27/15 at 12:00 P.M., the clinical record for Resident #20 was reviewed. The diagnoses included, but were not limited to the following: major depressive disorder, coronary artery disease, diabetes mellitus, chronic obstructive pulmonary disease and congestive heart failure.</p> <p>A physician's order, dated 1/13/15, indicated the following: Clonazepam 1 mg po [by mouth] q [every] HS [bedtime]. No indication for the use of the medication was indicated on the physicians order.</p> <p>The Behavioral Health Follow-Up Progress Note, dated 1/6/15, indicated "... Client states that he is feeling better now. However, he indicates that he had just spent the past 19 days in the hospital after blacking out and falling down. Client states that he continues to appreciate the support from his sister and from the staff. He continues to maintain mostly positive emotions..." No behavioral progress notes dated past 1/6/15, were noted in the resident's clinical record.</p> <p>The Nurse's Note dated 1/12/15 at 5 :15 A.M., indicated the following: "... Res stated he was having chest pain when</p>				

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	<p>arrived res [resident] was holding his left armpit and saying that his left hand tingled. Vitals were within [sic] normal limits. Res [resident] was non-diaphoretic as I began to talk to the resident he seemed to forget about the chest pain. He took his medications without [sic] difficulty. No longer held armpit or talked of chest pain...Additional note Res [resident] seems overall anxious and is having difficulty sleeping. He is also short-tempered which could be due to lack of sleep. Fax sent to DR. [name of physician] regarding sleep..." No further episodes were noted in the Nurse's Notes.</p> <p>The Behavioral Detailed Report dated 12/1/14 thru 1/27/14, did not indicate any d documented episodes of anxiety/restlessness.</p> <p>The Social Service Progress Notes, from 1/12/15 at 1:30 P.M., indicated but was not limited to the following: "...Writer met with [Resident #20] to do assessments. He shows some signs of depression. Currently takes antidepressant. He has had some refusal of meal, care and therapy. He stated he plans to stay in this facility to "live out his life...."</p> <p>The Plan of Care titled Acute Care Needs, dated 1/21/15, included but was</p>			

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	<p>not limited to the following: "...1/14/15 update I have a new medication for anxiety/restlessness. Please monitor me for s/s [signs and symptoms] of adverse reactions and monitor for effectiveness. Notify MD [medical doctor] prn [as needed], administer medication as per md order. My goal is to have my anxiety/restlessness resolve/controlled...."</p> <p>During an interview, on 1/27/15 at 4:30 P.M., the Social Worker indicated she had her progress notes from the time she has spoken with him but could not indicate the use of the antianxiety medication Clonazepam.</p> <p>On 1/27/14 at 4:45 P.M., a current policy, provided by the Director of Health Services, and titled Psychotropic Medication Usage and Gradual Dose Reductions was reviewed. The policy indicated but was not limited to the following: "... Procedure...1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...."</p> <p>3.1-48(a)(6)</p>						

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure the medication error was less than 5% for 2 of 8 residents observed during medication pass. Two medication errors were observed during 36 opportunities for error in medication administration. This resulted in a medication error rate of 5.5%. The errors involved 2 residents (Resident #77 and Resident #30) in a sample of 36.</p> <p>Findings include:</p> <p>1. On 1-23-15 at 8:12 A.M., LPN #11 was observed preparing medications for Resident #77. The resident was to receive vitamin B-12 1000 micrograms (mcg) two tablets (2000 mcg) orally per day. LPN #11 was observed preparing and administering one tablet of the vitamin B-12 1000 mcg. The LPN #11 indicated that an error had occurred as he should of administered 2 tablets of the vitamin B-12 1000 mcg to Resident #77.</p> <p>On 1-23-15 at 11:30 A.M., a review of the physician's admission orders indicated the resident was to receive</p>	F000332	<p>1) Resident #77 & 30 did not have any negative effects related to practice; they are both receiving medications per current physician order. 2) All residents who receive medications have the potential to be effected. Medication pass observation will be conducted with Licensed Nursing and CRMA's. 3) Licensed Nursing staff and CRMA's re-educated regarding medication administration. 4) DHS and/or designee will monitor medication pass 3 times a week for x 4 weeks; then weekly x 1months; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved.</p>	02/26/2015			

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F000425 SS=D	<p>2,000 mcg of cyanocobalamin (Vitamin B-12) po (by mouth) daily.</p> <p>2. On 1-23-15 at 9:10 A.M., RN #12 was observed preparing and administrating potassium chloride 10 milliequivalents (mEq) one tablet for Resident #30. The resident was to receive Potassium chloride 30 mEq which would be 3 tablets of the 10 mEq. of potassium chloride.</p> <p>On 1-23-15 at 1:05 P.M., a review of the physician's orders, dated 12-2415, indicated Resident #30 was to receive K-Dur (potassium chloride) 30 mEq three times a day.</p> <p>On 1-23-15 at 2:40 P.M. a current policy was received from the DON (Director of Nurses) titled "Specific Medication Administration Procedures" dated 9-17-2012. The policy indicated "...c) Read medication label three times (3) times before pouring...." The policy did not contain an administration procedure for checking dosage prior to administration of medications.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE</p>						

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	<p>PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure 2 of 3 medication carts were free from expired medications. (Resident #44 & Resident #51)</p> <p>Findings include:</p> <p>1. On 1-23-15 at 9:50 A.M., a medication cart inspection was conducted on the 200 hallway with LPN #13. The medication cart contained an expired vial of Lantus (insulin) for Resident #44. The open date was 12-25-14. The vial had expired on 1-22-15. LPN #13 indicated the resident had received 43 units of Lantus from the expired vial during the morning</p>	F000425	<p>1) Medication for Resident # 44 & 51 removed from cart and disposed. 2) All resident have the potential to be effected if medication expiration dates are not verified with each medication administration. Medication cart audited and expiration dates reviewed, expired or close to expired medications have been removed and re-ordered. 3) Licensed Nursing staff and CRCA's re-educated regarding the "Specific Medication Administration Procedures" Cart audit will be completed on each medication cart twice weekly. 4) DHS and/or designee will monitor medication pass 3 times a week for 4 four weeks, then weekly times 4 weeks, and then monthly</p>	02/26/2015

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	<p>medication pass.</p> <p>On 1-23-15 at 10:10 A.M., a form received from the Director of Nursing (DON) titled "Recommended Expiration Dates" indicated Lantus was to be discarded after 28 days after the vial was opened.</p> <p>2. On 1-23-15 at 10:05 A.M., a medication cart inspection was conducted on hallway 300 with LPN #11. The medication cart contained one vial of Humalog (insulin) for Resident #51. The open date on the Humalog vial was not legible, however the bag containing the vial indicated an open date of 12-20-14. The vial of Humalog had expired on 1-17-15. LPN #11 indicated the resident had received the Humalog at least 3 times a day, after the expiration date. LPN # 11 had given 2 units of Humalog from the expired vial, prior to breakfast.</p> <p>On 1-23-15 at 10:10 A.M., a form titled "Recommended Expiration Dates," was provided by the DON. This form indicated Humalog was to be discarded 28 days after the vial was opened.</p> <p>During an interview on 1-23-15 at 2:01 P.M., the DON indicated the vial open date was not legible and the date on the bag indicated the vial had been expired</p>		<p>for 4 months alternating staff so different staff will be monitored. Medication carts will be audited twice weekly and Findings will be reviewed by campus QAA committee for 6 months or until 100% compliance to determine future monitoring needs.</p>				

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F000441 SS=F	<p>since the 19th of January (2015).</p> <p>On 1-23-15 at 1:55 P.M., during an observation with LPN #11 the expired vial of Humalog for Resident #51 was noted to be back in the medication cart for the 300 hallway. LPN #11 was observed removing the vial of insulin from the medication cart and discarding the vial in the sharps container.</p> <p>On 1-23-15 at 2:20 P.M., a review of the Medication Administration Record (MAR) for Resident #51 indicated the resident was given another dose (4 units) prior to lunch.</p> <p>On 1-23-15 at 2:40 P.M. a current policy was received from the DON, titled "Specific Medication Administration Procedures" dated 9-17-2012. The policy indicated "...b) Check expiration date on package/container. When opening a multi-dose container; place the date on the container...."</p> <p>3.1-25(o)</p> <p>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</p>						

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	<p>development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</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.</p> <p>1. Based on observations and record review the facility failed to perform hand hygiene before and after administering medications for 2 of 8 resident's observed during a medication pass. (Resident #77 and Resident #25)</p>	F000441	It is the practice of Lakeland Rehab to 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. 1) No resident were	02/26/2015

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	<p>2. Based on interview and record review, the facility failed to follow their policy regarding tuberculin testing prior to employment for 3 of 10 employees reviewed for completion of tuberculin skin tests. In addition, the facility failed to follow their policy regarding completion of an annual tuberculosis screening questionnaire for 1 of 5 employees who had a positive tuberculin test with a negative chest x-ray. This had the potential to affect 50 of 50 residents in the facility.</p> <p>Findings include:</p> <p>1. On 1-23-15 at 8:20 A.M., LPN #11 was observed washing his hands 3-4 seconds after his administration of medications to Resident #77. LPN #11 returned to the medication cart and prepared medications for Resident #25. LPN #11 entered Resident #25's room and administered the medications. LPN #11 was observed washing his hands for 4 seconds before exiting the resident's room.</p> <p>On 1-23-15 at 11:30 A.M., a current policy titled "Guidelines For Handwashing" was received from the Director of Support Services, dated 10/2004. The policy indicated "...7. Wet hands with running water. Apply liquid</p>		<p>affected by the alleged deficient practice. 2) All resident residing at the campus have the potential to be affected by the alleged practice. 3) The campus has guidelines in place indicating how handwashing should be preformed and when glove use is indicated for administering medications. DHS and/or designee will re-educate nursing staff on campus these guidelines by February 26, 2015. New Hire TB Process: New process established to provide and monitor compliance with new hire TB testing and process added to new hire checklist as well for follow up. Annual TB Process: All employees to be done every year in the month of March. 4) DHS and/or designee will perform observations of handwashing and glove use during medication pass, 3 times a week for 4 four weeks, alternating staff so different staff will be monitored. ED will review all new hire paperwork checklist/TB testing prior to new employees being added to facility schedules. All annual TB testing and/or reviews will be reviewed by DHS or designee three days following scheduled annual testing schedules and 3 days a week, for 4 weeks then weekly times 5 months to ensure testings are completed in the appropriate time frame and will report findings to QA&A for 6 months or until 100% compliance is achieved.</p>				

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	<p>soap and work into lather. 8. Wash well for 20 seconds...."</p> <p>2 a. On 1/27/15 at 10:30 A.M., an employee file review indicated the Activity Assistant #1's hire date was 11/11/14. A form titled "Tuberculin Testing for Employees" indicated activity assistant #1 had an initial tuberculin skin test (ppd) on 1/13/15. Over 2 months after the hire date the form indicated the ppd test had been read on 1/15/15. There was no indication on the form a second step test had been completed.</p> <p>2 b. On 1/27/15 at 10:36 A.M., an employee file review indicated CNA #2's hire date was 9/10/14. A form titled "Tuberculin Testing for Employees" indicated CNA #2 had an initial ppd test on 10/17/14. Over a month after the hire date the form indicated the ppd test was read on 10/20/14. There was no indication on the form a second step test had been completed.</p> <p>A form titled, "Tuberculin Testing for Employees," dated 1/22/15, indicated CNA #2 had another ppd on 1/22/15, more than 3 months after the initial testing.</p> <p>2 c. On 1/27/15 at 10:45 A.M., an employee file review indicated RN #3's hire date was 10/28/14. A form titled,</p>			

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	<p>"Tuberculin Testing for Employees," indicated RN #3 had an initial ppd test on 11/20/14. Over 2 months after the form indicated the ppd test was read on 11/23/14. The form further indicated RN #3 had another ppd on 11/30/14, and was read on 12/2/14.</p> <p>2 d. On 1/27/15 at 10:55 A.M., an employee file review indicated LPN #4's hire date was 11/29/07. A form titled "Tuberculosis Screening Questionnaire," dated 10/8/13, indicated "...You have been identified as having a history of a significant reaction to a tuberculin skin test. There is no need to repeat the skin test, however, we do need your cooperation in completing this questionnaire...." A question at the bottom of the form "...reviewed by...." was blank. There was no indication in the employee file that a screening questionnaire was completed for 2014.</p> <p>A form titled "Tuberculosis Screening Questionnaire," dated 1/27/15, indicated LPN #4 had a chest x-ray on 11/9/10. A question at the bottom of the form "...reviewed by...." was blank.</p> <p>On 1/27/15 at 11:40 A.M., during an interview, the Assistant Director of Nursing (ADON) indicated a new employee should have a tuberculin skin</p>			

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	<p>test upon hire and a second step tuberculin test two weeks after the initial test. The ADON further indicated people who are reactors (positive reaction to a tuberculin skin test) should have a chest x-ray every five years and should complete a yearly tuberculosis screening questionnaire.</p> <p>On 1/27/15 at 11:45 A.M., review of the current policy titled, "Guidelines for TB Results Summary Documentation: Staff," received from the Director of Nursing indicated "...1. Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis...3. a. If the employee can provide a recent chest x-ray they may complete a Tuberculosis Screening Questionnaire that is reviewed by a RN or physician...7. Keep a tickler filer to ensure each employee is re-tested on their anniversary date with a one-step Mantoux or Tuberculosis Screening Questionnaire if they were a previous converter with a negative CXR (chest x-ray)...."</p> <p>3.1-14(t) 3.1-18(l)</p>				