

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2014
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NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 3, 4, 5, 6 &amp; 7, 2014</p> <p>Facility number: 000056 Provider number: 155131 AIM number: 100289450</p> <p>Survey team: Cynthia Stramel, RN, TC Lara Richards, RN Heather Tuttle, RN Yolanda Love, RN Jan Kulik, RN (February 3 &amp; 4, 2014)</p> <p>Census bed type: SNF: 22 SNF/NF: 169 Total: 191</p> <p>Census payor type: Medicare: 36 Medicaid: 22 Other: 33 Total: 191</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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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F000241 SS=D	<p>Quality review completed on February 14, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure each resident's dignity was maintained related to not calling the resident by their first name for 2 of 2 residents reviewed for dignity. (Resident #63 and #92)</p> <p>Findings include:</p> <p>1. Moving the resident, the Activity</p>	F000241	F-241 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to	02/28/2014			

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	<p>Aide said, "Are you ready to go, baby? Ok baby, I will be there in a minute, baby."</p> <p>2. On 2/6/14 at 11:40 a.m., Nurse #2 was called into Resident #63's room. During her assessment of the resident she called her, "honey", "sweetie", and "baby".</p> <p>Interview with the 2nd floor Unit Manager on 2/7/14 at 8:03 a.m., indicated the residents should be called by their first names and not nick names.</p> <p>3.1-3(t)</p>		<p>the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Observations 1 and 2, Social Service met with both residents to provide well visit. During visit, both residents verbalized no concern relating to not being addressed by their first name. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As it relates to Observations 1 and 2, the staff involved in the surveyor cited concern have been identified and have been provided with educational counseling on Residents Rights to dignity. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Formal in-servicing (See MMI Exhibit 1) has been provided to facility staff on the topic of Resident Rights to Dignity including avoiding use of terms of endearment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Twice weekly, Director of Nursing/or Designee will observe for the use of terms of endearment during routine</p>	

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident was able to choose their bedtime as well as when they wanted to take a shower for 2 of 3 residents reviewed for choices of the 5 residents who met the criteria for choices. (Resident's #28 &amp; #143)</p> <p>Findings include:</p> <p>On 2/03/14 at 12:25 p.m., Resident #143's daughter was interviewed. At that time, she indicated her mother used to stay up late to about 11:00 p.m. or 11:30 p.m., when she lived</p>	F000242	<p>facility rounds. The findings of these observations will be documented and reported to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. ADDENDUM: THESE OBSERVATIONS WILL BE PERFORMED ON ALL SHIFTS.</p> <p>By what date will the systemic changes be completed? February 28, 2014</p> <p>F-242 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be</p>	02/28/2014	

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	<p>with her prior to entering the nursing home. She further indicated she thinks now she goes to bed between 8:00 p.m. and 9:00 p.m. Her daughter indicated If she would have the choice she would stay up later.</p> <p>The record for Resident #143 was reviewed on 2/5/14 at 10:09 a.m. The resident was admitted on 2/7/12. The resident's diagnoses included, but were not limited to, insomnia and dementia.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment completed on 1/15/14 indicated the resident was moderately impaired for decision making. The interview for preferences of customary routine and activities indicated it was very important for her to choose her own bedtime.</p> <p>Review of the updated 1/2014 care plan indicated there was no care plan for preferences for sleep and when she wanted to go bed.</p> <p>Review of Social Service Progress Notes from 9/23/13 through 1/15/14 indicated there was no documentation indicating the resident requested to go to bed later.</p>		<p>accomplished for those residents found to have been affected by the deficient practice?As it relates to Observation 1, the facility has met with resident and family to review plan of care and verify preferences for bed time and shower schedule.</p> <p>As it relates to Observation 2, upon surveyor observation, Social Service immediately met with the resident and completed a "Who I Am Plan" to note preferences. The shower schedule has been reviewed and notes a schedule that meets with the residents preferences.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Staff has met with facility residents to discuss current shower schedules and bed time preferences to ensure specific preferences are being honored.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility Activity Staff will update preferences on a quarterly basis (following MDS schedule) with residents. In-servicing was provided to Activity staff on the expectations of this process. Formal in-servicing (See MMI Exhibit 1) has been provided to facility staff relative to honoring resident preferences.</p> <p>How the corrective action(s) will</p>		

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	<p>Review of the CNA care card indicated there was no information regarding what the resident's preference were regarding bedtime.</p> <p>Interview with CNA #1 on 2/6/14 at 3:15 p.m., indicated she works four days a week on the 5th floor and primarily works the 3-11 shift with Resident #143. She indicated the resident usually goes to bed between 7:00-7:30 p.m. CNA #1 indicated the resident was dependent on staff for putting her to bed every evening. She indicated no staff has ever instructed her to put the resident to bed at a later time. She indicated supper was served between 4:30-4:45 p.m., and was usually all over by 6:00 p.m. The CNA indicated they usually took her to the bathroom after supper and got her ready for bed. They then would come back between 7:00 p.m. and 7:30 p.m., and put her to bed.</p> <p>Interview with CNA #2 on 2/6/14 at 3:17 p.m., indicated she primarily works the 3-11 shift and sometimes takes care of the resident. She indicated the resident was always in bed by 8:00 p.m.</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Activity Director will complete interviews with a sample of five residents per floor/month to ensure personal preferences are being honored and updated on a quarterly basis. The findings of this audit will be reported to the Quality Assurance Committee on a quarterly basis and this audit shall remain in place for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>		

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	<p>Interview with Special Care Unit Director on 2/6/14 at 3:50 p.m., indicated the resident was interviewed for her preferences for customary routines. She further indicated she was unaware the resident's preferences for choosing her bed time was to stay up late.</p> <p>2. Interview with Resident #28 on 2/4/14 at 11:00 a.m., indicated she was not able to choose the frequency of her showers. She further indicated, the facility chose her shower days and she was bathed twice a week.</p> <p>Further interview with the resident on 2/6/14 at 11:23 a.m., indicated she would like to receive a shower at least every other day.</p> <p>The record for Resident #28 was reviewed on 2/5/14 at 9:15 a.m. The resident was admitted to the facility on 10/25/12. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, and arthritis.</p> <p>Review of the Annual 10/22/13 Minimum Data Set (MDS) Assessment, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented. The</p>			

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	<p>resident was interviewed for preferences and routines, and it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>Review of the Plan of Care book indicated no evidence of documentation of a Who I Am Plan (an assessment of resident preferences).</p> <p>Interview with the 2nd floor Social Services Director on 2/6/14 at 10:56 a.m., indicated she had not completed a Who I Am Plan with the resident.</p> <p>Interview with the 2nd floor Unit Manager on 2/6/14 at 1:43 p.m., indicated the resident's preferences are communicated to staff by the Plan of Care book which includes a Plan of Care card and the Who I Am Plan.</p> <p>3.1-3(u)(1)</p>				

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F000246 SS=E	<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. Based on observation, record review, and interview, the facility failed to ensure call lights were in reach for 4 of 40 residents observed during Stage 1. (Residents #16, #63, #83, and #149)</p> <p>Findings include:</p> <p>1. On 2/3/14 at 11:17 a.m., Resident #16 was observed in her room in bed. She was laying half in the bed and half out of the bed. The resident's call light was observed on the floor behind the bed.</p> <p>At 12:40 p.m., the resident was in her room seated in her wheelchair eating her lunch. The resident's call light was on the floor on the other side of the room underneath the resident's bed.</p> <p>On 2/4/14 at 8:30 a.m., the resident was observed in bed. The resident's call light was on the floor behind the bed.</p>	F000246	F-246 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to the Observations 1 through 4, each resident was visited and call lights were noted in reach. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The potential for a call light to not be in place or out of reach exists throughout the facility. An audit	02/28/2014			

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	<p>Interview with CNA #3 on 2/4/14 at 8:47 a.m., indicated the resident could use the call light, she further indicated the resident speaks Spanish, and rarely talks. The call light was still on the floor.</p> <p>2. On 2/4/14 at 10:00 a.m., Resident #63 was observed in her room. She was lying in bed resting. The call light was observed in between the mattress and the bed rail on the right side of the bed. The resident indicated she was unable to use the call light due to the cord and call light being stuck between the bed rail and mattress.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/5/13 indicated the resident's BIMS (brief interview for mental status) score was a 15, indicating the resident was cognitively intact.</p> <p>3. On 02/04/14 at 10:30 a.m., Resident #149 was observed in his room lying in bed. The resident's call light was observed on the floor. The resident indicated he was unable to reach his call light and that it was on the floor. He indicated he was able to use the light when it was in reach.</p>		<p>has been completed to ensure proper placement of call lights for each resident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility has completed in-servicing (See MMI Exhibit 1) with staff discussing the importance of call lights being placed within each residents reach.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Unit Director/or Designee will complete rounds of five rooms three times weekly to verify proper placement of call lights. The Unit Directors will report findings to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>				

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	<p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/17/13, indicated the resident's BIMS score was a 15, indicating the resident was cognitively intact.</p> <p>4. On 2/5/14 at 9:47 a.m., Resident #83 was observed in bed wearing a nightgown. The resident's call light was located on the floor behind the bed.</p> <p>On 2/5/14 at 12:00 p.m., the resident was observed sitting up in a wheelchair next to her bed. The resident's call light was located on the floor behind the bed.</p> <p>On 2/6/14 at 9:47 a.m., the resident was observed in bed. The resident's call light was located on the floor behind the bed.</p> <p>The record for Resident #83 was reviewed on 2/6/14 at 1:38 p.m. The resident was admitted to the facility on 12/18/13. The resident's diagnoses included, but were not limited to, depression, anxiety, and senile dementia.</p> <p>Interview with CNA #3 on 2/6/14 at 2:40 p.m., indicated the resident was able to use her call light.</p>						

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F000282 SS=E	<p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 3:00 p.m., indicated the resident was capable of using the call light.</p> <p>3.1-3(v)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to completing pressure ulcer treatments for 1 of 3 residents reviewed for pressure ulcers of the 6 who met the criteria for pressure ulcers, not ensuring non-skid</p>	F000282	<p>F282 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees</p>	02/28/2014

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	<p>footwear was in use for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents, insulin not given as ordered and behavior monitoring sheets not completed for 2 of 5 residents reviewed for unnecessary medications, and bruises not monitored for 1 of 3 residents reviewed for non-pressure skin conditions of the 5 who met the criteria for non-pressure skin conditions. (Residents #16, #116, #124, #143, #157, and #302)</p> <p>Findings include:</p> <p>1. The closed record for Resident #302 was reviewed on 2/6/14 at 8:30 a.m. A Physician's order dated 11/22/13, indicated the resident's Stage 3 right ischial pressure ulcer was to be cleansed daily with wound cleanser, apply Santyl (a debriding agent), cover with a dry sterile dressing and change as needed for soilage.</p> <p>Review of the November 2013 Treatment Administration Record (TAR), indicated the first time the treatment was signed out was on 11/25/13. There was no documentation in the Nursing progress notes to indicate the</p>		<p>who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Observation 1, Resident 302 no longer resides in the facility. No corrective actions can be made.</p> <p>As it relates to Observation 2, Resident 124's physician was notified of the surveyor cited concerns. There were no new orders received.</p> <p>As it relates to Observation 3, Resident 116 is currently wearing non-skid footwear and has had no recent falls.</p> <p>As it relates to Observation 4, Resident 16 is currently wearing non-skid footwear and has had no recent falls.</p> <p>As it relates to Observation 5, the physician of Resident 143 was notified of the surveyor cited concern.</p> <p>As it relates to Observation 6, Resident 157 has been added to the weekly skin check schedule and has had a skin check completed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? An audit</p>				

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	<p>medication was not available.</p> <p>The plan of care dated 11/22/13, indicated the resident had impaired skin integrity as evidenced by a Stage 3 pressure ulcer to the right ischial area. The interventions included, but were not limited to, treatment as ordered.</p> <p>Interview with the Wound nurse on 2/7/14 at 8:24 a.m., indicated that she had signed off on the order around 3:30 p.m. on 11/22/13. She indicated the Santyl should have come in that evening. After reviewing the Nursing progress notes, she indicated there was no documentation to indicate the medication was not available. She indicated the first time the treatment was signed out, was on 11/25/13.</p> <p>2. The record for Resident #124 was reviewed on 2/4/14 at 2:31 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's order dated 1/22/14, indicated the resident was to have accuchecks (a test to monitor a resident's blood sugar) twice a day at 6:00 a.m. and 4:00 p.m. The resident was to receive the following</p>		<p>was performed for each resident on wound care caseload from the first of February to ensure treatments have been performed. In the event a similar observation is made, staff responsible will be counseled on the necessity of completing all ordered treatments.</p> <p>An audit of residents with orders for sliding scale insulin and a review of the Diabetic Tracking form has been completed to ensure adherence to the physicians order.</p> <p>An informal in-service was provided to unit staff regarding footwear, availability of call lights and residents who are at risk for falls not being left unattended. Educational counseling was provided to staff involved. A plan of care review was completed to ensure appropriate fall prevention interventions are in place.</p> <p>The facility has completed an audit of residents receiving PRN orders for Trazadone to ensure appropriate documentation is in place.</p> <p>The facility Unit Directors have audited each unit's weekly skin check schedule and has verified accuracy of the schedules. An audit has been completed to ensure the presence of a current skin check.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Formal in-servicing (See MMI</p>		

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	<p>Novolog sliding scale insulin dose based on her accucheck:</p> <p>151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units &gt;350=10 units</p> <p>Review of the Diabetic Tracking form for the month of February 2014, indicated on 2/2/14 at 4:00 p.m., the resident's blood sugar was 258. There was no documentation of insulin being given.</p> <p>On 2/3/14 at 6:00 a.m., the resident's blood sugar was 231. The resident received 2 units of insulin rather than the ordered 4 units.</p> <p>Interview with the Unit Manager on 2/7/14 at 10:00 a.m., indicated the resident had received the wrong dose of sliding scale insulin.</p> <p>Interview with the Director of Nursing on 2/7/14 at 12:00 p.m., indicated the resident received the wrong dose of insulin.</p>		<p>Exhibit 2) was completed for licensed Professional Nursing staff to address the necessity of completing treatments as ordered by the physician and requirements to adhere to physicians orders for sliding scale insulin.</p> <p>A formal in-service (See MMI Exhibit 1) for staff was completed regarding footwear, availability of call lights and residents who are at risk for falls not being left unattended.</p> <p>Formal in-servicing (See MMI Exhibit 2) has been provided to Licensed Professional Nursing staff regarding the requirements properly document (on Psychoactive Flow Sheet) the non-medication interventions attempted prior to the use of PRN medication.</p> <p>A formal in-service (See MMI Exhibit 2) has been provided to Licensed Professional Nursing staff regarding the requirements to adhere to facility weekly skin check process.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Quality Assurance audit will be performed on a weekly basis by the facility Unit Directors/or Designee to monitor the completion of prescribed wound care treatments. The findings of the audit will be provided to the Director of Nursing on a weekly</p>		

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			<p>basis and a summary of the findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>The Director of Nursing/or Designee will complete an audit of twenty charts per month for residents with orders for sliding scale insulin coverage to ensure the adherence to physicians orders. The findings will be reported by the Director of Nursing to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. The Unit Directors/or Designee will complete observations of a sample of five residents per floor per week to ensure appropriate fall interventions are in place. Findings of the audit will be provided to the Director of Nursing on a weekly basis and a summary of findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>The Director of Nursing/or Designee will complete an audit of twenty charts per month for residents with orders for PRN psychoactive medications to ensure the appropriate documentation is in place. The findings will be reported to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>On a weekly basis, the facility</p>		

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	<p>3. On 2/04/14 at 9:14 a.m., Resident #116 was observed sitting in a wheelchair in her room, and there was no staff around. She was wearing plain white socks to both of her feet with no shoes noted on her feet.</p> <p>The record for Resident #116 was reviewed on 2/6/14 at 10:20 a.m. The resident's diagnoses included, but were limited to, right hip fracture, Alzheimer's disease, dementia with behavioral disorder, and anxiety.</p> <p>Review of the 11/6/13 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and had short and long term memory problems. The resident was moderately impaired for decision making.</p>		<p>Unit Directors will be responsible to complete an audit to ensure the completion of weekly skin checks and accuracy of posted weekly skin check schedule. Findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>		

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	<p>Review of the updated plan of care dated 1/9/14 indicated the problem of Fall with no injuries. The Nursing approaches were to wear non slip footwear.</p> <p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 10:30 a.m., indicated the resident's last fall was on 1/9/14. She further indicated the resident was supposed to wear non skid socks or shoes when she was up in a wheelchair.</p> <p>4. On 2/03/14 at 11:13 a.m., Resident #16 was observed lying in bed and wearing red colored socks to both of her feet. The socks had no non skid markings noted on the bottom.</p> <p>On 2/3/14 12:30 p.m., the resident was now dressed and was observed sitting in her wheelchair in her room eating lunch. At that time, she was wearing the same pair of red socks with no non skid markings noted on the bottom of her feet. There was no staff observed in the resident's room.</p> <p>The record for Resident #16 was reviewed on 2/4/14 at 2:36 p.m. The resident's diagnoses included, but not limited to, anxiety, dementia with</p>				

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	<p>behavioral disturbance, vertigo, and depression.</p> <p>Review of the 12/18/13 Annual Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and needed extensive with one person physical help with transfers.</p> <p>Review of the updated plan of care dated 2/1/14 indicated the resident was at risk for falls due to a history of falls. The Nursing approaches were to ensure proper foot wear.</p> <p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 10:30 a.m., indicated the resident should be wearing non skid socks to her feet at all times.</p> <p>5. The record for Resident #143 was reviewed on 2/5/14 at 10:09 a.m. The resident's diagnoses included, but were not limited to, insomnia, and dementia.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment dated 1/15/14 indicated the resident was not alert and oriented and was moderately impaired for decision making.</p>			

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	<p>Review of the current plan of care dated 1/14/14 indicated the problem of insomnia with the Nursing approaches to monitor by the way of the behavior flow sheet.</p> <p>Review of the Physician's Orders dated 10/29/13 indicated Trazadone (a medication used for sleep) 50 milligrams (mg) 1/2 tab at night time as needed for insomnia.</p> <p>Review of the Medication Administration Record (MAR) for the month of December 2013 indicated the Trazadone was administered on 12/13 at 1:00 a.m., 12/20 at 9:00 p.m., and on 12/21 at 9:00 p.m.</p> <p>Review of the MARs for January 2014 and part of February 2014 indicated the Trazadone was administered to the resident on 1/5 at 10:00 p.m., 1/7 at 10:00 p.m., 1/15 at 8:00 p.m., 1/20 9:00 p.m., 1/24 at 10 p.m., 1/26 at 9:00 p.m., 1/27 at 8:25 p.m., 1/28 at 8:45 p.m., 1/29 at 8:30 p.m., and on 2/4 at 11:30 p.m., all for insomnia.</p> <p>Review of the Behavior/Intervention flow sheet for the months of 12/2013, 1/2014 and 2/2014 indicated the only completed interventions before giving the as</p>						

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	<p>needed Trazadone at bed time for insomnia was on 1/27/14 and 1/28/14. The rest of the above dates were incomplete and left blank.</p> <p>Interview with the Fifth Unit Manager on 2/5/14 at 10:45 a.m., indicated the Behavior/Intervention flow sheets were to be completed each time the resident had an episode of insomnia.</p> <p>6. On 2/3/14 at 3:06 p.m., Resident #157 was observed in her room. She had three bruises on her left hand and forearm. The first bruise on her left hand, was dark purple and approximately 2 cm (centimeter) round. The second bruise was near her left wrist, bluish in color, irregular shaped approximately 1 cm wide by 2 cm long. The third bruise was on her left forearm, it was yellowish brown and approximately 2 cm round.</p> <p>The resident's record was reviewed on 2/4/14 at 2:25 .m. The resident was readmitted to the facility on 4/10/13. Diagnoses included, but were not limited to, Parkinson's disease and atrial fibrillation.</p> <p>The February 2014 Physician Order Statement indicated the resident</p>				

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	<p>was on coumadin (an anticoagulant) 5 mg daily.</p> <p>A care plan dated 1/16/14 was for risk of bleeding and bruising related to anticoagulant therapy. The goal was to decrease the risk of bleeding and bruising. Interventions included, but were not limited to, to monitor for bruising and report the the Physician.</p> <p>The Nurses notes, wound care notes and skin assessment sheets for January and February 2014 were reviewed, there was no documentation of bruising. The last skin assessment sheet was dated 1/1/14.</p> <p>Interview with LPN #1 and the Fourth Floor Unit Manager on 2/5/14 at 10:10 a.m., indicated all residents were assessed weekly for skin issues. The LPN indicated the schedule for skin checks, however, Resident #157 was not on the schedule. The LPN indicated the resident should have been on the schedule and had weekly skin assessments, she also indicated the last skin assessment was done 1/1/14. The Unit Manager indicated when bruises were found, an incident form was filled out and then</p>						

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F000309 SS=D	<p>the resident would be monitored for 72 hours. She indicated the resident would be assessed at this time.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 2 of 3 residents reviewed for non-pressure skin conditions of the 5 residents who met the criteria for non-pressure skin conditions. (Residents #79 and #157)</p> <p>Findings include:</p> <p>1. On 2/3/14 at 3:09 p.m., Resident #79 was observed with a fading bruise to the top of her left hand and</p>	F000309	<p>F-309 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following:</p>	02/28/2014	

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	<p>an area of greenish bruising to the left forearm.</p> <p>On 2/7/14 at 9:34 a.m., a dark discoloration was observed to the tops of the resident's hands. An area of greenish discoloration was also observed on the resident's left forearm.</p> <p>The record for Resident #79 was reviewed on 2/6/14 at 2:44 p.m. Review of the Nursing progress notes for the months of January and February 2014, indicated there was no documentation related to bruising.</p> <p>A Skin assessment form dated 2/6/14, indicated the resident had no skin issues, the skin was intact, and she had a scab to the center of her chest. There were no weekly skin assessments for the month of January 2014 and there were no weekly skin assessments completed for the month of February prior to 2/6/14.</p> <p>Interview with the Unit Manager on 2/7/14 at 9:35 a.m., indicated that she could not find any further weekly skin assessments and that she would assess the resident's skin.</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Observation 1, a skin check has been completed.</p> <p>As it relates to Observation 2, Resident 157 has been added to the weekly skin check schedule and has had a skin check completed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility Unit Directors have audited each unit's weekly skin check schedule and has verified accuracy of the schedules. An audit has been completed to ensure the presence of a current skin check.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A formal in-service (See MMI Exhibit 2) has been provided to Licensed Professional Nursing staff regarding the requirements to adhere to facility weekly skin check process.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?On a weekly basis, the facility Unit Directors will be responsible to complete an audit to ensure the completion of weekly skin checks and accuracy of posted weekly</p>				

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	<p>2. On 2/3/14 at 3:06 p.m., Resident #157 was observed in her room. She had three bruises on her left hand and forearm. The first bruise was on her left hand, dark purple and approximately 2 cm (centimeter) round. The second bruise was near her left wrist, bluish in color, irregular shaped approximately 1 cm wide by 2 cm long. The third bruise was on her left forearm, it was yellowish brown and approximately 2 cm round.</p> <p>The resident's record was reviewed on 2/4/14 at 2:25 a.m. The resident was readmitted to the facility on 4/10/13. Diagnoses included, but were not limited to, Parkinson's disease and atrial fibrillation.</p> <p>The February 2014 Physician Order Statement indicated the resident was on coumadin (an anticoagulant) 5 mg daily.</p> <p>A care plan dated 1/16/14 was for</p>		<p>skin check schedule. Findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>By what date will the systemic changes be completed? February 28, 2014</p>		

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	<p>risk of bleeding and bruising related to anticoagulant therapy. The goal was to decrease the risk of bleeding and bruising. Interventions included, but were not limited to, to monitor for bruising and report the the Physician.</p> <p>The nurses notes, wound care notes and skin assessment sheets for January and February 2014 were reviewed, there was no documentation of bruising. The last skin assessment sheet was dated 1/1/14.</p> <p>Interview with LPN #1 and the Fourth Floor Unit Manager on 2/5/14 at 10:10 a.m., indicated all residents were assessed weekly for skin issues. The LPN indicated the schedule for skin checks, however, Resident #157 was not on the schedule. The LPN indicated the resident should have been on the schedule and had weekly skin assessments, she also indicated the last skin assessment was done 1/1/14. The Unit Manager indicated when bruises were found, an incident form was filled out and then the resident would be monitored for 72 hours. She indicated the resident would be assessed at this time.</p>			

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F000310 SS=D	<p><b>3.1-37(a)</b></p> <p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, record review and interview, the facility failed to provide assistive devices to help maintain the resident's level of Activities of Daily Living (ADLs) related to providing foot pedals on the resident's wheelchair for 1 of 3 residents reviewed for Activities of Daily of living of the 4 residents who met the criteria for ADLs. (Resident #143)</p> <p>Findings include:</p>	F000310	F-310 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility	02/28/2014			

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	<p>On 2/04/14 at 8:55 a.m., Resident #143 was observed sitting in her wheelchair in her room. At that time the resident was wearing plain white socks to both of her feet and there were no foot pedals on the wheelchair. The resident's feet were dangling from the chair and did not reach the ground.</p> <p>On 2/4/14 at 2:20 p.m., the resident was observed up in her wheelchair. At that time she was wearing plain white socks and slippers to both of her feet. Her feet did not touch the ground and were dangling from the chair. There were no foot pedals observed on the chair.</p> <p>On 2/5/14 at 9:50 p.m., the resident was observed up in her wheelchair. At that time she was wearing plain white socks and slippers to both of her feet. Her feet did not touch the ground and were dangling from the chair. There were no foot pedals observed on the chair.</p> <p>On 2/5/14 at 11:33 a.m., the resident was taken out of the dining room after activities and taken to her room by the Nurse. The resident was still observed with her feet dangling from the chair and not on</p>		<p>dated February 17, 2014, the facility offers the following:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Occupational Therapy screened Resident 143 and her seating system. The wheelchair has been modified to ensure proper positioning, resident comfort and ability to place feet flat on the floor when seated in the wheelchair.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility has identified residents who do not have foot pedals on their wheelchairs. Those needing foot pedals have been identified and foot pedals have been provided. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility staff has been in-serviced (See MMI Exhibit 1) to ensure provided foot pedals are used appropriately.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Rehab/or Designee will observe five residents per floor weekly to ensure appropriate use of foot pedals. Findings from the audit</p>				

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	<p>foot pedals.</p> <p>The record for Resident #143 was reviewed on 2/5/14 at 10:09 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, high blood pressure, gout, macular degeneration, and dementia.</p> <p>Review of the Annual 1/15/14 Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. The resident was moderately impaired for decision making and had short term memory problems. The resident was extensive assist with bed mobility, transfers, dressing and personal hygiene.</p> <p>Interview with the Fifth Floor Unit Manager on 2/5/14 at 10:45 a.m., indicated she was aware the resident's feet dangle from the wheelchair. She further indicated the resident's daughter did not want foot pedals on the wheelchair. Further interview indicated the resident was primarily propelled in her wheelchair by staff.</p> <p>Interview with Occupational Therapy Assistant #1 on 2/5/14 at 11:00 a.m., indicated she does not recall</p>		<p>will be reported by the Director of Rehab to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>				

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F000314 SS=D	<p>ever screening the resident for foot pedals. She indicated she was just called by the Unit Manager today to assess the resident for foot pedals. The Occupational Therapy Assistant further indicated the resident should have foot pedals on her wheelchair due to the fact her feet do not touch the ground. She indicated her wheelchair was appropriate for her at this time.</p> <p>3.1-38(a)(2)(B)</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 record review and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered for 1 of 3</p>	F000314	F-314 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of	02/28/2014	

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	<p>residents reviewed for pressure ulcers of the 6 residents who met the criteria for pressure ulcers. (Resident #302)</p> <p>Findings include:</p> <p>The closed record for Resident #302 was reviewed on 2/6/14 at 8:30 a.m. The resident's diagnosis included, but was not limited to, right trochanter (hip) fracture.</p> <p>Review of the Wound care assessment dated 11/22/13, indicated the following: resident admitted on 11/16/13 with a right ischial stage 2 pressure area, 3 centimeters (cm) x 4 cm x &lt;0.1 cm. 100% red granulation, scant blood drainage. no odor. Today deteriorated, now a stage 3, 1.2 cm x 2.2 cm x &lt;0.1 cm. 20% red granulation, 40% epithilization, 40% slough, scant bloody drainage, no odor, area due to pressure. Will begin low air loss mattress. Pressure reduction cushion. Turn and reposition every 2 hours and as needed. Peri-care encouraged. Vicon forte (a vitamin) to promote healing. Treatments obtained/revised. Resident aware.</p> <p>A Physician's order dated 11/22/13,</p>		<p>Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident 302, we are unable to retrospectively address the surveyor identified concern as the resident no longer resides in the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? An audit was performed for each resident on wound care caseload from the first of February to ensure treatments have been performed. In the event a similar observation is made, staff responsible will be counseled on the necessity of completing all ordered treatments.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Formal in-servicing (See MMI Exhibit 2) was completed for</p>				

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	<p>indicated to discontinue the current treatment to the right ischial stage 2 pressure area and cleanse the stage 3 right ischial pressure ulcer daily with wound cleanser, apply Santyl (a debriding cream), cover with a dry sterile dressing and change as needed for removal/soilage.</p> <p>Review of the November 2013 Treatment Administration Record (TAR), indicated the treatment was not signed out until 11/25/13.</p> <p>Interview with the Wound nurse on 2/7/14 at 8:24 a.m., indicated that she had signed off on the new treatment order around 3:30 p.m. on 11/22/13. She indicated the Santyl should have come in that evening. After reviewing the Nursing progress notes, she indicated there was no documentation to indicate the medication was not available. She indicated the first time the treatment was signed out, was on 11/25/13.</p> <p>3.1-40(a)(2)</p>		<p>Licensed Professional Nursing staff to address the necessity of completing treatments as ordered by the physician.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Quality Assurance audit will be performed on a weekly basis by the facility Unit Directors/or Designee to monitor the completion of prescribed wound care treatments. The findings of the audit will be provided to the Director of Nursing on a weekly basis and a summary of the findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>By what date will the systemic changes be completed? February 28, 2014</p>		

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastronomy (PEG) tubes received the necessary care and treatment related to medication administration for 1 of 1 residents reviewed for PEG-tubes. (Resident #3)</p> <p>Findings include:</p>	F000322	<p>F-322</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to</p>	02/28/2014

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	<p>1. On 2/7/14 at 6:22 a.m., LPN #3 was observed preparing and administering medications for Resident #3. LPN #3 collected all Resident #3's medications, she crushed all the whole pills and then poured them into a plastic cup, she opened the capsule pills and poured them into the same plastic cup as the crushed pills. She proceeded to measure and pour the resident's liquid medications into the same cup. After all the medications were poured into the plastic cup, she stirred all the medications together and added water.</p> <p>After entering the resident's room, LPN #3 donned gloves and was observed turning off the resident's tube feeding. She disconnected the tube feeding and proceeded to administer all the mixed medications into the resident's PEG-tube. LPN #3 did not check for tube feeding placement prior to the medication administration, nor did she check the resident's stomach tube feeding residual. Once all the medications were administered LPN #3 then flushed the resident's PEG-tube and resumed the tube feeding.</p> <p>Interview with LPN #3 at that time, indicated she had checked the</p>		<p>the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 has had no complications related from the medication administration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with gastrostomy tubes have the potential to be affected by the same alleged deficient practice. The staff member involved in the surveyor cited observation has received educational in-servicing regarding administration of medications via a gastrostomy tube. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Formal in-servicing (See MMI Exhibit 2) was provided to Licensed Professional Staff on the topic of gastrostomy tube medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility Staff Developer/or Designee will complete an enteral medication pass audit with ten</p>		

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	<p>resident's PEG-tube placement at 1:00 a.m. when she completed the resident's scheduled water flush. She then indicated she did not perform residual checks on Resident #3.</p> <p>The record for Resident #3 was reviewed on 2/7/14 at 11:20 a.m. The resident was admitted to the facility on 6/16/09 with the readmission date of 8/1/13. The resident's diagnoses included, but were not limited to, persistent vegetative state, PEG-tube, and dysphasia.</p> <p>Review of the current plan of care dated 7/1/13, indicated the resident had a PEG-tube. The Nursing approaches included, but were not limited to, check for residual before and after each flush.</p> <p>Review of the Enteral Medication Administration policy indicated, "Medications should not be mixed together for administrations." Further review of the policy also indicated, "Check the stomach for residual feeding to ensure the resident is tolerating the feeding", and "Check the correct placement of feeding tube prior to administration of medication".</p>		<p>staff members monthly. The findings of the evaluations completed will be reported by the facility Staff Developer to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>		

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F000323 SS=D	<p>Interview with the Third Floor Unit Manager on 2/7/14 at 10:10 a.m., indicated nursing staff should check for placement and residual before each medication administration.</p> <p>3.1-44(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure each resident was free from accidents related to ensuring proper footwear was worn, keeping the call light in reach, and being left unattended while on the toilet in the bathroom for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Resident's #83 and #116)</p> <p>Findings include:</p>	F000323	F-323 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What	02/28/2014			

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	<p>1. On 2/3/14 at 11:10 a.m. Resident #83 was observed sitting in her wheelchair by the bathroom door. The resident was observed with a chair alarm attached to her wheelchair. The resident indicated she had to use the bathroom. At that time, she was assisted by CNA #4 who placed her on the toilet and then left the bathroom with the resident on the toilet by herself.</p> <p>On 2/5/14 at 9:47 a.m., Resident #83 was observed in bed wearing a nightgown and plain socks to both of her feet with no non skid soles noted on the bottom. The resident's call light was located on the floor behind the bed.</p> <p>On 2/5/14 at 12:00 p.m., the resident was observed sitting up in a wheelchair next to her bed. The resident's call light was located on the floor behind the bed.</p> <p>On 2/6/14 at 9:47 a.m., the resident was observed in bed. The resident was wearing a night gown and plain socks to both of her feet with no non skid soles noted on the bottom. The resident's call light was located on the floor behind the bed.</p> <p>The record for Resident #83 was</p>		<p>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?As it relates to Observation 1, Resident 83 has had no recent falls. As it relates to Observation 2, Resident 116 is currently wearing non-skid footwear and has had no recent falls. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?An informal in-service was provided to unit staff regarding footwear, availability of call lights and residents who are at risk for falls not being left unattended. Educational counseling was provided to staff involved. A plan of care review was completed to ensure appropriate fall prevention interventions are in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A formal in-service (See MMI Exhibit 1) for staff was completed regarding footwear, availability of call lights and residents who are at risk for falls not being left unattended. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Unit Directors/ Designee will complete observations of a</p>				

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	<p>reviewed on 2/6/14 at 1:38 p.m. The resident was admitted to the facility on 12/18/13. The resident's diagnoses included, but were not limited to, depression, anxiety, and senile dementia.</p> <p>A fall risk assessment was completed on 1/25/14 and indicated the resident was at risk for falls.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 12/25/13 indicated the resident was not alert and oriented, had no behavior problems. The resident had no history of falls prior to the nursing home.</p> <p>Review of the plan of care plan dated 2/4/14 indicated the resident was at risk for falls. The Nursing approaches were to have wheelchair alarm, bed alarm, and a room close to nurse station.</p> <p>Review of Nursing Progress Notes from December 18 through 31, 2013 indicated the resident had tried to stand from the wheelchair without assistance and made some attempts to get out of bed without assistance.</p> <p>Interview with CNA #3 on 2/6/14 at 2:40 p.m., indicated the resident was</p>		<p>sample of five residents per floor per week to ensure appropriate fall interventions are in place. Findings of the audit will be provided to the Director of Nursing on a weekly basis and a summary of findings will be reported by the Unit Directors to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>		

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	<p>to have a bed alarm and chair alarm for fall precautions. She further indicated the resident was not to be left alone in the bathroom while sitting on the toilet. She indicated when a resident was at risk for falls or has an alarm to the chair, staff were supposed to stay with the resident while they were on the toilet. The CNA also indicated the resident was capable of using the call light to call for assistance.</p> <p>2. On 2/04/14 at 9:14 a.m., Resident #116 was observed sitting in a wheelchair in her room, and there was no staff around. She was wearing plain white socks to both of her feet with no shoes noted on her feet.</p> <p>The record for Resident #116 was reviewed on 2/6/14 at 10:20 a.m. The resident's diagnoses included, but were limited to, right hip fracture, Alzheimer's disease, dementia with behavioral disorder, and anxiety.</p> <p>Review of the 11/6/13 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented and had short and long term memory problems. The resident was moderately impaired for decision</p>						

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	<p>making.</p> <p>Review of the updated plan of care dated 1/9/14 indicated the problem of Fall with no injuries. The Nursing approaches were to wear non slip footwear.</p> <p>Review of the fall risk assessment dated 11/6/13 indicated the resident was at risk for falls.</p> <p>Review of Nurses Notes dated 1/9/14 at 4:10 p.m., indicated the resident was in the room with daughter. The daughter indicated while walking with the resident she started to fall, she just slid her to the floor.</p> <p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 10:30 a.m., indicated the resident's last fall was on 1/9/14. She further indicated the resident was supposed to wear non skid socks or shoes when she was up in a wheelchair.</p> <p>3.1-45(a)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin was given as ordered as well as documenting interventions attempted prior to giving as needed hypnotics, antidepressants and antianxiety medications for 3 of 5 residents reviewed for unnecessary medications. (Residents #83, #124, and #143)</p> <p>Findings include:</p>	F000329	<p>F329</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility</p>	02/28/2014	

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	<p>1. The record for Resident #124 was reviewed on 2/4/14 at 2:31 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and insomnia.</p> <p>A Physician's order dated 1/22/14, indicated the resident was to have accuchecks (a test to monitor a resident's blood sugar) twice a day at 6:00 a.m. and 4:00 p.m. The resident was to receive the following Novolog sliding scale insulin dose based on her accucheck:</p> <p>151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units &gt;350=10 units</p> <p>Review of the Diabetic Tracking form for the month of February 2014, indicated on 2/2/14 at 4:00 p.m., the resident's blood sugar was 258. There was no documentation of insulin being given.</p> <p>On 2/3/14 at 6:00 a.m., the resident's blood sugar was 231. The resident received 2 units of insulin rather than the ordered 4 units.</p> <p>Interview with the Unit Manager on</p>		<p>dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to has been affected by the deficient practice?As it relates to Observation 1, the physician of Resident 124 have been notified of the surveyor cited concerns. There were no new orders received. As it relates to Observation 2, the physician of Resident 83 was notified of the surveyor cited concern. As it relates to Observation 3, the physician of Resident 143 was notified of the surveyor cited concern. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility has completed an audit of other residents currently with a sliding scale insulin order and a review of the Diabetic Tracking form has been completed to ensure adherence to the physicians order. The facility has completed an audit of residents receiving PRN orders for Ambien, Xanax, and Trazadone to ensure appropriate documentation is in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Formal in-servicing (See MMI Exhibit 2) has been provided to</p>		

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	<p>2/7/14 at 10:00 a.m., indicated the resident had received the wrong dose of sliding scale insulin.</p> <p>Interview with the Director of Nursing on 2/7/14 at 12:00 p.m., indicated the resident received the wrong dose of insulin.</p> <p>A Physician's order dated 12/18/13, indicated the resident was to receive Ambien (a sleeping pill) 5 milligrams (mg) by mouth at bedtime as needed for insomnia.</p> <p>Review of the December 2013 Medication Administration Record (MAR), indicated the resident received the Ambien on 12/22 and 12/25/13. The Behavior/intervention flow record for the month of December 2013 was blank, there was no documentation of episodes of insomnia on the sheet nor were there any interventions attempted prior to giving the Ambien.</p> <p>Review of the January 2014 MAR, indicated the resident received the Ambien on 1/31/13 at 11:30 p.m. for insomnia. The Behavior/intervention flow record for the month of January 2014, indicated there was no documentation of episodes of insomnia nor were there any</p>		<p>Licensed Professional Nursing staff regarding the requirements to adhere to physicians orders for sliding scale insulin and the requirement to properly document (on Psychoactive Flow Sheet) the non-medication interventions attempted prior to the use of PRN psychoactive medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing/or Designee will complete an audit of twenty charts per month for residents with orders for sliding scale insulin coverage to ensure the adherence to physicians orders. The findings will be reported by the Director of Nursing to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. The Director of Nursing/or Designee will complete an audit of twenty charts per month for residents with orders for PRN psychoactive medications to ensure the appropriate documentation is in place. The findings will be reported to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p>				

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	<p>interventions attempted prior to giving the Ambien.</p> <p>Interview with the Unit Manager on 2/7/14 at 10:00 a.m., indicated the behavior/intervention flow sheets were blank related to insomnia for the resident.</p> <p>Interview with the Director of Nursing on 2/7/14 at 12:00 p.m., indicated there were no episodes of insomnia documented and any interventions attempted prior to giving the Ambien on the Behavior/intervention flow record.</p> <p>2. The record for Resident #83 was reviewed on 2/6/14 at 1:38 p.m. The resident was admitted to the facility on 12/18/13. The resident's diagnoses included, but were not limited to, depression, anxiety, senile dementia, and insomnia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 12/25/13 indicated the resident was not alert and oriented. The resident indicated she had feelings of being down and tired. The resident had no behavior problems and was receiving antianxiety and antidepressant medication.</p> <p>Review of Physician Orders dated</p>						

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	<p>12/18/13 indicate Xanax (a medication used for anxiety) .25 milligrams (mg) three times a day as needed for anxiety.</p> <p>Review of a Psychiatric Reassessment and AIMS Testing dated 12/27/13 indicated the diagnostic impression for the resident was senile dementia, depressive disorder, anxiety, and insomnia. The current psychotropic medications were Zoloft (a medication used for depression) and Xanax as needed.</p> <p>Review of the Medication Administration Record (MAR) dated 1/2-1/29/14 indicated the resident was administered Xanax on 1/4, 1/5, and 1/6/14. On the back of the MAR indicated on 1/4 at 12:00 a.m., the resident received Xanax for complaints of anxiety. There was no other documentation on the back of the MAR to indicate what time the resident received the Xanax medication and for what on 1/5 and 1/6/14.</p> <p>Reviewed Nurses Notes for 1/5 and 1/6/14 indicated there was no documentation indicating why the resident received the as needed Xanax.</p>						

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	<p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 3:45 p.m., indicated there was no other documentation in the Nurses Notes or on the back of the MAR to indicate why the resident received the as needed Xanax.</p> <p>3. The Record for Resident #143 was reviewed on 2/5/14 at 10:09 a.m. The resident's diagnoses included, but were not limited to, insomnia and dementia.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated 1/15/14 indicated the resident was not alert and oriented and was moderately impaired for decision making.</p> <p>Review of the current plan of care dated 1/14/14 indicated the problem of insomnia with the Nursing approaches to monitor by the way of the behavior flow sheet.</p> <p>Review of the psychoactive evaluation dated 11/12/13 indicated the resident had the medical diagnoses of insomnia. The resident has had same behavior for last 90 days.</p>						

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	<p>Review of the Physician's Orders dated 10/29/13 indicated Trazadone (a medication used for sleep) 50 milligrams (mg) 1/2 tab at night time as needed for insomnia.</p> <p>Review of the Medication Administration Record (MAR) for the month of December 2013 indicated the Trazadone was administered on 12/13 at 1:00 a.m., 12/20 at 9:00 p.m., and on 12/21 at 9:00 p.m.</p> <p>Review of the back of 12/2013 MAR indicated the Trazadone was administered for complaints of insomnia.</p> <p>Review of the MARs for January 2014 and part of February 2014 indicated the Trazadone was administered to the resident on 1/5 at 10:00 p.m., 1/7 at 10:00 p.m., 1/15 at 8:00 p.m., 1/20 9:00 p.m., 1/24 at 10 p.m., 1/26 at 9:00 p.m., 1/27 at 8:25 p.m., 1/28 at 8:45 p.m., 1/29 at 8:30 p.m., and on 2/4 at 11:30 p.m., all for insomnia.</p> <p>Review of the back of 1/2014 MAR indicated the Trazadone was administered for complaints of insomnia.</p> <p>Review of the Behavior/Intervention</p>			

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	<p>flow sheet for the months of 12/2013, 1/2014 and 2/2014 indicated the only completed interventions before giving the as needed Trazadone at bed time for insomnia was on 1/27/14 and 1/28/14. The rest of the above dates were incomplete and left blank.</p> <p>Review of Nursing Progress Notes dated 12/31/13 indicated that was the last documented Nurse's Note and there was documentation of what interventions were tried first before giving the as needed Trazadone.</p> <p>Interview with the Fifth Floor Unit Manager on 2/5/14 at 10:45 a.m., indicated the Behavior/Intervention flow sheets were to be completed each time the resident had an episode of insomnia which would include interventions tried first before giving the as needed Trazadone. The Unit Manager indicated the resident was not alert and oriented and had dementia.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure a resident receiving Level II services for mental health received yearly reviews for 1 of 1 resident reviewed for Preadmission Screening and Resident Review (PASRR). (Resident #62)</p> <p>Findings include:</p> <p>On 2/5/14 at 9:07 a.m., the record for Resident #62 was reviewed. The resident was originally admitted to the facility on 9/29/10, she was readmitted on 1/27/14. Diagnoses included, but were not limited to,</p>	F000406	<p>F-406</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by</p>	02/28/2014	

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	<p>depressive disorder, dementia with psychosis, narcolepsy and anxiety. The resident was visited routinely for Psychiatric services.</p> <p>The PASRR Level II Mental Health Assessment was completed on 9/28/10. The resident was determined to be mentally ill, with Level II diagnoses of major depressive disorder and anxiety disorder. The Preadmission Screening Determination letter dated 9/28/10, indicated the resident was to continue with mental health services and have a yearly resident review. There were no yearly reviews in the resident's record.</p> <p>Interview with Fourth Floor Social Service Director on 2/6/14 at 2:07 p.m., indicated there were no yearly reviews completed since the original Level II assessment was done upon admission 9/28/10. She indicated she did not know why the yearly reviews had not been done, and had notified her supervisor.</p> <p>3.1-23(a)</p>		<p>the deficient practice?As it relates to Res 62, upon surveyor observation, a request was made to have an annual resident review completed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?The facility has identified the residents in the facility with a Level II in place. Each Level II has been reviewed to ensure recommendations are being addressed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Social Service receives all Level II assessments upon admission or upon completion post-admission. The Director of Social Service/or Designee will track the recommendations made through the Level II process. Social Service staff has been in-serviced on this process and the requirement to complete quarterly review of each Level II to ensure recommendations are being followed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?A Quality Assurance audit will be performed by the Director of Social Service on a quarterly basis to ensure compliance with</p>		

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify the non-compliance of monitoring behaviors and non-medication interventions prior to giving prn (as</p>	F000520	<p>aforementioned process. Findings from the audit will be reported by the Director of Social Service to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters. By what date will the systemic changes be completed? February 28, 2014</p> <p>F-520 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited.</p>	02/28/2014			

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	<p>needed) psychotropic medications through the facility's quality assurance protocol. (Residents #124, #83 and #143)</p> <p>Finding include:</p> <p>Interview with Administrator on 2/7/14 at 12:30 p.m., indicated the Quality Assessment and Assurance (QA &amp; A) committee consisted of herself, the Director of Nursing, department heads, Medical Director, laboratory representative and consulting Pharmacist. She indicated the committee met quarterly. She indicated the QA &amp; A committee had identified the need to decrease the use of psychotropic medications. The interventions currently used included gradual dose reductions, using proper diagnoses to justify medication use and Pharmacist reviews of medication regimens. She indicated there was not a system in place to monitor the use of non-medication interventions before giving a prn psychotropic medication. She further indicated that monitoring of non-medication interventions had not been identified or discussed in QA &amp; A meetings, but would be included in the future.</p>		<p>Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of the letter to this facility dated February 17, 2014, the facility offers the following: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A review of the Nursing Department Quality Assurance program was completed. It has been identified that an audit function addressing PRN Psychoactive Medications (Completion of Psychoactive Flow Sheet) was in place at the time of the surveyor cited concern. This audit has been expanded to include monitoring of hypnotic medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The audit for PRN Psychoactive Medication (Completion of Psychoactive Flow Sheets) including hypnotic medications has been performed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A formal in-service (See MMI Exhibit 2) has been performed for</p>				

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NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321			
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	<p>A Physician's order dated 12/18/13, indicated Resident #124 was to receive Ambien (a sleeping pill) 5 milligrams (mg) by mouth at bedtime as needed for insomnia.</p> <p>Review of the December 2013 Medication Administration Record (MAR), indicated the resident received the Ambien on 12/22 and 12/25/13. The Behavior/intervention flow record for the month of December 2013 was blank, there was no documentation of episodes of insomnia on the sheet nor were there any interventions attempted prior to giving the Ambien.</p> <p>Review of the January 2014 MAR, indicated the resident received the Ambien on 1/31/13 at 11:30 p.m. for insomnia. The Behavior/intervention flow record for the month of January 2014, indicated there was no documentation of episodes of insomnia nor were there any interventions attempted prior to giving the Ambien.</p> <p>Interview with the Unit Manager on 2/7/14 at 10:00 a.m., indicated the Behavior/intervention flow sheets were blank related to insomnia for the resident.</p>		<p>Licensed Professional Nursing staff discussing the requirement to attempt and document (on Psychoactive Flow Sheet) the use of non-medication interventions prior to the administration of a PRN psychoactive medication including anti-anxiety medications, hypnotic medications and other medications used to treat insomnia.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing will complete the Quality Assurance audit of PRN Psychoactive Medications including hypnotics on a monthly basis. The Director of Nursing will report findings to the Quality Assurance Committee on a quarterly basis for a minimum of three quarters.</p> <p>By what date will the systemic changes be completed? February 28, 2014</p>				

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	<p>Interview with the Director of Nursing on 2/7/14 at 12:00 p.m., indicated there were no episodes of insomnia documented and any interventions attempted prior to giving the Ambien on the Behavior/intervention flow record.</p> <p>The record for Resident #83 was reviewed on 2/6/14 at 1:38 p.m. The resident was admitted to the facility on 12/18/13. The resident's diagnoses included, but were not limited to, depression, anxiety, senile dementia, and insomnia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 12/25/13 indicated the resident was not alert and oriented. The resident indicated she had feelings of being down and tired. The resident had no behavior problems and was receiving antianxiety and antidepressant medication.</p> <p>Review of Physician Orders dated 12/18/13 indicate Xanax (a medication used for anxiety) .25 milligrams (mg) three times a day as needed for anxiety.</p> <p>Review of a Psychiatric Reassessment and AIMS Testing dated 12/27/13 indicated the</p>						

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	<p>diagnostic impression for the resident was senile dementia, depressive disorder, anxiety, and insomnia. The current psychotropic medications were Zoloft (a medication used for depression) and Xanax as needed.</p> <p>Review of the MAR dated 1/2-1/29/14 indicated the resident was administered Xanax on 1/4, 1/5, and 1/6/14. On the back of the MAR indicated on 1/4 at 12:00 a.m., the resident received Xanax for complaints of anxiety. There was no other documentation on the back of the MAR to indicate what time the resident received the Xanax medication and for what on 1/5 and 1/6/14.</p> <p>Reviewed Nurses Notes for 1/5 and 1/6/14 indicated there was no documentation indicating why the resident received the as needed Xanax.</p> <p>Interview with the Fifth Floor Unit Manager on 2/6/14 at 3:45 p.m., indicated there was no other documentation in the Nurses Notes or on the back of the MAR to indicate why the resident received the as needed Xanax.</p>				

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	<p>The Record for Resident #143 was reviewed on 2/5/14 at 10:09 a.m. The resident's diagnoses included, but were not limited to, insomnia and dementia.</p> <p>Review of the annual MDS assessment dated 1/15/14 indicated the resident was not alert and oriented and was moderately impaired for decision making.</p> <p>Review of the current plan of care dated 1/14/14 indicated the problem of insomnia with the Nursing approaches to monitor by the way of the behavior flow sheet.</p> <p>Review of the psychoactive evaluation dated 11/12/13 indicated the resident had the medical diagnoses of insomnia. The resident has had same behavior for last 90 days.</p> <p>Review of the Physician's Orders dated 10/29/13 indicated Trazadone (a medication used for sleep) 50 milligrams (mg) 1/2 tab at night time as needed for insomnia.</p> <p>Review of the MAR for the month of December 2013 indicated the Trazadone was administered on 12/13 at 1:00 a.m., 12/20 at 9:00</p>						

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	<p>p.m., and on 12/21 at 9:00 p.m.</p> <p>Review of the back of 12/2013 MAR indicated the Trazadone was administered for complaints of insomnia.</p> <p>Review of the MARs for January 2014 and part of February 2014 indicated the Trazadone was administered to the resident on 1/5 at 10:00 p.m., 1/7 at 10:00 p.m., 1/15 at 8:00 p.m., 1/20 9:00 p.m., 1/24 at 10 p.m., 1/26 at 9:00 p.m., 1/27 at 8:25 p.m., 1/28 at 8:45 p.m., 1/29 at 8:30 p.m., and on 2/4 at 11:30 p.m., all for insomnia.</p> <p>Review of the back of 1/2014 MAR indicated the Trazadone was administered for complaints of insomnia.</p> <p>Review of the Behavior/intervention flow sheet for the months of 12/2013, 1/2014 and 2/2014 indicated the only completed interventions before giving the as needed Trazadone at bed time for insomnia was on 1/27/14 and 1/28/14. The rest of the above dates were incomplete and left blank.</p> <p>Review of Nursing Progress Notes</p>				

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	<p>dated 12/31/13 indicated that was the last documented Nurse's Note and there was documentation of what interventions were tried first before giving the as needed Trazadone.</p> <p>Interview with the Fifth Floor Unit Manager on 2/5/14 at 10:45 a.m., indicated the Behavior/intervention flow sheets were to be completed each time the resident had an episode of insomnia which would include interventions tried first before giving the as needed Trazadone. The Unit Manager indicated the resident was not alert and oriented and had dementia.</p> <p>3.1-52(b)(2)</p>				