

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN46410
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F0000	<p>This visit was for the Investigation of Complaint IN00100422.</p> <p>Complaint IN00100422 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F314, F505 and F507.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: November 30 and December 1, 2011</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team; Kathleen (Kitty) Vargas, RN, TC Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 149 Total: 149</p> <p>Census payor type: Medicare: 21 Medicaid: 109 Other: 19 Total: 149</p> <p>Sample: 4</p>	F0000		

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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F0157 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/05/11 by Suzanne Williams, RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to promptly notify the</p>	F0157	F157	12/30/2011	

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	<p>resident's physician related to a tear in a percutaneous endoscopic gastrostomy (PEG) tube, an anti-seizure medication not being available, and lab results that were not available for 2 of 4 residents reviewed for physician orders in a sample of 4. (Residents #C and #E)</p> <p>Findings include:</p> <p>1. The record for Resident #C was reviewed on 11/30/11 at 10:45 a.m. Review of the Nursing Progress Notes dated 10/19/11 at 1:58 a.m., indicated "Tube feeding port has a tear unable to keep in place due to feeding tubing slipping out of port. LPN pass on in shift report to notify MD (physician) for new tube replacement." (sic)</p> <p>The next documented Nurse's Progress Note was on 10/21/11 at 11:36 p.m., and there was no information regarding the tear in the PEG tube. The next documented Nurse's Note was on 10/22/11 at 10:56 a.m., which indicated the tear in the port of the PEG tube remained; however, there was no documentation in the record that the Physician had been notified. The Nursing Progress note dated 10/29/11 at 2:15 p.m., indicated the resident's PEG tube had dislodged and was not in place. The resident was sent to the hospital where his</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> ·Resident #C's physician was notified on 10/29/11 that the resident's PEG tube was dislodged and resident was sent to hospital for replacement. ·Resident # E's physician was notified on 11/26/11 that medication was not available. ·Resident # E had CBC drawn on 11/30/11 <p>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</p> <p>All residents who utilize a percutaneous endoscopic gastrostomy (PEG) tube have the potential to be affected by the said alleged deficient practice.</p> <ul style="list-style-type: none"> ·Assessment of all resident utilizing PEG tubes were assessed and all are functioning with out problems. There were no issues found related to this potential alleged 		

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	<p>PEG tube was replaced.</p> <p>Interview with the D wing Unit Manager on 11/30/11 at 3:00 p.m., indicated the resident's Physician should have been notified in a more timely manner of the tear in the resident's PEG tube.</p>		<p>deficient practice.</p> <p>All residents newly admitted to the facility and residents receiving new medication/treatment orders have the potential to be affected by the alleged deficient practice.</p> <p>·All newly admitted residents and residents with new physicians orders will be reviewed per the facility guidelines. This review will include: 1 Printing all new orders report 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the administration record or treatment record to assure the order has been carried over correctly. 4 Verify that medication has arrived.</p> <p>·Any resident found to not have medication available will have physician notified if unable to obtain medications within 24 hours of initial order.</p> <p>All residents with physician's orders for labs have the potential to be affected by the alleged deficient practice.</p> <p>·NICL Laboratories</p>		

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			<p>representative has completed an audit of all residents' medical records on December 9, 2011</p> <ul style="list-style-type: none"> ·NCL Laboratories representative will complete a second audit of all residents' medical records by Dec 29, 2011 ·Any labs found to be out of compliance will have physician notified and orders will be obtained to rectify any possible omissions. <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <p>Licensed staff received re-education on Notification of Physician for any resident change of condition, any lab results or inability to obtain lab results for labs ordered, or for inability to obtain any medications from pharmacy within 24 hours of receiving new physicians orders.</p> <p>The Unit Managers of each unit or a member of the nursing management team will review the 24 hour report sheet for each unit and will also review nurses notes</p>		

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			<p>using the computerized Point Click Care system for each unit in order to review any resident with a change of condition and to verify that the physician has been notified of any change of condition.</p> <ul style="list-style-type: none"> This will be an ongoing process to ensure that physicians are notified of any change of condition for each resident. <p>The lab tracking process has been re-evaluated and re-implemented. This process includes:</p> <ul style="list-style-type: none"> Use of the "Lab Tracking Form". This form will be used by each Unit Manger or a member of Nurse Management team to review all orders for labs and will include documentation of date lab was ordered, date lab completed, date lab results received by facility and date physician was notified of lab results. This will be an ongoing process to ensure that follow through for all labs including notification of physicians is completed. <p>The monitoring of new admissions orders and new physicians orders has been re-evaluated and process implemented.</p> <ul style="list-style-type: none"> All newly admitted residents and resident's with new physicians orders will be reviewed by each Unit Manger or a member of Nurse Management 	

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			<p>team using the facility guidelines and the "Daily Start Up Change of Condition/Physicians Order Audit Form". This review will include: 1 Printing all new orders report 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the administration record or treatment record to assure the order has been carried over correctly. 4 Verify that medication has arrived.</p> <ul style="list-style-type: none"> ·Any resident found to not have medication available will have physician notified if unable to obtain medications within 24 hours of initial order. ·This will be an ongoing process to ensure that physician's orders are completed and that physician is notified if medication is not able to be obtained timely. <p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</i></p> <ul style="list-style-type: none"> ·The audit tools, "Lab Tracking Form" and " Daily Start Up 		

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	<p>2. The record for Resident #E was reviewed on 11/30/11 at 10:35 a.m. The resident had diagnoses that included, but were not limited to, diabetes, seizure disorder, subdural hematoma and hypertension. The resident was admitted to the facility on 11/23/11.</p> <p>The admission physician orders were reviewed. There was an order for Vimpat</p>		<p>Change of Condition/ Physicians Order Audit", will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <ul style="list-style-type: none"> ·Following the 3 month review by QA, the Director of Nursing/ designee will continue monitoring this process weekly as an ongoing program. If any issues begin to surface, the information will again be brought to the monthly QA meeting. ·The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance. <p>Compliance Date: December 30, 2011</p>		

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	<p>100 mg (an anti-seizure medication) to be administered to the resident two times per day. The medication was to start on 11/24/11. Review of the November 2011 MAR (Medication Administration Record) indicated the resident did not receive the Vimpat on 11/24/11, 11/25/11, 11/26/11 and 11/27/11. There was a notation written on the MAR dated 11/25/11 at 9:00 a.m. that indicated the Vimpat was not available, awaiting prescription. Another notation dated 11/26/11 indicated Vimpat not available need prescription, notified physician.</p> <p>The Progress Note dated 11/26/11 at 12:58 p.m., indicated that the resident's medication, Vimpat, was not available. The pharmacy was notified and the pharmacy indicated that a prescription must be written by the physician. The resident's physician was notified at that time, 3 days after the resident's admission to the facility.</p> <p>Interview with the Interim 200 Unit Manager on 11/30/11 at 2:15 p.m., indicated the resident's anti-seizure medication was not available. She also indicated the resident's physician was not notified timely that the medication was not available.</p> <p>There was a lab report of a CBC</p>				

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F0282 SS=D	<p>(Complete Blood Count) in the resident's record that was dated 11/25/11. The report indicated the resident's white blood cell count was 22.12 (High). The reference range for the white blood count was 4.80 - 10.80. The physician was notified of the result and the physician ordered a CBC to be drawn on 11/28/11.</p> <p>Review of the lab reports indicated there was no report of a CBC for 11/28/11. Review of the progress notes dated 11/28/11 and 11/29/11 indicated the physician was not notified that there were no CBC results for 11/28/11.</p> <p>Interview with LPN #1 on 12/1/11 at 10:05 a.m., indicated there were no results for a CBC obtained on 11/28/11. She indicated the physician was not notified on 11/28/11 or 11/29/11 that the lab results were not available.</p> <p>This Federal tag relates to Complaint #IN00100422.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</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 record review and interview, the</p>	F0282	F282	12/30/2011	

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	<p>facility failed to ensure Physician Orders were followed related to obtaining labs for 1 of 4 residents reviewed for Physician Orders in the sample of 4. (Resident #C)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 11/30/11 at 10:45 a.m. The resident was readmitted to the facility on 11/8/11 from the hospital. The Physician Order dated 11/8/11, indicated a Complete Blood Count (CBC) and a Comprehensive Metabolic Profile (CMP) was to be drawn every Monday, Wednesday, and Friday.</p> <p>Review of the Laboratory results indicated there was no CBC or CMP results for 11/11. There was no CMP results for 11/14/11.</p> <p>Interview with the D-Wing Unit Manager on 12/1/11 at 9:00 a.m., indicated the nurse that had admitted the resident on 11/8/11 had put the laboratory orders into the computer but failed to complete the lab requisition. Therefore the lab was not aware a CBC or CMP needed to be drawn on Monday, Wednesday, or Friday.</p> <p>This Federal tag relates to Complaint Number IN00100422.</p> <p>3.1-35(g)(2)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident # C had a STAT CBC and BMP drawn on 11/12/11</p> <p>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</p> <p>All resident with physician's orders for labs have the potential to be affected by the alleged deficient practice.</p> <p>·NICL Laboratories representative completed an audit of all residents' medical records on December 9, 2011</p> <p>·NICL Laboratories representative will complete a second audit of all residents' medical records by December 29, 2011</p> <p>·Any labs found to be out of compliance will have physician notified and orders will be obtained to rectify any possible omissions.</p>				

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			<p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <p>Licensed staff received re-education on transcription/computer input of physicians orders and order follow through including the completion of lab requisitions.</p> <p>The lab tracking process has been re-evaluated and implemented. This process includes:</p> <ul style="list-style-type: none"> · Use of the Lab Tracking Form . This form will be used by each Unit Manger or a member of the Nurse Management team to review all orders for labs and will include documentation of date lab was ordered, date lab completed, date lab results received by facility and date physician was notified of lab results. · This will be an ongoing process to ensure that follow through for all labs including notification of physicians is completed. 		

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			<p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</i></p> <p>·The audit tool, "Lab Tracking form" will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <p>·Following the 3 month review by QA, the Director of Nursing/ designee will continue monitoring this process weekly as an ongoing program. If any issues begin to surface, the information will again be brought to the monthly QA meeting.</p> <p>·The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance</p> <p>Compliance Date: December 30, 2011</p>		

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F0314 SS=D	<p>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.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure residents with pressure ulcers received the appropriate treatment to promote healing for 2 of 3 residents reviewed for pressure ulcers in the sample of 4. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. On 11/30/11 at 11:00 a.m., Resident #C was observed in bed. At that time, LPN #2 was performing a pressure ulcer treatment to the resident's bilateral lower legs. When the LPN had finished, Physical Therapist #1 entered the room to perform the wound treatment to the resident's coccyx area. The resident was rolled onto to his right side and his incontinent brief was removed. The resident's coccyx, and right and left buttock areas were open. The pressure ulcers were observed with yellow slough and red granulation tissue. There was a moderate amount of bright red blood</p>	F0314	<p>F314</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> ·Resident # C's physician's orders regarding treatments were reviewed and updated as needed. ·Resident # B has been discharged from the facility. <p><i>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</i></p> <ul style="list-style-type: none"> ·Residents who have documented skin issues have the potential to be affected by the alleged deficient practice. ·Residents with documented 	12/30/2011	

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	<p>observed oozing from the wounds. Interview with the D-Wing Unit Manager at the time, indicated the resident was readmitted to the facility on 11/8/11 with all of those pressure ulcers.</p> <p>The Physical Therapist indicated at the time, that the therapy department performed the treatment five times a week, Monday through Friday, and the Nursing staff were to do the treatments on the weekends. The Physical Therapist indicated he had also been performing sharp debridement of the coccyx wound at each of the dressing changes. The Physical Therapist then washed the wound with wound cleanser and patted them dry. He then removed a scalpel and performed some sharp debridement on the coccyx wound. The coccyx wound was observed with yellow slough. The left buttock was also observed with yellow slough. After debriding the coccyx wound, the Therapist applied Santyl (a debriding ointment) onto a gauze sponge and applied the Santyl to the wound base on the coccyx area only. He then covered the areas with a self adhesive dressing, in which the adhesive edges were actually touching some of the pressure ulcers. He then placed a smaller self adhesive dressing to the left buttock pressure ulcer. The Physical Therapist did not put the Santyl ointment on any of the other</p>		<p>skin issues will be assessed and have their medical records reviewed to assure that physician's orders are being followed and interventions are being implemented.</p> <p>·The Physical Therapist who was sighted for deficient practice was observed performing wound care by the Therapy District Manager following the guidelines of the Clean Dressing Change Audit</p> <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <p>·All therapy staff have been re-educated on implementation and following of physicians orders, care of pressure ulcers and clean dressing change protocols.</p> <p>·The Physical Therapist who was sighted for deficient practice will be audited for performance once monthly for next 2 months or until practice is satisfactory. This audited/observation will be completed by the Rehab Program Director and will be documented using the Clean Dressing Change Audit.</p>		

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	<p>pressure ulcers. They were covered with the dry dressing.</p> <p>Interview with the Physical Therapist at that time, indicated he has been only applying the Santyl ointment onto the coccyx wound and not to any of the other wounds. The Physical Therapist did not have the treatment record with him at the time of the dressing changes.</p> <p>Interview with the D-Wing Unit Manager at that time, indicated she was not aware of what the resident's treatments were.</p> <p>The record for Resident #C was reviewed on 11/30/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, renal insufficiency and renal failure, diabetes, stroke and dementia.</p> <p>Review of Physician Orders dated 11/9/11, indicated left and right buttocks cleanse with normal saline and apply Santyl ointment, cover with alldress daily. Cleanse the coccyx pressure ulcer with normal saline and apply Santyl ointment to the wound base, cover with alldress daily.</p> <p>Review of Physician Orders dated 11/18/11, indicated Physical Therapy for debridement buttocks ulcer for non</p>		<p>·Nursing staff have been re-educated on the necessity for providing preventive interventions and following treatments as ordered by physician. along with transcription and inputting into computer of physicians orders.</p> <p>·All newly admitted residents and resident's with new physicians orders will be reviewed by each Unit Manger or a member of Nurse Management team using the facility guidelines. This review will include: 1 Printing all new orders report 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the administration record or treatment record to assure the order has been carried over correctly. 4 Verify that medication has arrived.</p> <p>·The Wound Nurse and/or each Unit Manager or a member of the Nursing Management team will monitor the Treatment Records of residents with documented skin issues to verify that treatment orders are being completed as ordered.</p> <p>How will the corrective</p>		

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	<p>healing wound five times a week times eight weeks.</p> <p>Review of the Wound Evaluation Flow Sheet indicated the right buttock pressure ulcer was measured on 11/8/11 at a stage two, partial loss of dermis, and was 3.5 centimeters (cm) by 2.8 cm by .1 cm. The wound was measured weekly and the last recorded measurement was on 11/29/11 which indicated the open area was a stage two and measured 2 cm by 3.5 cm by .3 cm was 80% red and had 20% yellow slough.</p> <p>Review of the left buttock Wound Evaluation Flow Sheet indicated the wound was first seen on 11/8/11 in which it measured 4.3 cm by 2.7 cm by .1 cm. The wound had 20% yellow slough and was 80% red granulation tissue. The pressure ulcer was measured on 11/30/11 in which it measured 3 cm by 1.3 cm by .3 cm. The area was still a stage three, full tissue thickness loss, however, there was 60% yellow slough and 40% red granulation tissue.</p> <p>Review of the coccyx Wound Evaluation Flow Sheet indicated the wound was first seen on 11/8/11 and it measured 2.8 cm by 1 cm by .1 cm. The pressure ulcer was 90% pink and had 10% yellow slough. The wound was measured on 11/30/11 at</p>		<p>action(s) be monitored to ensure that alleged deficient practice will not recur, i.e.. what quality assurance program will be put in place?</p> <p>·The Physical Therapist who was sighted for deficient practice will be audited for performance once monthly for next 2 months or until practice is satisfactory. This audited/observation will be completed by the Rehab Program Director and will be documented using the Clean Dressing Change Audit. The result of this audit will be reported to the monthly Quality Assurance Committee.</p> <p>·The audit form " Daily Start Up Change of Condition/ Physicians Order Audit", will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <p>·Following the 3 month review by QA, the Director of Nursing/ designee will continue monitoring this process weekly as an ongoing program. If any issues begin to surface, the information will again be brought to the monthly QA meeting.</p>		

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	<p>4.9 cm by 1.8 cm by .3 cm at a stage three. The pressure ulcer was 80% red and 20% yellow slough.</p> <p>Interview with D-Wing Unit Manager on 11/30/11 at 3:20 p.m., indicated the Santyl ointment was to be used for all of the ulcers on his right and left buttock and coccyx areas.</p> <p>2. The record for Resident #B was reviewed on 11/30/11 at 1:00 p.m. The resident had diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease and Alzheimer's disease.</p> <p>An entry in the Progress Notes titled "Change of Condition" and dated 10/18/11 at 2:09 p.m., was reviewed. It indicated, "Writer called into to room by assigned CNA (Certified Nursing Assistant) to observe 3 abrasions to buttocks . . . res (resident) met in bed. Alert to staff only. Severe cognitive impairment r/t (related to) dx (diagnosis) . . . MD (physician) notified and new order for Calmo q (every) shift and after each incon (incontinent) episode."</p> <p>Review of the investigative report that was dated 10/18/11 at 1:15 p.m., indicated in the section that was titled, "Provide a</p>		<p>The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance.</p> <p>Compliance Date: December 30, 2011</p>		

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	<p>detailed description of event/allegation," three abrasions noted to bilateral buttocks, resident in bed at the time areas where observed. There was a hand written entry in the section that indicated, "Areas not abrasions. D/T (due to) moisture/pressure."</p> <p>The Wound Evaluation Flow Sheets were reviewed. Entries dated 10/18/11, indicated the measurements of the wounds. The measurement for the wound on the left buttock was 3.8 x 1.9 cm (centimeters) with a depth of less than 0.1 cm, there was no stage of the wound indicated. The measurement of the wound on the right upper buttocks was 1.3 x .9 cm in size with a depth of less than 0.1 cm, there was no stage of the wound indicated. The measurement of the wound on the right lower buttocks was .6 x .3 cm in size with a depth of less than 0.1 cm there was no stage of the wound indicated. The forms indicated the current treatment for the three wounds was Calmo every shift.</p> <p>The next entries dated 10/25/11, indicated the three areas were recorded as stage 2 pressure ulcers, with a partial thickness loss of dermis. It also indicated the current treatment to the three areas was Aquacel and Duoderm.</p>				

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F0323 SS=G	<p>There was a Physician's Order dated 10/20/11, that indicated a treatment to the resident's buttocks/coccyx. It indicated, "Cleanse area to buttocks/coccyx with NS (normal saline). Pat dry with gauze. Apply skin prep to periwound area. Apply Aquacel to wound base and cover with Duoderm q (every) 3 days and PRN (as needed)."</p> <p>Review of the October 2011 Treatment Administration Record indicated the treatment of Aquacel and Duoderm to the three pressure ulcers was not completed as ordered by the physician.</p> <p>Interview with the 200 Unit Manager on 12/1/11 at 9:45 a.m., indicated the treatment for the 3 pressure areas on the resident's buttocks was not completed as ordered by the physician.</p> <p>This Federal tag relates to Complaint #IN00100422.</p> <p>3.1-40(a)(2)</p> <p>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.</p> <p>Based on record review and interviews, the facility failed to ensure each resident</p>	F0323	F 323	12/30/2011	

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	<p>remained free from accidents related to a transfer using a mechanical lift with only one staff member in which the resident sustained a fracture for 1 of 3 residents reviewed for a significant change in status in the sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 12/1/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, Alzheimers disease and altered mental status.</p> <p>Review of Nursing Progress Notes dated 11/15/11 at 10:40 p.m., indicated "CNA was in resident's room attempting to transfer and clean resident. CNA heard resident's arm crack. Once assessed, resident was guarding left arm and not allowing to be touched...." The resident's physician was notified and new order to send the resident to the hospital for an evaluation was obtained. The incident happened at 4:30 p.m. The resident was sent back to the facility at 11:25 p.m., with a left humeral head fracture and her arm was placed in a sling.</p> <p>Review of the Facility Incident Reporting Form dated 11/15/11 at 4:30 p.m., indicated the CNA was preparing the resident for the sit to stand lift. The</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> ·Resident #D was re-evaluated for lift usage, assessed and care plan updated as applicable. ·At time of said incident, the staff member who was sighted for the deficient practice was immediately suspended and disciplinary action was taken which included termination. ·Nursing staff were re-educated at that time on the policy and procedure for use of mechanical lifts and reinforced that failure to follow the P&P would lead to disciplinary action up to and including termination . (No incident of failure to follow P&P has been noted since this education 10/11) <p>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</p> <p>All residents who must rely on a</p>		

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	<p>resident was positioned appropriately in the lift and secured. The CNA initiated incontinent care while the resident was in the standing position. The resident moved left arm from self support position and CNA noticed left arm was not secured by grasp to the lift. The resident changed her vocalization as if in pain and the CNA placed the resident back in the wheelchair. Upon observation the resident was not moving her left arm. The resident was sent to the hospital for further evaluation where she was diagnosed with a left humeral head fracture.</p> <p>Review of the CNA's witness statement of the actual events of the incident indicated at 4:15 p.m., the CNA prepared to provide incontinent care at the time of the transfer, so he placed a new brief, pants and wipes close by so they would be available. The CNA then indicated he placed the lift in front of himself and locked it because the resident had pushed it away. The CNA indicated he made sure the resident's arms were above and on the pads. The CNA indicated the resident had her arms on top and were holding onto the bars. The CNA then indicated he clipped her in, lifted her up with the lift, holding the lift in the right way and she raised her left arm in the middle of the brace, and her arm was all the way out. The CNA then got in back of her and was putting on her brief. At</p>		<p>mechanical lift for transfers have the potential to be affected by the same alleged deficient practice</p> <ul style="list-style-type: none"> ·Residents using the mechanical lift for transfer were re-evaluated for appropriateness. Care plans were reviewed and updated as needed to ensure interventions were correct. ·New admissions will be assessed at time of admit for usage of appropriate lift and care plans will be initiated as appropriate. <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·Nursing staff have been re-educated on the Policy and Procedure for the use of mechanical lifts which included that 2 staff are required for transfers. ·A successful return demonstration of proper use of mechanical lift was completed for each staff member. ·Nursing staff members were also re-educated on the consequences of not following facility policy and procedure for mechanical lifts which includes disciplinary action up to and 				

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	<p>that time, he heard a cracking sound. The resident then began singing and started saying "yoi, yoi, yoi." The CNA then put her back down to the wheelchair and noticed she could not move her left arm and that it just seemed to hang there. Further review of the CNA's witness statement indicated "I knew it required two people but I went to look for somebody, went down hall, while she was in wheelchair, went to go look for somebody, I have to get my work done, so I then did it by myself." The CNA's witness statement further indicated "I was told by (name) Staff Development Nurse while I was still doing my paperwork to get hired that all lifts had to have two aides. I was told by (name) CNA Mentor there always had to be two people for lifts. Yes, I've done this in the past but always made sure people were safe."</p> <p>Review of the current Policy for the Sit to Stand and Hoyer lifts provided by the Staff Development Nurse on 12/2/11, indicated "The policy for use of the Sit to Stand and Hoyer lifts requires a minimum of two licensed or Certified Care Providers to be present at all times during the lift and transfer process."</p> <p>Interview with the Staff Development Nurse on 12/1/11 at 10:30 a.m., indicated the CNA was supposed to get another</p>		<p>including termination.</p> <p>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <ul style="list-style-type: none"> · 5 staff members will have observation/audit of transfers completed each week for 4 weeks. The staff members will be chosen from the C wing and D wing and will be selected from 1st and 2nd shift. A member of Nursing Management will complete the observation/ audit. ·3 staff member will have observation/audit completed each week for the following 4 weeks. The staff member will be chosen from the C wing and D wing and will be from 1st and 2nd shift. A member of Nursing Management will complete the observation/ audit. ·Certified Nursing Assistants will have lift competencies completed on hire and annually. ·Review of Mechanical Lift Use policy and procedure will be completed quarterly. ·Any staff member found (at any time) to not follow the appropriate policy and procedure for use of mechanical lifts, will have progressive disciplinary 				

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F0333 SS=D	<p>CNA or Nurse to assist him with the transfer using the Sit to Stand lift. She further indicated the CNA was terminated for not properly transferring the resident with the Sit to Stand lift.</p> <p>3.1-45(a)(2)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors related to not administering an anti-seizure medication as ordered by the physician for 1 of 4 residents reviewed for following physician orders in a sample of 4. (Resident #E)</p> <p>Findings include.</p> <p>The record for Resident #E was reviewed on 11/30/11 at 10:35 a.m. The resident had diagnoses that included, but were not limited to, diabetes, seizure disorder,</p>	F0333	<p>action taken up to and including termination.</p> <ul style="list-style-type: none"> The lift transfer audits will be reviewed monthly by the Quality Assurance Committee. Audits will be continued until Committee verifies that the process is in compliance. The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance. <p>Compliance Date: December 30, 2011</p> <p>F333</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>Resident #E's physician was notified on 11/26/11 that medication was not available.</p> <p>q <i>How will you identify other resident(s) having the</i></p>	12/30/2011	

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	<p>subdural hematoma and hypertension. The resident was admitted to the facility on 11/23/11.</p> <p>The admission physician orders were reviewed. There was an order for Vimpat 100 mg (an anti-seizure medication) to be administered to the resident two times per day. The medication was to start on 11/24/11. Review of the November 2011 MAR (Medication Administration Record) indicated the resident did not receive the Vimpat on 11/24/11, 11/25/11, 11/26/11 and 11/27/11. There was notation written on the MAR dated 11/25/11 at 9:00 a.m. that indicated the Vimpat was not available, awaiting prescription. Another notation dated 11/26/11 indicated Vimpat not available need prescription, notified physician.</p> <p>The Progress Note dated 11/26/11 at 12:58 p.m., indicated that the resident's medication, Vimpat, was not available. The pharmacy was notified and the pharmacy indicated that a prescription must be written by the physician. The resident's physician was notified at that time.</p> <p>The resident did not receive the anti-seizure medication, Vimpat, until 11/28/11 at 9 a.m.</p>		<p><i>potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</i></p> <p>All residents newly admitted to the facility and residents receiving new medication/treatment orders have the potential to be affected by the alleged deficient practice.</p> <p>·All newly admitted residents and residents with new physicians orders will be reviewed per the facility guidelines using the "Daily Start Up Change of Condition/ Physicians Order Audit" form. This review will include: 1 Printing all new orders report 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the administration record or treatment record to assure the order has been carried over correctly. 4 Verify that medication has arrived.</p> <p>·Any resident found to not have medication available will have physician notified if unable to obtain medications within 24 hours of initial order.</p>				

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	<p>Interview with the Interim 200 Unit Manager on 11/30/11 at 2:15 p.m. indicated the resident did not receive the anti-seizure medication as ordered by the physician.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>		<p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·Licensed staff received re-education on transcription/computer input of physicians orders and order follow through including verifying medication availability, notification of physician for meds that are not available with in 24 hours of initial order. ·The monitoring of new admissions orders and new physicians orders has been re-evaluated and process implemented. ·All newly admitted residents and resident's with new physicians orders will be reviewed by each Unit Manger or a member of Nurse Management team per the facility guidelines using the "Daily Start Up Change of Condition/ Physicians Order Audit" form. This review will include: 1 Printing all new orders report 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the 		

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			<p>administration record or treatment record to assure the order has been carried over correctly. 4 Verify that medication has arrived.</p> <ul style="list-style-type: none"> Any resident found to not have medication available will have physician notified if unable to obtain medications within 24 hours of initial order. This will be an ongoing process to ensure that physician's orders are completed and that physician is notified if medication is not able to be obtained timely; <p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</i></p> <ul style="list-style-type: none"> The audit forms, "Daily Start Up Change of Condition/ Physicians Order Audit", will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then 		

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F0505 SS=D	<p>The facility must promptly notify the attending physician of the findings.</p> <p>Based on record review and interviews, the facility failed to promptly notify the resident's physician of STAT (immediate) labs related to a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP) for 1 of 4 residents reviewed for labs in the sample of 4. (Resident #C)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 11/30/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, renal insufficiency and renal failure. Review of a Laboratory Requisition dated 11/12/11, indicated a STAT CBC and CMP was to be drawn for the resident.</p> <p>Review of the lab results for the STAT CBC and CMP dated 11/12/11, indicated the results were faxed to the facility on</p>	F0505	<p>quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <p>The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance.</p> <p>Compliance Date: December 30, 2011</p> <p>F505</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>Resident# C's physician was notified on 11/17/11 of results for CBC and CMP.</p> <p><i>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective4 action will be taken?</i></p> <p>All residents with physician's</p>	12/30/2011	

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	<p>11/12/11 at 2:52 p.m. The resident's potassium level was 5.5, a high level (3.5-5.3 was normal). The resident's Blood Urea Nitrogen (BUN) was 32, a high level (9-20 was normal). The resident's sodium level was 135, a low level (137-145 was normal). At the bottom of the lab results it indicated "11/12 at 5:30 p.m., Physician (name) taking calls for Physician (name) not at home. Paged times two, awaiting call back."</p> <p>Review of Nursing Progress Notes dated 11/13-11/16/11, indicated there was no documentation indicating the resident's physician was notified of the abnormal labs.</p> <p>Review of the CMP results dated 11/16/11 which were reported to the facility at 2:33 p.m., on 11/16/11 indicated the resident's potassium was 5.9, a high level, the BUN was 62, a high level, and his sodium was 130, a low level. At the bottom of the lab result page, it indicated "11/16/11 physician paged, awaiting for return call."</p> <p>Review of Nursing Progress Notes dated 11/16/11, indicated there was no documentation regarding physician notification of the abnormal labs.</p>		<p>orders for labs have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> ·NICL Laboratories representative has completed an audit of all residents' medical records on December 9, 2011 ·NCL Laboratories representative will complete a second audit of all residents' medical records by Dec 29, 2011 ·Any labs found to be out of compliance will have physician notified and orders will be obtained to rectify any possible omissions. <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·Licensed staff received re-education on Notification of Physician for any resident lab results or inability to obtain lab results for labs ordered. <p>The lab tracking process has been re-evaluated and re-implemented. This process includes:</p> <ul style="list-style-type: none"> ·Use of the "Lab Tracking 		

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	<p>Nursing Progress Notes dated 11/17/11 at 3:32 a.m., indicated the resident's Physician was notified of the elevated potassium level and new orders to send the resident to the hospital were obtained. The resident was sent back to the facility at 7:30 a.m., on 11/17/11 with new orders to increase his PEG tube water flushes to 300 cubic centimeters four times a day.</p> <p>Interview with the D-Wing Unit Manager on 11/30/11 at 3:20 p.m., indicated the resident's physician should have been notified immediately of the STAT labs on 11/12/11.</p> <p>This Federal tag relates to Complaint Number IN00100422.</p> <p>3.1-49(f)(2)</p>		<p>Form". This form will be used by each Unit Manger or a member of Nurse Management team to review all orders for labs and will include documentation of date lab was ordered, date lab completed, date lab results received by facility and date physician was notified of lab results.</p> <p>·This will be an ongoing process to ensure that follow through for all labs including notification of physicians is completed.</p> <p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e.. what quality assurance program will be put in place?</i></p> <p>·The audit form, "Lab Tracking Form" will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <p>·Following the 3 month review by QA, the Director of Nursing/ designee will be monitoring this process weekly as an ongoing</p>		

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F0507 SS=D	<p>The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>Based on record review and interview, the facility failed to ensure the laboratory results for a Complete Blood Count were filed in the resident's record for 1 of 4 residents reviewed for labs in a sample of 4. (Resident #E)</p> <p>Findings include:</p> <p>The record for Resident #E was reviewed on 11/30/11 at 10:35 a.m. The resident had diagnoses that included, but were not limited to, diabetes, seizure disorder, subdural hematoma and hypertension. The resident was admitted to the facility on 11/23/11.</p> <p>There was a laboratory report of a CBC (Complete Blood Count) in the resident's</p>	F0507	<p>program. If any issues begin to surface, the information will again be brought to the monthly QA meeting.</p> <p>The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance.</p> <p>Compliance Date: December 30, 2011</p> <p>F507</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>Resident #E lab results were obtained from NICL Laboratories and were place in the appropriate area of the residents medical record.</p> <p><i>How will you identify other resident(s) having the potential to be affected by the same alleged deficient</i></p>	12/30/2011	

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	<p>record that was dated 11/25/11. The report indicated the resident's white blood cell count was 22.12 (High). The reference range was 4.80 - 10.80. The physician was notified of the result and ordered a CBC to be drawn on 11/28/11.</p> <p>Review of the lab reports indicated there was no report of a CBC for 11/28/11. Review of the laboratory request form indicated the blood specimen was obtained by the lab technician on 11/28/11. The technician's initials were on the request form and indicated the specimen was collected at 4:50 a.m.</p> <p>Interview with LPN #1 on 12/1/11 at 10:05 a.m., indicated there were no results for the CBC obtained on 11/28/11. She indicated the lab request form indicated the blood was drawn by the technician. The laboratory was notified on 11/30/11 and again on 12/1/11 and the results for the CBC were requested. She indicated the laboratory had not provided results of the CBC that was drawn on 11/28/11.</p> <p>This Federal tag relates to Complaint #IN00100422.</p> <p>3.1-49(f)(4)</p>		<p><i>practice and what corrective action will be taken?</i></p> <p>All residents with physician's orders for labs have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> ·NICL Laboratories representative has completed an audit of all residents' medical records on December 9, 2011 ·NCL Laboratories representative will complete a second audit of all residents' medical records by Dec 29, 2011 ·Any medical record found with omissions will have situation corrected. <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·Licensed staff received re-education on Notification of Physician for any resident with lab results or inability to obtain lab results for labs ordered. The lab tracking process has been re-evaluated and re-implemented. This process includes: 		

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			<p>·Use of the "Lab Tracking Form". This form will be used by each Unit Manger or a member of Nurse Management team to review all orders for labs and will include documentation of date lab was ordered, date lab completed, date lab results received by facility and date physician was notified of lab results.</p> <p>·This will be an ongoing process to ensure that follow through for all labs including verification of lab results in the resident's medical record.</p> <p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e.. what quality assurance program will be put in place?</i></p> <p>·The audit form, "Lab Tracking Form" will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance.</p> <p>·Following the 3 month review by QA, the Director of Nursing/ designee will be monitoring this</p>		

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interviews, the facility failed to ensure the resident's clinical records were complete and accurate related to the treatment of the pressure ulcers for 1 of 3 residents reviewed for pressure ulcers in the sample of 4. (Resident #C)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 11/30/11 at 10:45 a.m. Review of Physician Orders dated 11/8/11, indicated</p>	F0514	<p>process weekly as an ongoing program. If any issues begin to surface, the information will again be brought to the monthly QA meeting.</p> <p>The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance.</p> <p>Compliance Date: December 30, 2011</p> <p>F514 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident # C's orders regarding treatments were reviewed and updated as needed. How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Residents who have documented skin issues have the potential to be affected by the</p>	12/30/2011	

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	<p>to cleanse the left and right buttock wounds with normal saline and apply Santyl ointment daily and cover with an alldress dressing.</p> <p>Review of Physician Orders dated 11/18/11, indicated Physical Therapy was to perform sharp debridement to the non healing buttocks wounds five times a week times eight weeks.</p> <p>Review of the Treatment Administration Record (TAR) indicated on 11/10, 11/11, 11/14, 11/15, and 11/16/11 the word "therapy" was filled in on those days for the treatment of the left buttock pressure ulcer, indicating therapy had completed the treatment. Further review of the TAR indicated the right buttock treatment had not been signed out as being completed on 11/12, and 11/13/11.</p> <p>Interview with the D-Wing Unit Manager on 11/30/11 at 3:20 p.m., indicated physical therapy for sharp debridement of the resident's pressure ulcers did not begin until 11/21/11.</p> <p>3.1-50(a)(2)</p>		<p>alleged deficient practice.</p> <ul style="list-style-type: none"> ·Residents with documented skin issues will be assessed and have their medical records reviewed to assure that physician's orders are being followed and interventions are being implemented. <p><i>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·Nursing staff have been re-educated on the necessity for providing preventive interventions and following treatments as ordered by physician. along with transcription and inputting into computer of physicians orders. ·All therapy staff have been re-educated on implementation and following of physicians orders, care of pressure ulcers and clean dressing change protocols. ·All newly admitted residents and resident's with new physicians orders will be reviewed by each Unit Manger or a member of Nurse Management team using the facility guidelines. This review will include: 1 Printing all new orders report. · 2. Comparing the new order report with the physicians order sheet in the medical record for those with new orders. 3. Check the administration record or treatment record to assure the order has been carried over 		

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			<p>correctly. 4 Verify that medication has arrived.</p> <ul style="list-style-type: none"> ·The Wound Nurse and/or each Unit Manager or a member of the Nursing Management team will monitor the Treatment Records of residents with documented skin issues to verify that treatment orders are being completed as ordered. <p><i>How will the corrective action(s) be monitored to ensure that alleged deficient practice will not recur, i.e.. what quality assurance program will be put in place?</i></p> <ul style="list-style-type: none"> ·The audit forms " Daily Start Up Change of Condition/ Physicians Order Audit", will be reviewed monthly at the Quality Assurance meeting. The data will be analyzed for patterns and trends and action plans will be written and implemented as needed. This will be completed monthly times 3 months and then quarterly if the Quality Assurance Committee agrees that the process is in compliance. ·Following the 3 month review by QA, the Director of Nursing/ designee will continue monitoring this process weekly as an ongoing program. If any issues begin to surface, the information will again be brought to the monthly QA meeting. ·The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance <p>Compliance Date: December</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2012

FORM APPROVED

OMB NO. 0938-0391

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