

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-INDIAN CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 240 BEECHMONT DRIVE CORYDON, IN47112
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: May 16, 17, 18, 19, 2011</p> <p>Facility number: 000206 Provider number: 155312 AIM number: 100284940</p> <p>Survey team: Donna Groan, RN, TC Avona Connell, RN May 17, 19, 2011 Gloria Reisert, MSW Dorothy Navetta, RN</p> <p>Census bed type: SNF/NF: 127 Total: 127</p> <p>Census Payor Type: Medicare: 24 Medicaid: 64 Other: 39 Total: 127</p> <p>Sample: 24 Supplemental Sample: 21</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</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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	Quality review completed 5-24-11 Cathy Emswiller RN				

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F0157 SS=E	<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>A. Based on record review, observation and interview, the facility failed to notify the physician to obtain a physician's order to self-administer nebulizer treatments for 5 of 6 residents reviewed for self-administration of medications in a sample of 24 residents (Residents #100, #112, #118, #57, #55) and 1 of 1</p>	F0157	<p>F157</p> <p>1) Resident #100, #112, #118, #57, #55 were reassessed for self-administration of mini-nebulizers. Physician notified and orders written.</p> <p>Resident #64 family was notified of dentist's recommendation and family</p>	06/10/2011			

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	<p>resident in a supplemental sample of 21. (Resident #17) This deficient practice had the potential to effect 20 additional residents identified by the Director of Nursing as self-administering medication. (Resident #96, 36, 75, 79, 104, 114, 115, 120, 99, 101, 2, 5, 19, 26, 30, 33, 36, 37, 53, 60)</p> <p>B. Based on record review and interview, the facility failed to notify the resident's family for 1 of 5 residents reviewed for oral status in a sample of 24 residents when the consultant dentist made a recommendation for the resident to be evaluated by an oral surgeon. (Resident #64)</p> <p>C. Based on record review and interview, the facility failed to ensure the physician was notified of a resident declining hospice care for 1 of 2 hospice residents reviewed in a sample of 24. (Resident #93)</p> <p>Findings include:</p> <p>A. 1. Review of the clinical record for Resident#100 on 5/16/2011 at 11:05 a.m., indicated the resident was admitted on 4/14/2011 and had diagnoses which included, but were not limited to, rheumatoid arthritis, chronic pain, and chronic obstructive pulmonary disease.</p>		<p>declined surgery.</p> <p>For resident #93, physician was notified of resident declining hospice care.</p> <p>2) Reviewed records of residents with self-administration medication. Updated assessments, physicians notified and orders written as needed.</p> <p>Audited all current resident records for evidence of dental recommendations and notification to family and physician.</p> <p>Reviewed documentation of all residents with referrals to hospice for accurate documentation of referral outcome.</p> <p>3) Nursing was inserviced on self-administration of mini-nebulizers, physician orders and need for resident signature when they request to self-administer mini-nebulizers.</p> <p>Director of Nursing Services, or designee, will review all dental consults for orders and provide appropriate follow-up.</p> <p>Social Service Director, or designee, will monitor all hospice orders for</p>		

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	<p>The hospital discharge orders included, but were not limited to, "Duoneb Nebulizer Inhalation Four Times Daily PRN [as needed] for SOA [shortness of air]/wheezing." On 5/2/2011, the orders were changed to: Duoneb Mini Neb 2 times a day for SOA and then later in the day to: Duo Mini-Neb Treatment Q [every] 8 hours for SOA.</p> <p>On 4/30/2011, a care plan was written for the resident to be able to self-administer her own respiratory treatment after the nurse set them up. Documentation was lacking of the physician having been notified to obtain an order for the resident to self-administer her medication/neb treatments until 5/18/2011 when it was brought to the DoN's attention at 2:20 p.m.</p> <p>A. 2. Review of the clinical record for Resident #112 on 5/18/2011 at 12:55 p.m., indicated the resident had diagnoses which included, but was not limited to, dementia with behavior disturbance, status post upper respiratory infection.</p> <p>On 4/18/2011, the resident received a new physician order for Albuterol (a bronco dilator for the lungs) - nebulizer inhalation every 4 hours PRN for SOA.</p>		<p>follow up charting.</p> <p>4) The Director of Nursing Services or designee will review physicians' orders and self-administration assessments for accurate documentation. Audits will be daily x 2 weeks, weekly x 4 weeks, and monthly x 3 months.</p> <p>The Director of Nursing Services or designee will review all dental consults to ensure all recommendations are addressed timely. Results will be reviewed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter.</p> <p>SSD, or designee, will log all hospice referrals to confirm proper documentation and follow up. E.D., or designee, will review log weekly for accuracy.</p> <p>All results of will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed.</p>		

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	<p>Review of the April MAR indicated the resident received the Neb treatment routinely.</p> <p>On 5/17/2011 at 4:20 p.m., the DoN presented a list of residents who self-administered their respiratory treatments. Resident #112 was among those listed.</p> <p>Documentation was lacking of the physician having been notified to obtain an order for the resident to self-administer her medication/neb treatments until 5/18/2011 when it was brought to the DoN's attention at 2:20 p.m.</p> <p>During an interview on 5/19/2011 at 12:30 p.m., the Director of Nursing indicated she did not realize she needed to obtain an order for the residents to self-administer their respiratory treatments.</p> <p>A. 3. The clinical record for resident #118 was reviewed on 5/17/11 at 11:03 a.m. The resident diagnoses included, but were not limited to: end stage renal disease, dialysis and chronic airway obstruction. An Assessment for Self-Administration of Medications dated 4/20/11 included, but was not limited to: "INSTRUCTIONS: Before performing this assessment, verify that there is a</p>				

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	<p>physician order in the resident's chart for self-administration of the specific medication under consideration and that the resident has signed the appropriate document(s) stating the desire to self-administer his/her own medication. Proceed by checking the appropriate response below for each of the 19 items listed. The resident must be able to perform each step indicated below prior to beginning self-administration of medications. The Interdisciplinary team will be responsible for approving self-medication using this assessment as a guide. Checked #18 can administer inhalant medications with proper procedure fully capable." Documentation was lacking of a physician order and lack of a signature the resident requested to self-administer the inhalant.</p> <p>On 5/17/11 at 11:03 a.m., the most recent MDS (Minimum Data Set) initial review, dated 4/27/11 indicated the resident was cognitively intact and made their own decisions.</p> <p>A. 4. The clinical record for resident #57 was reviewed on 5/18/11 at 11:50 a.m. The resident diagnoses included, but were not limited to: Alzheimer's and dementia. An Assessment for Self-Administration of Medications dated 4/13/11 indicated the following: "#18 Can administer inhalant medications with proper procedure and checked Able with Assist." Documentation was</p>				

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	<p>lacking of a physician order.</p> <p>On 5/18/11 at 11:50 a.m. the most recent MDS quarterly, dated 4/13/11, indicated the resident was cognitively impaired for decision making.</p> <p>A. 5. The clinical record for Resident # 17 was reviewed on 5/17/11 at 12 p.m. The resident had diagnoses including, but not limited to: malignant neoplasm bronchial/lung, dementia with behavior disturbance, hypertension, chronic bronchitis.</p> <p>During the medication pass observation on 5/17/11 between 11 a.m. and 11:25 a.m., LPN # 2 was observed to place Atrovent (bronchodilator) 0.02% into the nebulizer, placed the mask on the resident, turned the nebulizer on and left the room. Physician orders reviewed at 11:45 a.m., lacked an order to self administer the mini nebulizer treatment. On 5/18/11 at 11:00 a.m. a telephone order was obtained from the physician which indicated "may self administer mini nebs per IDT (Interdisciplinary Team) assessment".</p> <p>A. 6. The clinical record for Resident #55 was reviewed on 5/17/11 at 3:15 p.m. Resident #55 had diagnoses including, but not limited to: hypertension, chronic obstructive pulmonary disorder, schizophrenia, Alzheimer's, congestive</p>						

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	<p>heart disease, depressing disorders.</p> <p>Resident # 55 was able to self-administer medication according to care plan updates on 4/30/11 indicating "res. will safely admin resp meds when nurse dispenses meds and turns on machine & off". Documentation of physician order to self medicate was lacking and record review of history and physical indicated on 4/8/11 the physician documented "patient does not communicate with me".</p> <p>On 5/19/11 at 9:10 a.m. D.O.N. provided an updated residents self administration record which indicated that resident #55 was no longer able to self medicate. The list included residents identified by the Director of Nursing as self-administering medication. (Resident #96, 36, 75, 79, 104, 114, 115, 120, 99, 101, 2, 5, 19, 26, 30, 33, 36, 37, 53, 60)</p> <p>B 1. Review of the clinical record for Resident #64 on 5/17/2011 at 1:55 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia, muscle disorder, and anxiety state.</p> <p>On 4/15/2011, the consultant dentist made a recommendation for: "Referral to Oral Surgeon; Please evaluate for extractions according to finances." Review of the nursing notes between 4/15 and 5/17/2011 failed to locate documentation of the referral having been made for the oral surgeon.</p> <p>During an interview with Social Worker #2 on</p>				

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	<p>5/17/2011 at 3:13 p.m., she indicated nursing was responsible for contacting the resident's family to determine what they wanted to do and then for making the referral if needed.</p> <p>On 5/19/2011 at 9:13 a.m., the Director of Nursing presented a copy of a nursing note to indicate nursing had contacted the family this morning to determine what they would like to do about the dentist's recommendation for the resident to be seen by an Oral Surgeon.</p> <p>C. The clinical record for Resident #93 was reviewed on 5/17/11 at 1:40 p.m. The resident diagnoses included, but were not limited to: paraplegia and cancer of the spine. A physician telephone order dated 5/2/11 indicated "Hospice Consult".</p> <p>In interview with Social Worker #2 on 5/17/11 at 3:05 p.m., she indicated the resident refused hospice care at this time.</p> <p>Documentation was lacking of the physician being notified of the resident declining hospice care.</p> <p>3.1-5(a)(3)</p>						
F0176 SS=E	<p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on record review, observation and</p>	F0176	F176			06/10/2011	

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	<p>interview the facility failed to ensure residents who self administered a mini-nebulizer (a device to administer medication to assist in breathing) treatment requested to do so and failed to obtain a physician order for 5 of 7 residents reviewed for self-medication in a sample of 24 (Resident #118, #57, #100, #112, #55) and 1 of 1 resident in a supplemental sample of 21 reviewed for self-administration of medication. (Resident #17). This deficient practice had the potential to effect 20 additional residents identified by the Director of Nursing as self-administering medication. (Resident #96, 36, 75, 79, 104, 114, 115, 120, 99, 101, 2, 5, 19, 26, 30, 33, 36, 37, 53, 60)</p> <p>Findings include:</p> <p>1. The clinical record for resident #118 was reviewed on 5/17/11 at 11:03 a.m. The resident diagnoses included, but were not limited to: end stage renal disease, dialysis and chronic airway obstruction. An Assessment for Self-Administration of Medications dated 4/20/11 included, but was not limited to:</p> <p>"INSTRUCTIONS: Before performing this assessment, verify that there is a physician order in the resident's chart for self-administration of the specific medication under consideration and that</p>		<p>1) Resident #100, #112, #118, #57, #55 were reassessed for self-administration of mini-nebulizers. Physician notified and orders written.</p> <p>2) Reviewed records of residents with self-administration medication. Updated assessments, physicians notified and orders written as needed.</p> <p>3) Licensed nurses were inserviced on self-administration of mini-nebulizers, physician orders and need for resident signature when they request to self-administer mini-nebulizers. This same inservice will be provided to licensed nurses in orientation.</p> <p>4) The Director of Nursing Services or designee will review physicians' orders and self-administration assessments for accurate documentation. Audits will be daily x 2 weeks, weekly x 4 weeks, and monthly x 3 months. All results of will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed.</p>		

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	<p>the resident has signed the appropriate document(s) stating the desire to self-administer his/her own medication. Proceed by checking the appropriate response below for each of the 19 items listed. The resident must be able to perform each step indicated below prior to beginning self-administration of medications. The Interdisciplinary team will be responsible for approving self medication using this assessment as a guide. Checked #18 can administer inhalant medications with proper procedure fully capable." Documentation was lacking of a physician order and lack of a signature the resident requested to self-administer the inhalant.</p> <p>On 5/17/11 at 11:03 a.m., the most recent MDS (Minimum Data Set) initial review, dated 4/27/11 indicated the resident was cognitively intact and made their own decisions.</p> <p>2. The clinical record for resident #57 was reviewed on 5/18/11 at 11:50 a.m. The resident diagnoses included, but were not limited to: Alzheimer's and dementia. An Assessment for Self-Administration of Medications dated 4/13/11 indicated the following: "#18 Can administer inhalant medications with proper procedure and checked Able with Assist." Documentation was lacking of a physician order and lack of a signature the resident requested to self-administer the inhalant.</p>						

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	<p>On 5/18/11 at 11:50 a.m. the most recent MDS quarterly, dated 4/13/11, indicated the resident was cognitively impaired for decision making.</p> <p>3. Review of the clinical record for Resident#100 on 5/16/2011 at 11:05 a.m., indicated the resident was admitted on 4/14/2011 and had diagnoses which included, but were not limited to, rheumatoid arthritis, chronic pain, and chronic obstructive pulmonary disease.</p> <p>The hospital discharge orders included, but were not limited to, "Duoneb Nebulizer Inhalation Four Times Daily PRN [as needed] for SOA [shortness of air]/wheezing." On 5/2/2011, the orders were changed to: Duoneb Mini Neb 2 times a day for SOA and then later in the day to: Duo Mini-Neb Treatment Q [every] 8 hours for SOA.</p> <p>Review of the 4/14/11 Admission "Assessment for Self-Administration of Medications" indicated the resident was unable to demonstrate the ability to self-administer any of her medications.</p> <p>On 4/30/2011, a new care plan was written for the resident to be able to self-administer her respiratory treatments after the nurse set them up for her. Documentation was lacking of a new assessment having been completed to re-evaluate the resident to show she was</p>						

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	<p>now able to self-administer her respiratory treatments safely.</p> <p>Review of the May 2011 MAR indicated the resident was self-administering her respiratory treatments since 5/2/2011. During an observation on 5/18/2011 at 1:50 p.m., Resident #100 self-administered her respiratory treatment after RN #1 set her up. RN #1 indicated at this time that sometimes nursing will stay with the residents during their treatments to monitor them and at other times, they did not as it depended on how busy they were that day. She also indicated the resident was capable of doing her respiratory treatments after it was set up for her.</p> <p>On 5/19/2011 at 9:13 a.m., the DoN presented a physician's order dated 5/18/2011 for the resident to be able to self-administer her respiratory treatments. At 10:30 a.m., the DoN had indicated the Interdisciplinary team had reviewed the resident this morning and decided the resident was not safe to self-administer her own respiratory treatments as she had a tendency sometimes to lay the piece with the medication in it down on her bed instead of keeping it in her mouth.</p> <p>4. Review of the clinical record for</p>						

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	<p>Resident #112 on 5/18/2011 at 12:55 p.m., indicated the resident had diagnoses which included, but was not limited to, dementia with behavior disturbance, status post upper respiratory infection.</p> <p>On 4/18/2011, the resident received a new physician order for Albuterol (a bronco dilator for the lungs) - nebulizer inhalation every 4 hours PRN for SOA. Review of the April MAR indicated the resident received the Neb treatment routinely.</p> <p>On 5/17/2011 at 4:20 p.m., the DoN presented a list of residents who self-administered their respiratory treatments. Resident #112 was among those listed.</p> <p>Documentation was lacking of an assessment on the resident by the interdisciplinary team to determine if she was able to safely self-administer her own respiratory treatments until 5/18/2011 when it was brought to the DoN's attention on 5/18/2011 at 2:20 p.m. A care plan was developed on 5/17/2011 on the resident now self-administering her own respiratory treatment - a day before the Interdisciplinary team had assessed and determined it was safe for her to do so.</p> <p>5. Resident # 17 has diagnoses including, but not limited to: malignant neoplasm</p>						

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	<p>bronchial/lung, dementia with behavior disturbance, hypertension, chronic bronchitis. On 05/17/11 at 11: 25 a.m., Licensed Practical Nurse (LPN) #2, was observed to administer Atrovent 0.02 % (bronchodilator medication) to resident #17. The LPN placed the Atrovent into the nebulizer after checking the lung sounds and apical heart rate, she then placed the mask on the resident and left the room. Physicians orders were reviewed at 11:45, documentation was lacking for orders to self administer the nebulizer treatment. Assessment for self administration of medications dated 5/11/11 indicated "res to leave mask in place during mn (minineb) tx (treatment), nurse to insert med turn on and off machine". On 5/18/11 at 11:00 a.m. a telephone order was obtained from the physician which indicated "may self administer mini nebs per IDT (Interdisciplinary Team) assessment".</p> <p>In interview on 5/19/11 at 12:30 p.m. with the Director of Nursing (D.O.N.) she indicated her understanding of self administration of mini nebs, was the resident may be left alone after nursing puts mask on resident. The D.O.N. indicated she" didn't realize they needed a order for self administration of mini nebs."</p>						

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	<p>6. The clinical record for Resident #55 was reviewed on 5/17/11 at 3:15 p.m. Resident #55 had diagnoses including, but not limited to: hypertension, chronic obstructive pulmonary disorder, schizophrenia, Alzheimer's, congestive heart disease, depressing disorders. Resident # 55 was able to self-administer medication according to care plan updates on 4/30/11 indicating "res. will safely admin resp meds when nurse dispenses meds and turns on machine & off".</p> <p>Documentation of physician order to self medicate was lacking and record review of history and physical indicated on 4/8/11 the physician documented "patient does not communicate with me".</p> <p>In the record review the progress notes, dated 5/16/11 at 1230 p.m. and 8:00 p.m., nursing indicated the resident was fed per staff and the resident was unable to make needs known.</p> <p>Social services indicated on 5/2/11 at 11:00 a.m. the resident was unable to complete brief interview for mental status (BIMS) and that resident's "thinking was disorganized, has difficulty focusing attention." Interview on 5/17/11 at 3:15 was unsuccessful as resident was completely unable to converse and mumbling incoherently. Resident was not</p>				

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	<p>able to verbalize needs, and was pulling on clothes and picking at sheets.</p> <p>On 5/18/11 at 9:10 a.m., the policy and procedure for Self Administration of Medication. The policy indicated, "The patient may self-administer drugs if the interdisciplinary team has determined that this practice is safe." The compliance guidelines indicates: #1 "The patient requests to exercise this right either verbally or in writing"...#3 "Physician's orders are obtained for those drugs which may be self-administered while the patient is in the center or SAU (Sub Acute Unit)".#4 "Pharmacy is notified and individual drugs are dispensed with a label identifying the medication is for self-administration".</p> <p>On 5/18/11 at 9:30 a.m., the D.O.N. clarification of SAU was "sub acute unit". She indicated they do not have a sub acute unit.</p> <p>On 5/18/11 at 2:20 p.m., the Director of Nursing (D.O.N.), during interview, indicated resident #55 needed to be reassessed for self administration.</p> <p>On 5/19/11 at 9:10 a.m. D.O.N. provided an updated residents self administration record which indicated resident #55 was no longer able to self medicate. The list</p>						

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F0278 SS=D	<p>provided by the Director of Nursing as self-administering medication included Resident #96, 36, 75, 79, 104, 114, 115, 120, 99, 101, 2, 5, 19, 26, 30, 33, 36, 37, 53, 60.</p> <p>3.1-11(a)</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 resident with an "Elopement/Wandering Risk Assessments" accurately reflected the current status of the resident in a sample of 24 residents. (Resident #73)</p>	F0278	<p>F278</p> <p>1) Wander elopement assessment for resident #73 was updated to accurately reflect the current status of the resident.</p> <p>2) Audited assessments of all</p>	06/10/2011	

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	<p>Finding includes:</p> <p>Review of the clinical record for Resident #73 on 5/17/2011 at 11:00 a.m., indicated the resident was admitted to the facility on 5/11/2011 and had diagnoses which included, but were not limited to, multiple cerebral infarctions (strokes) and severe dementia.</p> <p>Review of the 5/18/2011 "Wander/Elopement Risk Evaluation" indicated the following: Risk Factors: - is cognitively impaired - resident frequently paces or wanders in areas/others' rooms without purpose - has impaired decision making skills that decrease her awareness of safety</p> <p>Summary: Resident is not at risk for wandering and not at risk for elopement.</p> <p>Review of the nursing notes between 5/11 and 5/17/2011 indicated entries on a daily basis of the resident wandering and of going towards the exit door although was easily re-directed.</p> <p>During an interview with the Director of Nursing on 5/19/2011 at 9:13 a.m., she indicated that after checking the current assessment the day before, she also found that the summary did not match the</p>		<p>wander elopement risk residents and updated as needed to accurately reflect the current status of the residents.</p> <p>3) All licensed nurses were inserviced on accurate completion of wander elopement assessment. The same inservice will be done for licensed nurses in orientation.</p> <p>4) Director of Nursing Services, or designee, will audit all new admissions and the 24 hour report, to ensure that the wander elopement assessment accurately represents the resident. Audits will be daily x 2 weeks, weekly x 4 weeks, and monthly x 3 months. Results of will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed.</p>				

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F0280 SS=D	<p>answers to the assessment and indicated a new assessment had then been completed on 5/18/2011 to reflect the accurate status of the resident.</p> <p>3.1-31(i)</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise the care plan for 1 of 4 residents reviewed for oral care in a sample of 24 residents when the dentist made recommendations for gum care and monitoring for bleeding (Resident #64).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident</p>	F0280	<p>F280</p> <p>1) Care plan for resident #64 reviewed and revised to address potential for bleeding due to brushing as per dentist.</p> <p>2) Audited all current resident records and care planned those at risk for bleeding due to dental care.</p> <p>3) Assistant Director of Nursing Services, or designee, will review all dental consults when received, to</p>	06/10/2011	

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	<p>#64 on 5/17/2011 at 1:55 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia, muscle disorder, and anxiety state.</p> <p>On 4/15/2011, the consultant dentist wrote a treatment order for: "Gentle daily brushing of gums. Expect some bleeding."</p> <p>A 3/11/2011 care plan "Self care deficit, bed mobility, transfers, bathing, dressing, grooming, R/T [related to] cognitive status, pain." Among the approaches listed was: "(05) assist res [resident] as requested with combing hair and/or oral care." Documentation was lacking of the care plan having been updated to reflect the possibility of bleeding while doing oral care.</p> <p>During an interview on 5/18/2011 at 1:30 p.m., LPN #1 indicated it didn't need to be added to the CNAs' [certified nursing assistant] assignment sheets or care plan for monitoring as the staff just knew to tell the nurse if they noticed any bleeding.</p> <p>3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)</p>		<p>ensure appropriate care plans are implemented.</p> <p>4) Director of Nursing Services will review care plan accuracy for each dental visit for three months. Results of dental consult reviews will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed</p>		

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F0329 SS=D	<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 the residents' drug regimen was free from unnecessary use of an anti-depressant/general anxiety disorder without indications for use for 1 of 6 residents reviewed for unnecessary drug usage in a sample of 24 residents. (Resident #58) and for 1 of 2 residents receiving antibiotics in a sample of 24 residents. (Resident #118)</p> <p>Finding includes:</p> <p>1. The clinical record for resident #58 was reviewed on 5/18/11 at 10:25 a.m. The resident diagnoses included, but were</p>	F0329	F329 1) Resident #58's physician reviewed the necessity of the medication. The medication was discontinued. Diagnosis was obtained for Resident #118 for antibiotic usage. 2) The Director of Nursing Services, or her designee, will conduct a chart audit to identify other unnecessary psychotropic drugs or antibiotics and contact physicians accordingly. 3) Licensed nursing staff, certified nursing assistants, and Social Services staff were inserviced on unnecessary drugs with an emphasis on assuring supporting diagnoses and behavior documentation. This inservicing will be provided for licensed	06/10/2011			

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	<p>not limited to: dementia with disturbance of mood and delusions. A Physician Telephone Order dated 5/11/11 indicated "Lexapro (anti-depressant/general anxiety disorder) 10 mg (milligram) po (by mouth) qd (every day) for anxiety"</p> <p>Review of the Monthly Behavior Monitoring Flowsheets for April 2011 and May 2011 lacked any behaviors related to "anxiety."</p> <p>In interview with Social Worker #1 on 5/18/11 at 1:07 p.m., she indicated she had spoken with Nurse Practitioner #1 and wanted to get rid of the Risperidol (anti-psychotic) and thought Lexapro could be added.</p> <p>On 5/18/11 at 10:25 a.m., review of the Psychiatric Follow-Up Evaluation form dated 5/10/11 lacked any documentation of the resident having increased anxiety.</p> <p>2. The clinical record for resident #118 was reviewed on 5/17/11 at 11:03 a.m. The resident diagnoses included, but were not limited to: end stage renal disease, dialysis and chronic airway obstruction. On 5/16/11 at 6:10 p.m., a fax was sent from [named] dialysis center which included, but was not limited to: "Keflex (antibiotic) 250 mg po BID (two times a day) x (times) 7 days" Documentation</p>		nurses, certified nursing assistants, and social workers in orientation as well. 4) The Director of Nursing, or her designee, will monitor physicians' orders for diagnosis and behavior documentation, daily x 2 weeks, weekly x 4 weeks, and monthly x 3 months. Results will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed.				

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F0411 SS=D	<p>was lacking as to the indication for use.</p> <p>In interview with the Director of Nursing on 5/17/11 at 1:35 p.m., she indicated an attempt was made to call the dialysis center, but they were closed and not answering the phone. On 5/16/11 at 8 p.m. and 5/17/11 at 8 a.m., the Medication Administration Record for May 2011 indicated the medication was obtained from the Emergency Drug Kit and begun without indication for usage. Documentation was lacking of communication with the Dialysis Center and the diagnosis for the Keflex.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p>						

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	<p>Based on record review and interview, the facility failed to follow-up on a dental recommendation and obtain an oral surgeon consult for 1 of 4 residents reviewed for dental issues in a sample of 24 residents. (Resident #64)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #64 on 5/17/2011 at 1:55 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia, muscle disorder, and anxiety state.</p> <p>On 4/15/2011, the consultant dentist made a recommendation for: "Referral to Oral Surgeon; Please evaluate for extractions according to finances." Review of the nursing notes between 4/15 and 5/17/2011 failed to locate documentation of the referral having been made for the oral surgeon.</p> <p>During an interview with Social Worker #2 on 5/17/2011 at 3:13 p.m., she indicated nursing was responsible for making an oral surgeon appointment for Resident #64 as she was only responsible for putting them on the dentist list for the initial appointments.</p>	F0411	<p>F411</p> <p>1) Resident #64 and family declined oral surgery.</p> <p>2) Audited all current resident records for evidence of dental recommendations and appropriate follow up completed.</p> <p>3) Assistant Director of Nursing Services, or designee, will review dentists' documentation for recommendations and providing appropriate follow-up.</p> <p>4) The Director of Nursing Services or designee will review all dental consults to ensure all recommendations are addressed timely for next three months' of dental visits. Results will be discussed in the monthly Quality Assurance meeting, monthly x 3 months and quarterly thereafter, with corrective action implemented as needed.</p>	06/10/2011	

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F0514 SS=D	<p>3.1-24(a)(1) 3.1-24(a)(3) 3.1-24(b)</p> <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>A. Based on record review and interview the facility failed to ensure the clinical record was complete and accurately documented for 1 of 2 hospice resident records reviewed in a sample of 24 residents. (Resident #93)</p> <p>B. Based on record review, observation and interview, the facility failed to accurately document the amount of a nutritional supplement 1 of 5 residents reviewed for nutritional supplements in a sample of 24 residents consumed. (Resident #100)</p> <p>Findings include:</p> <p>A. The clinical record for Resident #93 was reviewed on 5/17/11 at 1:40 p.m.</p>	F0514	<p>F514</p> <p>1) For resident #93, hospice documentation was obtained and placed on chart.</p> <p>For resident #100, nutritional supplement was changed.</p> <p>2) Reviewed documentation of all residents with referrals to hospice for accurate documentation of referral outcome.</p> <p>Audited documentation of nutritional supplement consumption for accuracy.</p> <p>3) Social Service Director, or designee, will monitor all hospice orders for follow up charting.</p>	06/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155312	X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X(3) DATE SURVEY COMPLETED 05/19/2011
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	<p>The resident diagnoses included, but were not limited to: paraplegia and cancer of the spine. A physician telephone order dated 5/2/11 indicated "Hospice Consult". In interview with the Social Worker #2 on 5/17/11 at 3:05 p.m., she indicated [named] hospice had been in to meet with the resident and the resident refused hospice at this time. Documentation was lacking in the clinical record of the resident refusal.</p> <p>On 5/18/11 at 10:55 a.m., the Director of Nursing provided the [named] Hospice Interdisciplinary Hospice Communication forms dated 5/2, 5/3, 5/4, and 5/5/ 2011. The forms were faxed to the facility on 5/17/11 at 15:44 (3:44 p.m.).</p> <p>B. Review of the clinical record for Resident#100 on 5/16/2011 at 11:05 a.m., indicated the resident was admitted on 4/14/2011 and had diagnoses which included, but were not limited to, rheumatoid arthritis, chronic pain, and chronic obstructive pulmonary disease.</p>		<p>Licensed nursing staff and certified nursing assistants were inserviced on accurately documenting supplementconsumption. This inservicing will be provided for licensed nurses and certifiednursing assistants in orientation as well.</p> <p>4) SSD, or designee, will log all hospice referrals to confirm proper documentation and follow up. E.D., or designee, will review log weekly for accuracy.</p> <p>Director of Nursing Services, or designee, will monitor nutritional supplement consumption daily x 2weeks, weekly x 4 weeks, and monthly x 3 months to ensure accuracy of documentation.</p> <p>All results will be reviewed monthly forthe next 3months, then quarterly, at the Quality Assurance meeting with subsequent plan of correction developed and implemented as needed.</p>		

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	<p>Review of the physician telephone orders for 4/14/2011 through 5/16/2011 indicated an order dated 4/29/2011 to discontinue Ensure (a nutritional supplement) and begin Health shakes at 10:00 a.m., 2:00 p.m. and at bedtime. On 5/10/2011, a new physician order was received to change the times of the Health shake to 8:00 a.m., noon, and 5:00 p.m. - with meals.</p> <p>Entries on the April and May 2011 Medication Administration Record [MAR] between 4/29/2011 and 5/16/2011 indicated the resident consumed 100% of the nutritional supplement.</p> <p>During a lunch meal observation on 5/16/2011 at 1:00 p.m., the resident was observed to have left her vanilla Health shake unopened on the table. When asked by CNA #1, the resident replied she was not going to drink that shake as she hated it. The CNA also indicated the resident had not drunk the Health shake since it was ordered as she did not like it.</p> <p>During an interview on 5/17/2011 at 1:40 p.m., CNA #1 and CNA #2 both indicated the resident did not drink her Health shake this morning nor at lunch and had not drunk it since being ordered as she did not like it.</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-50(a)(2)				