

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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F000000	<p>This visit was for the Recertification and State Licensure Survey. .</p> <p>Survey dates: July 21, 22, 23, 24, and 25, 2014</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>Survey Team: Jennifer Redlin, RN - TC Heather Hite, RN Julie Ferguson, RN Caitlyn Doyle, RN</p> <p>Census Bed Type: SNF/NF: 26 NF: 16 Total: 42</p> <p>Census Payor Type: Medicare: 3 Medicaid: 33 Other: 6 Total: 42</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>1. The facility is unable to retrospectively address the cited concern. 2. A review of each employee's online education and training has been completed to identify individuals that have not completed the required 6 hour dementia training. All staff have completed the 6 hour training as required. 3. An in-service calendar has been put into place to ensure all employees complete the initial 6 hours of required dementia training within the first 6 months of employment. 4. On a monthly basis, human resources will review all employee's online training to ensure the facility remains in compliance. Those employees that fail to complete the 6 hour dementia training within the required 6 month time frame will be removed from the schedule. The results of this review will be submitted to the Quality Assurance Committee on a quarterly basis for no less than 1 year. 5. August 24, 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000225 SS=D	<p>Quality review completed on July 31, 2014, by Janelyn Kulik, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other</p>			

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	<p>officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Administrator immediately for 1 of 3 allegations of abuse reviewed. (Resident #42)</p> <p>Findings include:</p> <p>The closed record for Resident #42 was reviewed on 7/22/14 at 8:30 a.m. The Admission Minimum Data Set (MDS) Assessment completed on 2/19/14 indicated the resident was cognitively impaired. The resident's diagnoses included, but were not limited to, dementia and depression. The MDS indicated the resident was an extensive 2+ person assist for transfers. The Assessment indicated the resident had no behaviors or indicators of psychosis.</p> <p>A reportable occurrence was reviewed that occurred on 6/14/14 at 5:00 p.m. The reportable occurrence investigation indicated Resident #42 was eating dinner in the dining room on 6/14/14 at approximately 5:00 p.m. The resident became anxious and upset and was</p>	F000225	<p>1. As it relates to the resident identified as resident # 42, we respectfully submit that immediately upon receipt of the allegation of abuse, the facility commenced a detailed investigation and reported the allegation to the Indiana State Department of Health. The staff members in question were immediately removed from the schedule. Two of whom were subsequently terminated from employment. The staff member that reported the incident after the fact was provided a written warning and provided with education on facility protocols for reporting allegations of abuse.</p> <p>2. To our knowledge, there are no outstanding allegations of abuse. Immediately following the cited incident, all staff were in-serviced on identifying and reporting possible abuse.</p> <p>3. In addition to the current quarterly, mandatory online in-services related to abuse prevention an additional in-service will be completed on a quarterly basis with all staff. This in-service will include identifying different types of abuse and protocols for reporting allegations of abuse.</p> <p>4. On a monthly basis the facility Administrator or</p>	08/24/2014

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	<p>asking where her husband was. According to CNA #2, Terminated RN #1 placed her arm across Resident #42's chest to prevent her from rising from her wheelchair. Resident #42 continued to insist on going into her husband's room, Terminated RN #1 used the residents husband's wheelchair to block the doorway. Resident #42 responded by hitting and kicking Terminated RN #1. Staff attempted to calm the resident down and removed her from the dining room. Resident #42 then began to throw herself out of her wheelchair. CNA's #2 and #3 eased the resident to the floor near the nurses station where Terminated RN #1 and CNA #3 monitored her on the floor. Staff then got her back up into her wheelchair and the resident received her evening medications. Prior to going to bed for the evening she again became agitated and refused to let staff assist her. The staff then eased her to the floor a second time, while in her room.</p> <p>An undated statement from CNA #2 indicated Terminated RN #1 put her arm across Resident #42's chest to prevent her from getting out of her chair. The statement further indicated Resident #42 was in the dining room cursing. Terminated CNA #1 made a comment about it and the resident told her "you're full of sh**". Terminated CNA #1 got up</p>		<p>Designee will survey 10 % of all staff on the above referenced abuse protocols. The results of these surveys will be submitted to the Quality Assurance Committee for review on a quarterly basis for one year. (see attachment #1) 5. August 24, 2014</p>	

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	<p>from the table and walked over to Resident #42's table and stated, "I am full of sh**, my eyes are brown. What are you gonna do about it?" The resident responded, "I should knock the sh** out of you". The statement from CNA #2 further indicated Terminated CNA #1 was laughing at Resident #42 when she saw her on the floor. The resident responded with a disgusted look and Terminated CNA #1 responded "What? This is funny!!" "This is my entertainment for the day. If you can't beat em join em!"</p> <p>A statement from Terminated RN #1, dated 6/15/14, indicated she did not place a chair behind or restrain Resident #42 in the chair. She indicated she held the resident's chair and locked it.</p> <p>A correction action form dated 6/26/14 and signed by the Administrator, the Director of Nursing (DoN) and Terminated RN #1 indicated on 6/14/14 the employee refused to allow Resident #42 to enter her husbands room by blocking the door way and restraining the resident. The employee had an interaction with a resident not meeting company expectations. Terminated RN#1 was discharged on 6/26/14. Terminated RN#1 indicated she did not physically restrain the resident only used</p>			

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	<p>the brakes on the wheelchair and positioned her to the table applying the brakes each time.</p> <p>An undated statement from Terminated CNA #1 indicated she did not observe Terminated RN #1 physically holding Resident #42 down in her wheelchair, nor did she make any negative comments.</p> <p>A correction action form dated 6/18/14 and signed by the Administrator, the DoN and Terminated CNA #1 indicated on 6/14/14 the employee laughed and made antagonistic remarks towards a resident during a behavioral outburst. The employee continued to joke about the situation after the fact. The employee had inappropriate behavior and poor decision making. Terminated CNA #1 was discharged on 6/18/14. Terminated CNA #1 indicated during the situation she never laughed or antagonized the resident nor did she joke about the matter.</p> <p>A correction action form dated 6/22/14 and signed by the Administrator, the DoN and CNA #2 indicated a written warning for failure to provide a concern in a timely manner and not stop a negative interaction.</p> <p>Interview with the Administrator on</p>						

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F000226 SS=D	<p>7/22/14 at 3:25 p.m., indicated she discharged Terminated RN #1 and Terminated CNA #1 because they could not tell her what they did wrong and did not have any idea on what they should have done differently during the situation. She further indicated they did not use any interventions or redirection for Resident #42. She further indicated she was unable to substantiate abuse because of conflicting stories from staff members and residents. She also indicated CNA #2 received a written warning for failure to report the incident until 11:00 p.m. to the nurse coming onto shift. She indicated CNA #2 was supposed to report the incident to Administrator immediately.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the Abuse Prevention Program Policy was followed related to the timely reporting of an allegation of abuse to the Administrator for 1 of 3 allegations of abuse reviewed.</p>	F000226	1. As it relates to the resident identified as resident # 42, we respectfully submit that immediately upon receipt of the allegation of abuse, the facility commenced a detailed investigation and reported the	08/24/2014

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	<p>(Resident #42)</p> <p>Findings include:</p> <p>The closed record for Resident #42 was reviewed on 7/22/14 at 8:30 a.m. The Admission Minimum Data Set (MDS) Assessment completed on 2/19/14 indicated the resident was cognitively impaired. The resident's diagnoses included, but were not limited to, dementia and depression. The MDS indicated the resident was an extensive 2+ person assist for transfers. The Assessment indicated the resident had no behaviors or indicators of psychosis.</p> <p>A reportable occurrence was reviewed that occurred on 6/14/14 at 5:00 p.m. The reportable occurrence investigation indicated Resident #42 was eating dinner in the dining room on 6/14/14 at approximately 5:00 p.m. The resident became anxious and upset and was asking where her husband was. According to CNA #2, Terminated RN #1 placed her arm across Resident #42's chest to prevent her from rising from her wheelchair. Resident #42 continued to insist on going into her husband's room, Terminated RN #1 used the residents husband's wheelchair to block the doorway. Resident #42 responded by hitting and kicking Terminated RN #1.</p>		<p>allegation to the Indiana State Department of Health. The staff members in question were immediately removed from the schedule. Two of whom were subsequently terminated from employment. The staff member that reported the incident after the fact was provided a written warning and provided with education on facility protocols for reporting allegations of abuse. 2. To our knowledge, there are no outstanding allegations of abuse. Immediately following the cited incident, all staff were in-serviced on identifying and reporting possible abuse. 3. In addition to the current quarterly, mandatory online in-services related to abuse prevention an additional in-service will be completed on a quarterly basis with all staff. This in-service will include identifying different types of abuse and protocols for reporting allegations of abuse. 4. On a monthly basis the facility Administrator or Designee will survey 10 % of all staff on the above referenced abuse protocols. The results of these surveys will be submitted to the Quality Assurance Committee for review on a quarterly basis for one year. (see attachment #1) 5. August 24, 2014</p>		

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	<p>Staff attempted to calm the resident down and removed her from the dining room. Resident #42 then began to throw herself out of her wheelchair. CNA's #2 and #3 eased the resident to the floor near the nurses station where Terminated RN #1 and CNA #3 monitored her on the floor. Staff then got her back up into her wheelchair and the resident received her evening medications. Prior to going to bed for the evening she again became agitated and refused to let staff assist her. The staff then eased her to the floor a second time, while in her room.</p> <p>An undated statement from CNA #2 indicated Terminated RN #1 put her arm across Resident #42's chest to prevent her from getting out of her chair. The statement further indicated Resident #42 was in the dining room cursing. Terminated CNA #1 made a comment about it and the resident told her "you're full of sh**". Terminated CNA #1 got up from the table and walked over to Resident #42's table and stated, "I am full of sh**, my eyes are brown. What are you gonna do about it?" The resident responded, "I should knock the sh** out of you". The statement from CNA #2 further indicated Terminated CNA #1 was laughing at Resident #42 when she saw her on the floor. The resident responded with a disgusted look and</p>			

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	<p>Terminated CNA #1 responded "What? This is funny!!" "This is my entertainment for the day. If you can't beat em join em!"</p> <p>A statement from Terminated RN #1, dated 6/15/14, indicated she did not place a chair behind or restrain Resident #42 in the chair. She indicated she held the resident's chair and locked it.</p> <p>A correction action form dated 6/26/14 and signed by the Administrator, the Director of Nursing (DoN) and Terminated RN #1 indicated on 6/14/14 the employee refused to allow Resident #42 to enter her husbands room by blocking the door way and restraining the resident. The employee had an interaction with a resident not meeting company expectations. Terminated RN#1 was discharged on 6/26/14.</p> <p>Terminated RN#1 indicated she did not physically restrain the resident only used the brakes on the wheelchair and positioned her to the table applying the brakes each time.</p> <p>An undated statement from Terminated CNA #1 indicated she did not observe Terminated RN #1 physically holding Resident #42 down in her wheelchair, nor did she make any negative comments.</p>						

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	<p>A correction action form dated 6/18/14 and signed by the Administrator, the DoN and Terminated CNA #1 indicated on 6/14/14 the employee laughed and made antagonistic remarks towards a resident during a behavioral outburst. The employee continued to joke about the situation after the fact. The employee had inappropriate behavior and poor decision making. Terminated CNA #1 was discharged on 6/18/14. Terminated CNA #1 indicated during the situation she never laughed or antagonized the resident nor did she joke about the matter.</p> <p>A correction action form dated 6/22/14 and signed by the Administrator, the DoN and CNA #2 indicated a written warning for failure to provide a concern in a timely manner and not stop a negative interaction.</p> <p>Interview with the Administrator on 7/22/14 at 3:25 p.m., indicated she discharged Terminated RN #1 and Terminated CNA #1 because they could not tell her what they did wrong and did not have any idea on what they should have done differently during the situation. She further indicated they did not use any interventions or redirection for Resident #42. She further indicated she was unable to substantiate abuse</p>			

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F000282 SS=D	<p>because of conflicting stories from staff members and residents. She also indicated CNA #2 received a written warning for failure to report the incident until 11:00 p.m. to the nurse coming onto shift. She indicated CNA #2 she was supposed to report the incident to the Administrator immediately.</p> <p>Review of the facility Abuse Prevention Program policy on 7/22/14 at 3:00 p.m., which was provided by the Administrator and identified as current, indicated the following: "Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs or symptoms of abuse/neglect to their supervisor or to the director of nursing services. The Administrator should then be notified immediately."</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure Physicians's orders and/or the plan of care were</p>	F000282	What corrective actions will be accomplished for those residents found to be affected by the deficient practice: Resident #25,	08/24/2014

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	<p>followed as written related to lack of physician notification for elevated blood sugar lack of documentation of blood sugar and insulin administration, lack of documentation of any non-pharmacological interventions for prn (when necessary) pain medication was completed, or prn pain medication effectiveness followed up on for 3 of 6 residents reviewed for unnecessary medications. (Residents #37, #25, #46)</p> <p>Findings include:</p> <p>1. Record review for Resident #37 was completed on 7/22/14 at 11:36 a.m. The Admission Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, depression, diabetes. The MDS indicated the resident received scheduled pain medication, received prn pain medication and received non-medication interventions for pain. The assessment also included the resident received insulin injections 7 x in the 7 day assessment period.</p> <p>a. A care plan dated 6/24/14 indicated the resident was at risk for complications associated with diabetes. Nursing interventions include: Glucose monitoring as prescribed, diabetes</p>		<p>#37 and #46 –The facility is unable to retrospectively correct the surveyor concern related to these residents. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents in the facility receiving PRN pain medications have been identified through a chart review. Residents identified have been provided a PRN Medication Tracking Form. Each resident's PRN Medication Tracking Form has been reviewed to ensure that a non-pharmacological intervention has been attempted prior to the administration of a PRN pain med and that the effectiveness of the medication administered was monitored and documented. All residents with physician's orders for blood glucose monitoring have been identified. A review of their Medication Administration Record has been completed to ensure that all blood sugar results have been documented and that sliding scale insulin has been administered per physician's orders. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The facility has implemented a revised PRN Medication Tracking Form and a new Diabetic Tracking Form. An in-service will be provided to the Licensed Professional Nursing</p>				

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	<p>medications as prescribed.</p> <p>The Physicians Order Summary for June and July 2014 indicated an order for Novolin R (diabetes medication) to monitor the blood sugar and administer the insulin per a sliding scale. The sliding scale read as follows: 0-150 = 0 units 151-200 = 2 units</p> <p>The June 2014 Medication Administration Record (MAR) lacked documentation the blood sugars were completed and insulin given for the 4:00 p.m., medication administration on the following dates:</p> <p>6/13/14 6/22/14 6/23/14 6/25/14 6/26/14 6/27/14</p> <p>The July 2014 MAR on 7/20/14 at 6:00 a.m., indicated Resident # 37's blood sugar was 152 and no insulin was given. The resident should have received 2 units of Novolin R insulin. The record lacked documentation any insulin was given.</p> <p>An interview with the Director of Nursing (DoN) on 7/23/14 at 10:29 a.m.,</p>		<p>Staff regarding the importance of attempting anon-pharmacological intervention prior to the administration of a PRN pain medication and monitoring and documenting the effectiveness of the PRN pain medication administered. An in-service will be provided to the Licensed Professional Staff regarding timely documentation of blood sugar results and the importance of following physician's orders as it relates to the administration of sliding scale insulin. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: An audit tool has been created to monitor each resident's PRN pain medication usage and ensure that the effectiveness of the medication administered is monitored and documented. The audit will be completed weekly by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed fora minimum of two quarters. An audit tool has been developed to ensure each resident's blood sugar results are documented timely and that the correct dose of sliding scale insulin has been administered. The DON/designee will be responsible to complete the audit a minimum of twice a week. The results of this audit will</p>	

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	<p>indicated she could not find any indication the blood sugar monitoring or insulin administration was completed. She further indicated the resident should have received the 2 units on 7/20/14 at 6:00 a.m., but could not find any indication the insulin was given.</p> <p>b. Review of the MAR for June 2014, indicated Resident #37 received prn Tramadol (pain medication) 50 milligrams (mg) on 6/23/14, 6/24/14, 6/25/14, 6/26/14, and 6/29/14. There was no indication of any non-pharmacological interventions attempted prior to the administration of the Tramadol.</p> <p>Review of the MAR for July 2014, indicated Resident #37 received prn Tramadol 50 mg on 7/5/14, 7/7/14, 7/8/14, 7/9/14, 7/12/14, 7/13/14, 7/14/14, 7/15/14, 7/16/14, 7/18/14, 7/20/14, and 7/21/14. There was no indication of any non-pharmacological interventions attempted prior to the administration of the Tramadol.</p> <p>Interview with the DoN on 7/24/14 at 9:10 a.m., indicated there was usually a prn flow sheet in the MAR where nurses should document prior interventions of prn medications. She further indicated she could not find a prn flow sheet for Resident #37. She indicated there should</p>		<p>be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters.(see attachment #2) By what date the systemic changes will be completed:August 24, 2014</p>	

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	<p>have been a prn flow sheet in place and non-pharmacological interventions should have been attempted prior to administration of the Tramadol.</p> <p>2. Resident #25's record was reviewed on 7/22/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, gout, hypertension and congestive heart failure.</p> <p>Review of the 7/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 5/325, one tablet by mouth two times a day as needed for pain.</p> <p>Review of the Medication Administration Record (MAR), dated 7/2014, indicated there was no indication of any interventions attempted prior to the administration of the Norco on 7/8/14, 7/10/14, 7/12/14, and 7/13/14. There was no indication that the effectiveness of the Norco had been assessed on 7/10/14 and 7/12/14.</p> <p>Resident #25 had a care plan for risk for pain related to gout. The nursing interventions included, "...evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on</p>			

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	<p>cognition..."</p> <p>Interview with the Director of Nursing (DoN) on 7/23/14 at 11:19 a.m., indicated there was usually a PRN (as needed) flow sheet in the MAR where nurses should document prior interventions and effectiveness of PRN medications. She further indicated she could not find a PRN flow sheet for Resident #25. She indicated there should have been a PRN flow sheet in place, interventions should have been attempted prior to administration of the Norco and the effectiveness of the pain medication should have been assessed.</p> <p>3. Resident #46's record was reviewed on 07/22/14 at 1:11 p.m.. The resident's diagnoses included, but were not limited to, lack of coordination, abnormal posture, muscular wasting and disuse atrophy, Alzheimer's disease, hypertension (high blood pressure), diabetes, anemia (lack of iron), hypothyroidism, cognitive deficits due to stroke, Myasthenia Gravis (autoimmune disease), and dementia.</p> <p>a. Review of Physician's Order Summary (POS) dated June 2014, included an order for "ACCU (Accucheck)(a blood sugar test) check TID (three times daily)...Novolog insulin s/s (sliding scale) 0-149=0 Units, 150-19=1 Units,</p>			

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	<p>180-209=2 Units, 210-239=3 Units, 240-269=4 Units, 270-299=5 Units, 300-329=6 Units, 330-359=7 Units, 360-400=9 units and call MD (Physician).</p> <p>A review of June 2014 MAR indicated no blood sugar glucose monitoring was completed for the following dates and times:</p> <ul style="list-style-type: none"> -6/5 at 5 p.m. -6/12 at 5 p.m. -6/13 at 5 p.m. -6/16 at 5 p.m. -6/17 at 5 p.m. -6/18 at 5 p.m. -6/21 at 11 a.m. -6/21 at 5 p.m. -6/22 at 5 p.m. -6/23 at 11 a.m. -6/30 at 5 p.m. <p>A review of the resident's July 2014 MAR indicated, on 7/5 at 6:00 a.m. the resident's blood sugar was 155 and the resident received no insulin and should have received 1 unit of insulin, on 7/6 at 6:00 a.m. the blood sugar was 155 and the resident received no insulin and should have received 1 unit of insulin, on 7/8 at 6:00 a.m. the blood sugar was 172, the resident received no insulin and should have received 1 unit, and on 7/15</p>				

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	<p>at 6:00 a.m. the resident's blood sugar was 168 and the resident received no insulin and should have received 1 unit of insulin.</p> <p>The resident's current care plan dated 4/30/14 for DM (diabetes mellitus) indicated "at risk for complications associated with DM. Interventions: ... monitor/document/notify MD s/sx (signs and symptoms) hyperglycemic/hypoglycemic (high and low blood sugars) reactions, notify MD s/sx infection.</p> <p>Interview on 07/22/14 at 3:20 p.m. with the DoN (Director of Nursing), indicated there was no indication the blood glucose monitoring was completed on the above dates or insulin administered.</p> <p>b. Located in the resident's MAR, the "PAIN MANAGEMENT FLOW SHEET" indicated the PRN (as needed) pain medication lacked indication of "Non-Med Interventions" had been completed.</p> <p>The July 2014 MAR indicated the current medication Norco 5/325 tablet take 1 or 2 tablets by mouth every 4 hours as needed for pain.</p> <p>The resident care plan for pain dated</p>						

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	<p>4/30/14 included the intervention, monitor/report to nurse any s/sx of non-verbal pain.</p> <p>The 60 day MDS (Minimum Data Set) Assessment dated 6/13/14 indicated the resident received non-medication interventions for pain.</p> <p>The nurse notes were reviewed and did not indicate any non-pharmacological interventions on the dates the pain medication Norco was given.</p> <p>Interview on 7/24/14 at 8:20 a.m. with the ADoN (Assistant Director of Nursing), indicated the lack of documentation of "Non-Med Intervention" on the "Pain Management Flow Sheet" and the care plan for pain also lacked interventions for non-pharmacological interventions. She also indicated the nurse notes lacked any documentation for non-pharmacological interventions on times and days that PRN medication Norco was given. She indicated there should have been non-pharmacological interventions tried before giving the PRN pain medication.</p> <p>4. An undated facility policy, titled, "Specific Procedures for All Medications Policy," received from the DoN as</p>			

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	<p>current on 7/23/14 at 3:00 p.m., indicated, "...M. When administering an 'as needed' (PRN) medication, observe for medication actions/reactions and record on the PRN effectiveness sheet/nurse's notes..."</p> <p>5. On 7/23/14 at 1:45 p.m., the DoN (Director of Nursing) provided the policy for "Change in a Resident's Condition or Status," and indicated this document was current. This policy indicated the following: " Policy Statement. Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and /or status...1. d. Abnormal lab results that require physician intervention...." On 7/23/14 at 12:45 p.m. the Administrator provided the policy titled "Diabetes Mellitus-Routine Care" and indicated this policy was current. This policy indicated "...an abnormal lab or blood glucose level must be reported to the physician. Results are to be recorded on the medication administration record (MAR) or blood glucose log record...MEDICATION: Insulin should be prepared and given immediately...."</p> <p>3.1-35 (g)(2)</p>			

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure blood sugars were assessed, insulin was given and non-pharmacological interventions for pain were attempted prior to medications being given for 3 of 6 residents reviewed</p>	F000329	What corrective actions will be accomplished for those residents found to be affected by the deficient practice: Resident #25, #37 and #46 –The facility is unable to retrospectively correct the surveyor concern related to	08/24/2014

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	<p>of unnecessary medications (Residents #37, #25, and #46).</p> <p>Findings include:</p> <p>1. Record review for Resident #37 was completed on 7/22/14 at 11:36 a.m. The Admission Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, depression, diabetes. The MDS indicated the resident received scheduled pain medication, received prn pain medication and received non-medication interventions for pain. The assessment also included the resident received insulin injections 7 x in the 7 day assessment period.</p> <p>a. A care plan dated 6/24/14 indicated the resident was at risk for complications associated with diabetes. Nursing interventions include: Glucose monitoring as prescribed, diabetes medications as prescribed.</p> <p>The Physicians Order Summary for June and July 2014 indicated an order for Novolin R (diabetes medication) to monitor the blood sugar and administer the insulin per a sliding scale. The sliding scale read as follows: 0-150 = 0 units</p>		<p>these residents. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents in the facility receiving PRN pain medications have been identified through a chart review. Residents identified have been provided a PRN Medication Tracking Form. Each resident's PRN Medication Tracking Form has been reviewed to ensure that a non-pharmacological intervention has been attempted prior to the administration of a PRN pain med and that the effectiveness of the medication administered was monitored and documented. All residents with physician's orders for bloodglucose monitoring have been identified. A review of their Medication Administration Record has been completed to ensure that all blood sugar results have been documented and that sliding scale insulin has been administered per physician's orders. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The facility has implemented a revised PRN Medication Tracking Form and a new Diabetic Tracking Form. An in-service will be provided to the Licensed Professional Nursing Staff regarding the importance of attempting anon-pharmacological intervention prior to the</p>				

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	<p>151-200 = 2 units</p> <p>The June 2014 Medication Administration Record (MAR) lacked documentation the blood sugars were completed and insulin given for the 4:00 p.m., medication administration on the following dates:</p> <p>6/13/14 6/22/14 6/23/14 6/25/14 6/26/14 6/27/14</p> <p>The July 2014 MAR on 7/20/14 at 6:00 a.m., indicated Resident # 37's blood sugar was 152 and no insulin was given. The resident should have received 2 units of Novolin R insulin. The record lacked documentation any insulin was given.</p> <p>An interview with the Director of Nursing (DoN) on 7/23/14 at 10:29 a.m., indicated she could not find any indication the blood sugar monitoring or insulin administration was completed. She further indicated the resident should have received the 2 units on 7/20/14 at 6:00 a.m., but could not find any indication the insulin was given.</p> <p>b. Review of the MAR for June 2014,</p>		<p>administration of a PRN pain medication and monitoring and documenting the effectiveness of the PRN pain medication administered. An in-service will be provided to the Licensed Professional Staff regarding timely documentation of blood sugar results and the importance of following physician's orders as it relates to the administration of sliding scale insulin. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: An audit tool has been created to monitor each resident's PRN pain medication usage and ensure that the effectiveness of the medication administered is monitored and documented. The audit will be completed weekly by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters. An audit tool has been developed to ensure each resident's blood sugar results are documented timely and that the correct dose of sliding scale insulin has been administered. The DON/designee will be responsible to complete the audit a minimum of twice a week. The results of this audit will be compiled monthly and presented to the Quality</p>	

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	<p>indicated Resident #37 received prn Tramadol (pain medication) 50 milligrams (mg) on 6/23/14, 6/24/14, 6/25/14, 6/26/14, and 6/29/14. There was no indication of any non-pharmacological interventions attempted prior to the administration of the Tramadol.</p> <p>Review of the MAR for July 2014, indicated Resident #37 received prn Tramadol 50 mg on 7/5/14, 7/7/14, 7/8/14, 7/9/14, 7/12/14, 7/13/14, 7/14/14, 7/15/14, 7/16/14, 7/18/14, 7/20/14, and 7/21/14. There was no indication of any non-pharmacological interventions attempted prior to the administration of the Tramadol.</p> <p>Interview with the DoN on 7/24/14 at 9:10 a.m., indicated there was usually a prn (as needed) flow sheet in the MAR where nurses should document prior interventions of prn medications. She further indicated she could not find a prn flow sheet for Resident #37. She indicated there should have been a prn flow sheet in place and non-pharmacological interventions should have been attempted prior to administration of the Tramadol.</p> <p>2. Resident #25's record was reviewed on 7/22/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, gout, hypertension and congestive</p>		Assurance Committee for review. This audit will be completed for a minimum of two quarters. By what date the systemic changes will be completed: August 24, 2014	

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	<p>heart failure.</p> <p>Review of the 7/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 5/235, one tablet by mouth two times a day as needed for pain.</p> <p>Review of the Medication Administration Record (MAR), dated 7/2014, indicated there was no indication of any interventions were attempted prior to the administration of the Norco on 7/8/14, 7/10/14, 7/12/14, and 7/13/14. There was no indication of the effectiveness of the Norco had been assessed on 7/10/14 and 7/12/14.</p> <p>Resident #25 had a care plan for risk for pain related to gout. The nursing interventions included, "...evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition..."</p> <p>Interview with the Director of Nursing (DoN) on 7/23/14 at 11:19 a.m., indicated there was usually a PRN (as needed) flow sheet in the MAR where nurses should document prior interventions and effectiveness of PRN</p>			

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	<p>medications. She further indicated she could not find a PRN flow sheet for Resident #25. She indicated there should have been a PRN flow sheet in place, interventions should have been attempted prior to administration of the Norco and the effectiveness of the pain medication should have been assessed.</p> <p>3. Resident #46's record was reviewed on 07/22/14 at 1:11 p.m.. The resident's diagnoses included, but were not limited to, lack of coordination, abnormal posture, muscular wasting and disuse atrophy, Alzheimer's disease, hypertension (high blood pressure), diabetes, anemia (lack of iron), hypothyroidism, cognitive deficits due to stroke, Myasthenia Gravis (autoimmune disease), and dementia.</p> <p>a. Review of Physician's Order Summary (POS) dated June 2014, included an order for "ACCU (Accucheck)(a blood sugar test) check TID (three times daily)...Novolog insulin s/s (sliding scale) 0-149=0 Units, 150-19=1 Units, 180-209=2 Units, 210-239=3 Units, 240-269=4 Units, 270-299=5 Units, 300-329=6 Units, 330-359=7 Units, 360-400=9 units and call MD (Physician).</p> <p>A review of June 2014 MAR indicated no blood sugar glucose monitoring was</p>						

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	<p>completed for the following dates and times:</p> <ul style="list-style-type: none"> -6/5 at 5 p.m. -6/12 at 5 p.m. -6/13 at 5 p.m. -6/16 at 5 p.m. -6/17 at 5 p.m. -6/18 at 5 p.m. -6/21 at 11 a.m. -6/21 at 5 p.m. -6/22 at 5 p.m. -6/23 at 11 a.m. -6/30 at 5 p.m. <p>A review of the resident's July 2014 MAR indicated, on 7/5 at 6:00 a.m. the resident's blood sugar was 155 and the resident received no insulin and should have received 1 unit of insulin, on 7/6 at 6:00 a.m. the blood sugar was 155 and the resident received no insulin and should have received 1 unit of insulin, on 7/8 at 6:00 a.m. the blood sugar was 172, the resident received no insulin and should have received 1 unit, and on 7/15 at 6:00 a.m. the resident's blood sugar was 168 and the resident received no insulin and should have received 1 unit of insulin.</p> <p>The resident's current care plan dated 4/30/14 for DM (diabetes mellitus) indicated "at risk for complications</p>						

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	<p>associated with DM. Interventions: ... monitor/document/notify MD s/sx (signs and symptoms) hyperglycemic/hypoglycemic (high and low blood sugars) reactions, notify MD s/sx infection.</p> <p>Interview on 07/22/14 at 3:20 p.m. with the DoN (Director of Nursing), indicated there was no indication the blood glucose monitoring was completed on the above dates or insulin administered.</p> <p>b. Located in the resident's MAR, the "PAIN MANAGEMENT FLOW SHEET" indicated the PRN (as needed) pain medication lacked indication of "Non-Med Interventions" had been completed.</p> <p>The July 2014 MAR indicated the current medication Norco 5/325 tablet take 1 or 2 tablets by mouth every 4 hours as needed for pain.</p> <p>The resident care plan for pain dated 4/30/14 included the intervention, monitor/report to nurse any s/sx of non-verbal pain.</p> <p>The 60 day MDS (Minimum Data Set) Assessment dated 6/13/14 indicated the resident received non-medication interventions for pain.</p>			

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	<p>The nurse notes were reviewed and did not indicate any non-pharmacological interventions on the dates the pain medication Norco was given.</p> <p>Interview on 7/24/14 at 8:20 a.m. with the ADoN (Assistant Director of Nursing), indicated the lack of documentation of "Non-Med Intervention" on the "Pain Management Flow Sheet" and the care plan for pain also lacked interventions for non-pharmacological interventions. She also indicated the nurse notes lacked any documentation for non-pharmacological interventions on times and days that PRN medication Norco was given. She indicated there should have been non-pharmacological interventions tried before giving the PRN pain medication.</p> <p>4. An undated facility policy, titled, "Specific Procedures for All Medications Policy," received from the DoN as current on 7/23/14 at 3:00 p.m., indicated, "...M. When administering an 'as needed' (PRN) medication, observe for medication actions/reactions and record on the PRN effectiveness sheet/nurse's notes..."</p> <p>5. On 7/23/14 at 1:45 p.m., the DoN (Director of Nursing) provided the policy</p>			

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F000356 SS=C	<p>for "Change in a Resident's Condition or Status," and indicated this document was current. This policy indicated the following: " Policy Statement. Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and /or status...1. d. Abnormal lab results that require physician intervention...." On 7/23/14 at 12:45 p.m. the Administrator provided the policy titled "Diabetes Mellitus-Routine Care" and indicated this policy was current. This policy indicated "...an abnormal lab or blood glucose level must be reported to the physician. Results are to be recorded on the medication administration record (MAR) or blood glucose log record...MEDICATION: Insulin should be prepared and given immediately...."</p> <p>3.1-48(a)(6)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p>						

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	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review and interview the facility failed to ensure the current staffing pattern was posted on a daily basis. This had the potential to affect the 42 residents residing in the facility.</p> <p>Findings include:</p>	F000356	What corrective actions will be accomplished for those residents found to be affected by the deficient practice: The posting for the nurse staffing was up dated indicating the date, census and the number of staff working that day. How other residents having the potential to be affected by the same deficient practice will be	08/24/2014

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	<p>On initial tour on 7/21/14 at 9:15 a.m., the posted staffing sign located in the facility foyer was incomplete. It lacked the facility's name, the current date, total number and actual number of hours worked for licensed and unlicensed nursing staff and current resident census.</p> <p>During an observation at 3:28 p.m. that same day, staff posting had not yet been updated.</p> <p>The staff posting was observed on 07/22/14 at 8:30 a.m. to be incomplete and lacked the facility's name, the current date, total number and actual hours number of hours worked for licensed and unlicensed nursing staff and current resident census.</p> <p>Interview with the Administrator on 7/22/14 at 8:41 a.m., indicated the staff posting was not current or completed.</p> <p>Interview with the DoN (Director of Nursing) on 7/25/14 at 10:55 a.m., indicated there was not a policy for staff postings.</p> <p>3.1-13(a)</p>		<p>identified and what corrective actions will be taken: Rounds were done to ensure that the nurse staffing board was updated on a daily basis. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The ADON and/or designee will be responsible to ensure that the nurse staffing board is updated on a daily basis. An in-service has been completed with staff regarding this process. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: An audit will be completed by the DON and/or designee a minimum of five days a week to ensure that the nurse staffing board is updated daily. The results of the audit will be submitted quarterly to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters. By what date the systemic changes will be completed: August 24, 2014</p>	

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and</p>	F000431	What corrective actions will be	08/24/2014

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	<p>interview, the facility failed to have the proper medication labels and lacked an open date for nasal sprays and a heart medication on 1 of 2 medication carts. (Resident #27, #19, #44, and #47)</p> <p>Findings include:</p> <p>1. Observation on 7/23/14 at 11:06 a.m. on the "AB" hallway medication cart with LPN #1:</p> <p>a. Resident #44's Ferrous Sulfate bottle label indicated to give the medication by mouth.</p> <p>The Physician's Order Summary (POS) for July 2014 indicated the Ferrous Sulfate was to be given per peg tube (internal tube for nutrition and medications).</p> <p>Interview on 7/23/14 at 1:44 p.m. with LPN #1, indicated the label on the current Ferrous Sulfate bottle was incorrect and should be given per peg tube.</p> <p>b. Resident #47's direction for medication label for Carvedilol was crossed out by staff in a red marker and it indicated to "See MAR" (Medication Administration Record). The label indicated to take one 25 mg(milligram) tablet twice a day by mouth.</p>		<p>accomplished for those residents found to be affected by the deficient practice: Resident #44 - Upon surveyor observation the residents medications were reviewed. The route of administration for all medications had recently been changed to via peg tube. A "Directions Changed Refer to Chart" sticker was applied to any medication that indicated it was to be administered by mouth. Resident # 47 - Upon surveyor observation the residents medications were reviewed. A "Directions Changed Refer to Chart" sticker was placed on any medication whose label did not correlate with the current physician's order. Resident #27 - Upon surveyor observation the medication was re-ordered. Upon receipt of the new medication the bottle was labeled with an open date. Resident #19 - Upon surveyor observation the medication was re-ordered. Upon receipt of the new medication the bottle was labeled with an open date. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Each medication cart was checked for open bottles of Nitrostat. Each bottle identified was checked to ensure that a date was present indicating the date it was opened. Each medication cart was checked for open nasal sprays.</p>	

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	<p>The Physician's Order Summary (POS) for July 2014 indicated Carvedilol 12.5 MG tablet, Take 1 tablet by mouth twice a day.</p> <p>Interview on 7/23/14 at 1:43 p.m. with DoN (Director of Nursing) indicated there should have been a new label on the Carvedilol per policy.</p> <p>On 7/23/14 at 1:45 p.m., the DoN provided the policy titled "MEDICATION ORDERING AND RECEIVING FROM PHARMACY," and indicated this document was current. This policy indicated "...F. Medication labels are not altered, modified, or marked in any by nursing personnel....1) If the physician's directions for use change or the label is inaccurate, the nurse may place a 'change of order-check chart'...."</p> <p>c. Resident #27's Nitrostat S.L. (heart medication for under the tongue) was opened, still used by resident and lacked an opened date.</p> <p>d. Resident #19 had 2 bottles of Saline Mist 0.65% opened and lacking an opened date.</p> <p>During the observation and interview</p>		<p>Each open bottle of nasal spray identified was checked to ensure that it was not expired. Each resident's medication was compared to the Medication Administration Record to ensure that the orders matched. If the instructions on the medication did not correlate with the order on the Medication Administration Record the sticker "Directions Changed Refer to Chart" was affixed to the medication. An informal in-service was immediately provided to the Licensed Professional Nursing Staff regarding the use of the stickers indicating a change in orders. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Nursing staff was educated on appropriate medication storage procedures. The ADON and/or designee will review all new orders to ensure that if indicated a "Directions Changed Refer to Chart" sticker is affixed to the medication card. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: An audit will be completed on a weekly basis to ensure that appropriate medication storage procedures are adhered to. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review.</p>	

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F000441 SS=D	<p>with LPN #1, the LPN indicated the medications lacked an open date, were currently open, still in use by residents and should have had been labeled with an opened date.</p> <p>On 7/23/14 at 1:45 p.m. the DoN provided the policy "Williams LTC Expiration dating policy". This current policy indicated "...Nitroglycerin Sublingual Tablets expire 6 months after opening...Nasal solutions, unopened-Mfg (Manufacture) expiration date; opened -28 days *unless mfg Pkg (package) inset states otherwise...."</p> <p>3.1-25(j)(k) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>		This audit will be completed for a minimum of two quarters. (see attachment #5) By what date the systemic changes will be completed: August 24, 2014				

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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to ensure infection control practices and standards were maintained related to hand washing before applying a barrier cream to a resident after perineal care (personal hygiene) for 1 of 1 observations of peri-care. (Resident #46)</p> <p>Findings include:</p>	F000441	1. The facility is unable to retrospectively address the cited surveyor observation. 2. To our knowledge this was an isolated incident and no other residents have been affected by the alleged deficient practice. 3. An in-service related to the proper procedure for rendering peri-care has been completed with all direct care staff. 4. The Director of Nursing or Designee will observe	08/24/2014			

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F000458	<p>On 7/22/14 at 1:31 p.m., peri-care for Resident #46, was observed: CNA #1 was observed to have wiped her soiled glove onto the resident's old brief several times during the cleansing of the resident after she had a bowel movement. Without removing the soiled gloves, CNA #1 then reached into the resident's bedside stand and pulled out the resident's barrier cream. CNA #1 then applied this barrier cream to the resident's inner buttocks using her same soiled gloves. No open areas to resident's buttocks, nor did resident have current urinary tract infection.</p> <p>Interview on 7/22/14 at 1:45 p.m. with CNA #1, indicated she should have changed her gloves, used hand sanitizer, and applied new gloves.</p> <p>Interview on 7/22/14 at 2:32 p.m. with the DoN (Director of Nursing), indicated there was not a current policy on peri-care with applying barrier cream. The CNA should have changed gloves, washed hands and applied new gloves before applying the barrier cream.</p> <p>3.1-18(l)</p> <p>483.70(d)(1)(ii)</p>		<p>peri-care on 10% of all residents on a monthly basis to ensure proper procedure is being followed. The results of these observations will be presented to the Quality Assurance Committee Quarterly for no less than 6 months. (see attachment #6) 5. August 24, 2014</p>	

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SS=E	<p>BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review, observation and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms and 100 sq ft in single occupancy rooms. This was evidenced in 9 of 29 resident rooms in the facility. (Rooms 101, 104, 111, 114, 201, 202, 204, 206, 208)</p> <p>Findings include:</p> <p>Review of the facility's Room Size Certification, received from the Administrator on 7/21/14, the following measurements of the rooms were:</p> <p>1. The floor area of the following single resident room measured: a. Room 111-1 resident, 96.2 SQ (Square) FT (feet). NF.</p> <p>2. The floor areas of the following multiple resident room s measured: a. Room 101-1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. Room 104-1 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. Room 114-2 residents, 196.0 SQ FT,</p>	F000458	<p>1. All affected rooms were measured and floor planned including necessary furnishings.</p> <p>2. All affected residents conditions were reviewed for safety, comfort, nursing care delivery and privacy to ensure there were no adverse side to placement in a room with waivers related to square footage.</p> <p>3. Prior to admission, residents needs will be reviewed to determine appropriate room assignment. Residents will be placed in rooms based on medical necessity, and resident and family preference.</p> <p>4. During quarterly care plan conferences the interdisciplinary team will review appropriateness of room assignments. If the team feels a room transfer is necessary social service with discuss this with the resident and or responsible party and arrange a smooth transition to a new room. These results of these reviews will be submitted to the Quality Assurance Committee on a quarterly basis for one year to ensure no problems arise.(see attachment #7)</p> <p>5. August 24, 2014</p>	08/24/2014

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	<p>98.0 SQ FT per bed. NF. d. Room 201-2 residents, 149.0 SQ FT, 74.5 SQ FT per bed. NF. e. Room 202-1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. Room 204-1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. g. Room 206-1 resident, 140.0 SQ FT, 70.5 SQ FT per bed. NF. h. Room 208-1 resident, 146.9 SQ FT, 73.4 SQ FT per bed. NF.</p> <p>The facility rooms with room variances were observed on 7/25/14 at 10:00 a.m. The rooms were observed to have the following amounts of beds: Room 101-1 bed Room 104-1 bed Room 111-1 bed Room 114-2 beds Room 201-2 beds Room 202-1 bed Room 204-2 beds Room 206-2 beds Room 208-2 beds</p> <p>An interview with the Administrator on 7/25/14 at 11:27 a.m. indicated these were the rooms which had the variance waivers. She indicated some of the rooms were licensed for double occupancy but currently had only one bed in the room.</p>						

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F000465 SS=E	<p>3.1-19(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to sagging and stained ceiling tiles, gouged doors and walls, marred doors and walls, chipped paint, loose base molding, rusty metal, broken toilet paper holders, warped radiators, stained call light pull cords, cracked floor tiles, ripped wheelchair arm pads, and duct - taped window air conditioner units on 4 of 4 hallways throughout the facility. (A hall, B hall, C hall & 2nd floor). This had the potential to affect 42 residents residing in the facility.</p> <p>Findings include:</p> <p>During an Environmental tour on 7/25/14 at 10:40 a.m., with the Administrator, the following was observed:</p> <p>1. Main Dining Room (downstairs): The</p>	F000465	<p>1. All of the cited areas have been cleaned, repaired or replaced. 2. A complete round of the facility was completed to ensure the environment meets with regulatory compliance. 3. A thorough inspection of each room and common area in the facility will be completed on a weekly basis by the Environmental Service Supervisor and Maintenance Director. These inspections will include the specific cited issues. A copy of these inspections will be submitted to the Administrator. (See attachment #8) 4. The results of these inspections will be submitted to the Quality Assurance Committee on a quarterly basis for no less than one year. 5. August 24, 2014</p>	08/24/2014

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	<p>ceiling tiles were sagging & stained throughout the room. There were 20 residents eating in this dining room at the time of the initial observation on 7/21/14 at 12:00 p.m.</p> <p>2. Hall A (main entrance hallway):</p> <p>a. The ceiling tiles were stained in the hallway by the DoN's (Director of Nursing) office.</p> <p>b. Room 102: The metal radiator panel was bent. There was a hole in the wall behind the TV above the light fixture. One resident resided in this room.</p> <p>c. Room 106: The floor tile was cracked near the room entrance. Two residents resided in this room.</p> <p>3. Hall B:</p> <p>a. Room 110: The the door frame to the bathroom was marred and the wall by the bathroom was gouged. Two residents resided in this room.</p> <p>b. Room 114: There was a gap around the window AC (air conditioning) unit which was covered by silver duct tape. There were also mars on the wall by the bed. One resident resided in this room.</p>			

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	<p>c. Room 115: The drain plug in the sink and the toilet handle were rusty. Two residents resided in this room.</p> <p>d. Room 116: There was considerable rust on the underside of the toilet seat and stabilizer bars. There was also a brown substance on the push button call light in the bathroom. Two residents resided in this room.</p> <p>4. Hall C:</p> <p>a. Room 121: There was a brown stain on the bathroom call light pull cord. The wall behind Bed #1 was also marred, Two residents resided in this room.</p> <p>b. Room 122: The bathroom door was gouged and the door jamb was marred and paint chipped. There was also a brown stain on the bathroom call light pull cord. Two residents resided in this room.</p> <p>c. Room 123: The closet door was gouged. The paint was chipped to the wall behind the TV and there were multiple exposed, unused nails. The paint was also chipped to the bathroom doorway. One resident resided in this room.</p> <p>d. Room 124: The outer bathroom door</p>			

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	<p>was gouged and the paint to the bathroom doorway was chipped. The toilet paper holder was broken and the bathroom call light pull cord was stained. There were areas of chipped paint to the walls of the room and bathroom. Two residents resided in this room, however the Administrator indicated neither currently used the bathroom in the room.</p> <p>e. Room 125: The walls behind Bed #1 were marred. There were gouges to the bathroom door and the bathroom doorway paint was chipped. The bathroom call light pull cord was also stained. One resident resided in this room.</p> <p>f. Room 126: There were gouges to the bathroom door & door jamb. Two residents resided in this room.</p> <p>g. Room 127: There was chipped paint to the wall behind Bed #1 and the paint to the bathroom door was also chipped. Two residents resided in this room.</p> <p>h. Room 128: The floor had long cracks in the tiles. The bathroom door was badly gouged and the doorway chipped. Two residents resided in this room.</p> <p>5. Second floor:</p>			

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	<p>a. Sitting room: The radiator on the lower wall had a bent metal piece which was sticking out. The hallway had a loose piece of molding. The carpet was stained in several places. There were 10 residents who resided on the second floor who would use the sitting room.</p> <p>b. Room 201: There were brown stains on the ceiling between the two beds and the outer bathroom door was gouged. The floor tile was also cracked. In the shared bathroom with room 203, the floor was marred, the pipes under the sink & supporting the toilet seat were rusted, there was a whitish buildup on the faucet, and black marks on the bathroom floor. Two residents resided in this room and four residents used this bathroom.</p> <p>c. Room 203: There were gouges to the room and bathroom doors. The floor by the bathroom had black marks. There were also black mars to the radiator on the wall. In the shared bathroom with room 201, the floor was marred, the pipes under the sink & supporting the toilet seat were rusted, there was a whitish buildup on the faucet, and black marks on the bathroom floor. Two residents resided in this room and four residents used this bathroom.</p> <p>d. Room 205: The radiator had a large</p>			

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	<p>dented piece. The arm pads of Resident #12's wheelchair were also ripped and had holes. The bathroom shared with Room 207 had a brown stain on the wall by the toilet paper holder and the wall above the sink had an area missing paint. One resident resided in this room and two residents used this bathroom.</p> <p>e. Room 206: The outer bathroom door was gouged. In the bathroom shared with Room 208, there was an area between the sink and toilet which had chipped paint and a gouged wall. There was one resident who resided in this room and two residents who used this bathroom.</p> <p>f. Room 208: The end piece of the lower wall radiator was off and sitting on a shelf above the unit. The resident indicated it had been there "for awhile." The paint was also chipped off the wall by the radiator. There were gouges on the outer bathroom door and mars on the wall by the bathroom. In the bathroom shared with Room 206, there was an area between the sink and toilet which had chipped paint and a gouged wall. There was one resident who resided in this room and two residents who used this bathroom.</p> <p>Interview with the Administrator at the time of the tour, indicated all of the areas</p>						

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F000514 SS=D	<p>were in need of cleaning, repair, or replacement.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 interview, the facility failed to ensure a resident's record was accurate, related to Physician's orders transposed incorrectly on the Physician Order Summary (POS)</p>	F000514	What corrective actions will be accomplished for those residents found to be affected by the deficient practice: Resident #24 - Upon surveyor observation the order was clarified and transcribed correctly onto the	08/24/2014	

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	<p>and the Medication Administration Record (MAR) for 2 of 6 residents reviewed for unnecessary medications. (Residents #24 and #46)</p> <p>Findings include:</p> <p>1. Resident #24's record was reviewed on 7/24/14 at 9:52 a.m. The Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Diagnoses included, but were not limited to, diabetes, depression, orthostatic hypotension, and heart failure. The resident was receiving dialysis treatments.</p> <p>Review of the July 2014 Physician Order Summary (POS) indicated the resident was receiving Midodrine HCL (blood pressure elevating medication) 10 mg tablet, take 1 tablet by mouth twice a day (Hold if systolic blood pressure <170 (below 170) for orthostatic hypotension (low blood pressure).</p> <p>Review of the June and July 2014 Medication Administration Record (MAR) indicated the resident received the medication every day when systolic blood pressure was below 170.</p>		<p>Medication Administration Record. Resident #46 - Upon surveyor observation the current POS was reviewed to ensure the sliding scale order was correct. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the same deficient practice. The facility is confident that with in-servicing this issue will not recur. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Staff will be in-serviced on transcription of orders. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: The DON/designee will complete a random audit of 10% of the medical records on a monthly basis to ensure accuracy in the transcription of orders. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of two quarters. See attachment #8) By what date the systemic changes will be completed: August 24, 2014</p>	

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	<p>Review of the May 2014 POS indicated the resident was Midodrine HCL (blood pressure elevating medication) 10 mg tablet, take 1 tablet by mouth twice a day (Hold if systolic blood pressure >170 (greater 170) for orthostatic hypotension (low blood pressure).</p> <p>Review of the May 2014 MAR indicated the resident received the medication according to the order.</p> <p>Interview with the Director of Nursing on 7/24/14 at 11:16 a.m., indicated the May POS was correct. The order was transposed incorrectly for June and July from the pharmacy and the facility should have caught the inaccurate symbol for the order.</p> <p>2. Resident #46's record was reviewed on 07/22/14 at 1:11 p.m. The resident's diagnoses included, but were not limited to diabetes.</p> <p>The physician's order date 4/29/14 "Novolog Sliding Scale Accuchecks (blood sugar monitoring) TID (three times a day) 1-149= 0 units, 150-179=1 unit, 180-209=2 units, 210-239=3 units, 240-269=4 units, 270-299=5 units, 300-329=6 units, 330-359=7 units, 360-400=8 units, over 400=9 units & Call MD (physician).</p>			

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F009999	<p>The June 2014 MAR (Medication Administration Record) indicated Novolog Sliding Scale: 0-149 0=units, 150-179= 1 unit, 180-209= 2 units, 240-269= 4 units, 270-299= 5 units, 300-329= 6 units, 330-359= 7 units, 360-400= 9 units & call MD.</p> <p>Interview on 7/22/14 at 4:05 p.m. with the DoN (Director of Nursing), indicated the 4/29/14 physician's order was transposed onto the June 2014's MAR incorrectly.</p> <p>3.1-50(a)(1) 3.1-50(2)(2)</p> <p>3.1-14 PERSONNEL</p> <p>In addition to the required inservice hours in subsection (I), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain</p>	F009999	<p>1. The facility is unable to retrospectively address the cited concern. 2. A review of each employee's online education and training has been completed to identify individuals that have not completed the required 6 hour dementia training. All staff have completed the 6 hour training as required. 3. An in-service calendar has been put into place to ensure all employees complete the initial 6 hours of required dementia training within the first 6 months of employment. 4. On a monthly basis, human resources will review employee's online training to ensure the facility</p>	08/24/2014

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	<p>understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six hours of dementia - specific training annually for 2 out of 10 employees whose records were reviewed for 2013 - 2014. (RN #1 and LPN #2)</p> <p>Findings include:</p> <p>Facility staff personal files were reviewed on 7/25/14 at 9:00 a.m. Files lacked documentation of dementia training for 2013 - 2014 for two employees who had worked in the facility longer than six months.</p> <p>1. RN #1 was hired on 9/12/13 and was still employed with the facility. The staff personal file indicated no dementia training had been completed.</p> <p>2. LPN #2 was hired on 8/29/13 and was still employed with the facility. The staff personal file indicated no dementia training had been completed.</p> <p>Interview with the Administrator on 7/25/14 at 9:30 a.m., indicated each</p>		<p>remains in compliance. Those employees that fail to complete the 6 hour dementia training within the required 6 month time frame will be removed from the schedule. The results of this review will be submitted to the Quality Assurance Committee on a quarterly basis for no less than 1 year. 5. August 24, 2014</p>		

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	<p>department head is responsible for making sure dementia training is completed.</p> <p>Interview with the DoN on 7/25/14 at 10:00 a.m., indicated she could not find any documentation the above staff had the required dementia training for 2013 - 2014.</p> <p>3.1-14(u)</p>				