

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2012
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NAME OF PROVIDER OR SUPPLIER  SCOTT VILLA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the investigation of complaint numbers IN00102017 and IN00101919</p> <p>Complaint IN00102017 Substantiated - Federal/State deficiencies related to the allegations are cited at F157, F226, F323 and F514.</p> <p>Complaint IN00101919 Substantiated -Federal/State deficiencies related to the allegations are cited at F157, F226, F323 and F514.</p> <p>Survey Dates: January 17, 18, 19, 20, 23, 2012</p> <p>Facility number: 000168 Provider number: 155267 Aim number: 100267020</p> <p>Survey Team: Avona Connell, RN, TC Donna Groan RN. Dorothy Navetta, RN (January 17, 18, 19, 20, 2012) Gloria J. Reisert, MSW (January 18, 19, 20,23, 2012)</p>	F0000	The submission of this Plan of Correction does not constitute an admission by the Provider of any fact or conclusion set forth in the statement of deficiencies. The Plan of Correction is submitted because it is required by law.	

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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	<p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor Type: Medicare: 15 Medicaid: 34 Other: 09 Total: 58</p> <p>Sample: 15 Supplemental sample: 24</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/27/12 Cathy Emswiller RN</p>			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to notify the physician of a change in condition for a resident with behaviors for 1 of 5 residents reviewed with behaviors in a sample of 11.</p>	F0157	1.)Resident B no longer resides at the facility.2.)Licensed nurses were re-educated on notifying the physician when a change in the resident's clinical condition exists. A one time chart review occurred	02/17/2012

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	<p>(Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/17/12 at 1 p.m. The resident's diagnoses included, but were not limited to: senile dementia, toxic metabolic encephalon and anxiety. The resident was admitted to the facility on 12/26/11.</p> <p>Progress Notes included, but were not limited to the following:</p> <p>12/26/11 11:50 p "Res resting abed...Speech slurred @ times..."</p> <p>12/27/11 8:30 a.m., "Res. (resident) ref'd (refused) meds this AM. Pulled out tube connector to F/C (foley/cath). Ref'd to let it be re-attached. Res seeing 'a little girl under my chair.' Documentation was lacking of the physician being notified of the hallucination.</p> <p>On 1/19/12 at 7:15 a.m., in interview with the Director of Nursing, she indicated the MD should have been called and informed of the hallucinations.</p> <p>On 1/12/12 at 10:40 a.m., the Administrator provided the policy and procedure for Physician Notification</p>		<p>to ensure that all changes in resident's condition were reported to the MD for the last 30 days.3.)System change to include the DON/designee will review nurse's notes 5x week x 12 weeks, then bimonthly x 3 months to ensure if there was a change in the resident's clinical condition that MD notification occurred.4.)Results of the audits will be reviewed at the monthly QA meeting for a least 6 months. Any further incidents will results in re-education and/or disciplinary action by the HFA/DON.</p>				

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	<p>which included, but was not limited to: "Communicate effectively with the Medical Doctor (MD), Nurse Practitioners (NP), and Physicians Assistant (PA) when a resident has had an acute change in condition..."</p> <p>This federal tag relates to Complaint(s) IN00101919 and IN00102017.</p> <p>3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to ensure the policy and procedure for interviewing residents possibly affected by another residents behaviors was implemented for 1 of 4 residents reviewed for behaviors in a sample of 15. (Resident B, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z )</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/17/12 at 1 p.m. The resident's diagnoses included, but were not limited to: senile dementia, toxic metabolic encephalopathy and anxiety The resident was admitted to the facility on 12/26/11.</p> <p>Progress Notes included, but were not limited to: 12/29/11 7:26 p.m. "Res (resident) came to [named unit] pushing chair down hall. Came to nurses station. Res. confused agitated (sic). Became verbal abusive stating he wasn't getting a divorce &amp; wife &amp; friend were coming to hurt him. Res grabbed water pitcher off</p>	F0226	<p>1.)Resident B no longer resides at the facility.2.)DON/HFA re-educated on Investigation policy and procedure by the RDCO. A one time chart review was conducted on investigations that occurred in the last 30 days to ensure the investigation of policy and procedure was followed.3.)System change: DON/Designee to complete QA tool with each investigation to ensure all steps are done according to policy and procedure x 12 weeks then bimonthly x 3 months. 4.)Results of the audits will be reviewed at the monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action.</p>	02/17/2012

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	<p>of med cart &amp; ran into a room slinging water out of pitcher, then threw water pitcher on floor, grabbed bed side table &amp; began to throw bedside table but staff interven (sic) then began hitting window with table. Knocked this writer into wall/window and staff member encouraged res to sit in chair..."</p> <p>12/29/11 7:45 p.m. "When res. came to his unit he grabbed crash cart &amp; tipped it over. Res. was very agitated (sic) at this point &amp; started trying to find things to throw. LPN #2 came to unit &amp; tried talking with res. to calm him down but no results. Res. became physically abusive by hitting, trying to bite, head butting staff. Res. got behind nurses station &amp; started unplugging machines &amp; picking things up trying to throw them. Res. entered other res. rooms &amp; staff had to redirect him to hallway. Ambulance members came with stretcher &amp; res. attempted to trip EMT (Emergency Medical Technician). Then res. fought with EMT's so soft gauze were applied to wrists &amp; ankles."</p> <p>12/30/11 12:30 AM "Made aware per [named] LPN that [hospital] had called facility, stated that res. would be returning to facility. [Named] Administrator, made aware of pending return, she, requested staff to call [hospital] with request to have</p>						

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	<p>resident kept @ [hospital] ER (Emergency Room) until morning. This nurse spoke with [hospital named] ER why stated 'No, you have to take him back.' [Named] Administrator made aware via phone of conversation."</p> <p>2:15 A "Res returned to facility @ this time. New order noted to start Levaquin 750 mg 1 tab dly (daily) Total of #10. Hospital staff stated he had pneumonia. Res. family @ bedside res becoming loud @ times but easily redirect.</p> <p>3 A. Res in room with family members @ bedside.</p> <p>5 A. Res cont. to be in room family member getting ready to leave. Will cont with frequent monitoring &amp; initiate 24 hr. flow sheet.</p> <p>5:10 A lab tech here to draw PT (Protime)/INR (International Ratio). res tolerated procedure well.</p> <p>5:15 A A fax sent to MD to see if res can have PT/INR while on Levaquin, because of medication interaction. No adverse reactions noted to Levaquin that was given @ hospital.</p> <p>5:30 A. frequent check done and staff noticed that window was open. Staff</p>			

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	<p>began checking all rooms and began to go outside &amp; do search. Staff notified that res was in empty dumpster. 4 staff members assisted Res out. 1 staff member went to get w/c (wheelchair) to take res into facility. When ask why he entered dumpster he stated he though (sic) he was be (sic) shot at....DON &amp; administer (sic) were made aware 911 was dispatched family was made aware of incident.</p> <p>12/30/11 8:30 AM Res noted agitated. Resident not able to calm down. MD. notified. New order received to send resident to ER for eval &amp; treat. 2 EMTs present and police officer present during transfer. POA (Power of Attorney) updated. 12/30/11 11 AM this writer called [named hospital] ER. Nurse in Er stated resident to be admitted to [named behavior hospital]."</p> <p>On 1/18/12 at 1:30 p.m. during the Group Interview with 15 alert and oriented residents (Resident L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z) as identified by the Activities Director indicated they were not afraid of any current residents in the building.</p> <p>On 1/19/12 in interview with LPN #1 at 6:55 a.m., she indicated Res. I was scared and was going to leave the facility, if</p>			

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	<p>Resident B came back.</p> <p>On 1/19/12 in interview with the Director of Nursing at 7:15 a.m., she indicated she was not aware of Resident B going into any resident rooms. Social Services was not involved. Residents were interviewed, but "notes were not written down." Documentation was lacking of any resident interviews after the alleged incident.</p> <p>On 1/17/12 at 4 p.m., the Administrator provided the facility policy and procedure for Accident and Incident Reporting revised 2010 which included, but was not limited to: "Subject Accidents and Incidents: Report, Investigation, Follow-up, and Final Disposition; Procedure: 9. Initiate an investigation by collecting information that corroborates or disproves the incident and document the findings for each incident. A thorough investigation may include: interviewing alleged victim(s) and witness(es); Interviewing other residents to determine if they have been abused or mistreated;" Documentation was lacking of any resident interviews related to the incident of 12/29/11.</p> <p>On 1/19/12 at 10 a.m., the Medical Records person provided a list of residents identified as being interviewed</p>				

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	<p>by the Director of Nursing related to the incident on 12/29/11. Resident interviews were not part of the review of the reportable incident as the DON indicated she did not write up the interviews.</p> <p>This federal tag relates to Complaint(s) IN00101919 and IN00102017.</p> <p>3.1-28(a)</p>			

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F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, record review and interview the facility failed to ensure equipment was clean, functioning, and in good repair in 2 of 2 shower rooms, 1 of 3 sitting areas. This had the potential to affect 29 residents on halls 100, 200, and 300 and 31 residents on the 400, 500, and 600 halls.</p> <p>Findings include:</p> <p>1. On 01/18/12 at 8:29 a.m. the following was noted in the shower room on the 300 hall:</p> <p>A. The paint was peeling from the ceiling in the 1st shower stall and the lights failed to turn on.</p> <p>B. On 01/17/12 upon entrance to the facility at 2:30 p.m., the glass on the bird aviary was soiled with bird droppings.</p> <p>C. At 12:50 p.m., in interview with the Maintenance Director he indicated he was not aware lights were out in the 300 hall shower room.</p> <p>D. A large plastic pipe reclining shower</p>	F0253	<p>1.)300 shower room ceiling was repaired. All lights in the shower room are in good working condition. The bird aviary was cleaned to remove the soiled bird droppings. Facility shower chairs were cleaned to remove any debris. The tile in the shower room was repaired. The shower curtains with soiled stains were removed. The picture frame and 2 artificial trees were dusted. The ceiling light by the 300 nursing desk was repaired. The rubber mat on the platform of the weight scale was cleaned. The 600 hall shower room lights were replaced. The sharps box and artificial flower in the women's restroom were dusted.2.)Education has been provided to the Maintenance Director and the Housekeeping Supervisor to ensure the facility is clean and in good working condition according to policy and procedure. A one time walk through of the building was completed to make sure all of the above items were corrected. 3.)System change: Maintenance Director and Housekeeping Supervisor/designee will conduct rounds 5x/week x 12 weeks then bimonthly x 3 months to ensure</p>	02/17/2012	

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	<p>chair was soiled with a green and brown substance under the toilet seat.</p> <p>E. A regular size plastic pipe shower chair was soiled with black and brown substance at base of chair.</p> <p>2. On 01/19/12 between 5:07 a.m. and 6:17 a.m., the following was noted :</p> <p>F. The tile between the first and second shower stall was broken and missing in an area approximately 4 inches in the 600 hall shower room. Three shower curtains were soiled with browns stains.</p> <p>G. The picture frame and two artificial trees in the front sitting area by the bird aviary were soiled with heavy dust. Two panes of glass of the aviary were soiled with bird excrement..</p> <p>H. The cover on the ceiling light in the hall by the 300 nursing desk was broken with a piece approximately 3 inches missing.</p> <p>I. The rubber mat on the platform of the weight scale was soiled with dirt and dust.</p> <p>J. The 600 hall shower room had the light out over the hand sink. The curtain on the stall near the hand sink was soiled with a brown stain.</p>		<p>items are corrected.4.)Results of the audits will be reviewed at the monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action.</p>		

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	M. Heavy dust was observed on the sharps box and artificial flower near the hand sink in the women's bathroom.  3.1-19(b)			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update the resident's care plan when a new order was received for fluid restrictions to indicate who would be responsible for the breakdown of fluid offered the resident throughout the day. This deficient practice affected 1 of 1 resident reviewed for fluid restrictions in a sample of 15 residents. (Resident#A)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #A on 1/20/2012 at 8:35 a.m., indicated the resident had diagnoses which</p>	F0280	<p>1.)Resident A is no longer on fluid restrictions.2.)All residents on fluid restrictions have the potential to be affected. License nurses were re-educated on fluid restrictions and how to breakdown the fluids and to update care plans to reflect the restrictions.3.)DON/Designee will review new physician orders 5x week x 12 weeks, the bimonthly x 3 months to ensure fluid restrictions are broke down correctly and care plans are update to reflect the restrictions.4.)Results of the audits will be reviewed at monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or</p>	02/17/2012

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	<p>included, but were not limited to: schizoaffective disorder, dementia with behavior disturbance, anxiety state and depression.</p> <p>Review of the January 2012 monthly physician orders indicated the resident had an order for 4000 cc [cubic centimeters]/24 hour fluid restrictions dated 12/15/2011 when she returned from the hospital.</p> <p>Review of the December 2011 to January 2012 treatment records, medication administration records, monthly physician orders, tray cards, dietary progress notes and the "Nutrition Risk Plan of care" dated 12/15/2011 failed to include documentation of how the 4000 cc restrictions would be broken down as to who gives what amount to the resident.</p> <p>During an interview with the Director of Nursing [DoN] on 1/20/2012 at 9:55 a.m., she indicated the breakdown of how much was given to the resident by what department - nursing or dietary - should be documented on the nutritional care plan. She also indicated the resident had a tendency to drink much more than 4000 ccs if she was allowed as she will ask numerous staff for a drink.</p>		disciplinary action by the HFA/DON.				

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	<p>On 1/23/2012 at 9:15 a.m., the DoN presented a copy of the facility's current policy and procedure on "Fluid Restriction". Review of this policy at this time included, but was not limited to:</p> <p>"Policy: [facility name] strives to assure that all residents with a fluid restriction are receiving appropriate fluid amounts according to the resident's physician order. The Nutrition Services Department will collaborate with Nursing Services Department to assure this occurs... Procedure:...7. Document the fluid restriction pattern on the resident's Nutritional Risks Plan Of Care, and Resident Care Delivery...with clear delineation of how many mls [milliliters] each department provides..."</p> <p>3.1-35(a) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician orders for daily weight monitoring and follow through on recommendations from the neurologist for 1 of 1 resident reviewed for physician orders and recommendations in a sample of 15 residents. (Resident #40).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #40 on 1/18/2012 at 8:30 a.m., indicated the resident had diagnoses which included, but were not limited to: anxiety, hyperlipidemia, depression, diabetes mellitus, and seizure disorder.</p> <p>On 11/16/2011, the resident returned from a neurologist appointment for follow up due to tremors. Review of the progress note indicated the neurologist recommended a trial of a motorized wheel chair to see if it helped with her mobility. Review of the nursing note for this date indicated that at 3:15 p.m., the resident returned with no new orders.</p>	F0282	<p>1.)Resident #40 no longer requires a daily weight and the recommendation for the motorized w/c was discontinued r/t resident did not want it.2.)A one time chart review was completed to ensure all progress notes and daily weights were followed through that were obtained within the last 30 days. Licensed nurses were re-educated on obtaining daily weights and following recommendations obtained at MD offices.3.)System change: DON/Designee will review physician orders 5x/week x 12 weeks then bimonthly x 3 months to ensure physician orders are followed through and will review progress notes after physician visits.4.) Results of the audits will be reviewed at monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012			

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	<p>On 12/28/2011, the resident returned from the neurologist appointment due to increased falls and tremors. Review of the progress note indicated the neurologist was going to check a head CT [CAT] scan given the falls. Review of the nursing note for this date indicated that at 5:00 p.m., the resident returned with no new orders.</p> <p>During an interview with LPN #2 on 1/18/2012 at 1:20 p.m., she indicated that she did not see either of the recommendations by the neurologist as they were not written on a physician order form. She also indicated she would have to clarify with the neurologist if he still wanted the trial of the motorized wheel chair and if he wanted to just look at the head CTs from the summer or if he meant for a new one to be done.</p> <p>During an interview with Resident #40 on 1/19/2012 at 3:00 p.m., she indicated she wanted to be more mobile and her goal was really to walk but just thought if she had an electric wheelchair, she could get around faster and not have to rely on the staff so much.</p> <p>Review of the January 2012 monthly physician orders indicated the resident had an order dated 7/28/2011 for "Daily weights - call MD [physician] if &gt;</p>			

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	<p>[greater] 2 # [pound] gain in 24 hours or 5 # gain in 1 week or less".</p> <p>During an interview with LPN #3 on 1/18/2012 at 9:40 a.m., she indicated the daily weights were documented in the treatment record and were now also being put into the computer. Review of the monthly treatment records between July 2011 and December 2011 failed to indicate the weights were being monitored daily per order.</p> <p>During an interview with the Administrator on 1/18/2012 at 11:50 a.m., she indicated she had checked the computer and the record and that although the resident was supposed to be on daily weights, they were not done daily until January 2012.</p> <p>During interviews with CNAs [certified nursing assistants] #6 and #7 on 1/20/2012 at 10:30 a.m. and at 10:40 a.m., they indicated they did not know Resident #40 was on daily weights until recently. They indicated the nurse would be the one to tell them who was on daily weights or had orders for specific things to be done.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to monitor a resident's daily weight per physician order and follow through on recommendations from the neurologist for 1 of 1 resident reviewed for physician orders and recommendations in a sample of 15 residents. (Resident #40).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #40 on 1/18/2012 at 8:30 a.m., indicated the resident had diagnoses which included, but were not limited to: anxiety, hyperlipidemia, depression, diabetes mellitus, and seizure disorder.</p> <p>On 11/16/2011, the resident returned from a neurologist appointment for follow up due to tremors. Review of the progress note indicated the neurologist recommended a trial of a motorized wheel chair to see if it helped with her mobility. Review of the nursing note for this date indicated that at 3:15 p.m., the resident</p>	F0309	<p>1.)Resident #40 no longer requires a daily weight and the recommendation for the motorized w/c was discontinued r/t resident did not want it.2.)A one time chart review was completed to ensure all progress notes and daily weights were followed through that were obtained within the last 30 days. Licensed nurses were re-educated on obtaining daily weights and following recommendations obtained at MD offices.3.)System change: DON/Designee will review physician orders 5x/week x 12 weeks then bimonthly x 3 months to ensure physician orders are followed through and will review progress notes after physician visits.4.) Results of the audits will be reviewed at monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012			

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	<p>returned with no new orders.</p> <p>On 12/28/2011, the resident returned from the neurologist appointment due to increased falls and tremors. Review of the progress note indicated the neurologist was going to check a head CT [CAT] scan given the falls. Review of the nursing note for this date indicated that at 5:00 p.m., the resident returned with no new orders.</p> <p>During an interview with LPN #2 on 1/18/2012 at 1:20 p.m., she indicated that she did not see either of the recommendations by the neurologist as they were not written on a physician order form. She also indicated she would have to clarify with the neurologist if he still wanted the trial of the motorized wheel chair and if he wanted to just look at the head CTs from the summer or if he meant for a new one to be done.</p> <p>During an interview with Resident #40 on 1/19/2012 at 3:00 p.m., she indicated she wanted to be more mobile and her goal was really to walk but just thought if she had an electric wheelchair, she could get around faster and not have to rely on the staff so much.</p> <p>Review of the January 2012 monthly physician orders indicated the resident</p>						

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	<p>had an order dated 7/28/2011 for "Daily weights - call MD [physician] if &gt; [greater] 2 # [pound] gain in 24 hours or 5 # gain in 1 week or less".</p> <p>During an interview with LPN #3 on 1/18/2012 at 9:40 a.m., she indicated the daily weights were documented in the treatment record and were now also being put into the computer. Review of the monthly treatment records between July 2011 and December 2011 failed to indicate the weights were being monitored daily per order.</p> <p>During an interview with the Administrator on 1/18/2012 at 11:50 a.m., she indicated she had checked the computer and the record and that although the resident was supposed to be on daily weights, they were not done daily until January 2012.</p> <p>During interviews with CNAs [certified nursing assistants] #6 and #7 on 1/20/2012 at 10:30 a.m. and at 10:40 a.m., they indicated they did not know Resident #40 was on daily weights until recently. They indicated the nurse would be the one to tell them who was on daily weights or had orders for specific things to be done.</p> <p>3.1-37(a)</p>						

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review, observation and interview the facility failed to ensure a resident utilizing a nasal canula for the administration of oxygen had routine skin checks to prevent a pressure ulcer over the ear and padding over the oxygen tubing for 1 of 3 residents reviewed for pressure ulcer in a sample of 15 and 3 of 4 residents reviewed with a nasal canula in a supplemental sample of 24. (Resident C, E, F, G )</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 1/17/12 at 5:55 p.m. The resident diagnose's included, but were not limited to; schizophrenia, diabetes mellitus and acute renal failure and congestive heart failure. The admission minimum data set assessment (MDS) dated 10/18/11 included, but was not limited to: Cognitive intact admitted with</p>	F0314	<p>1.)Resident C no longer resides at the facility.2.)A one time review was completed on all resident who have a n/c to ensure no redness or open area were present. Licensed nurses were re-educated to provide routine checks during daily care for residents with oxygen to ensure resident have no complaints of pain, redness or open areas from the oxygen.3.)System change: Licensed nurses will assess resident's with oxygen every shift and document any new findings. 4.)Results of the audits will be reviewed at monthly QA meeting for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012

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	<p>Stage III pressure ulcer to L (left) hip.</p> <p>The Skin Integrity Assessment: Prevention and Treatment Plan of Care dated 11/30/11 included, but was not limited to: 11/30/11 "Assessment: At risk related to: O2 tubing; Interventions: Keep skin clean, dry, and free of body wastes, perspiration, and wound drainage." Documentation was lacking of a specific intervention related to the oxygen tubing.</p> <p>A Skin Grid - Pressure/Venous Insufficiency Ulcer/other sheet dated 1/2/12 included, but was not limited to: "Initial Identification: was not present on admission; abrasion dark red" on the right ear.</p> <p>An intervention added to the Skin Integrity Assessment Plan of Care indicated "1/3/12 Pad O2 tubing at all times"</p> <p>The Progress Notes for the IDT (Interdisciplinary Team) included, but was not limited to: 1/3/12 "IDT met and reviewed. N/O (New Order) O2 tubing to be padded as preventative. Apply bacitracin to (L) ear BID (2 x day) x 14 days then re-eval."</p> <p>2. On 1/19/12 between 8:35 a.m. and 9</p>			
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	<p>a.m., the following was observed: Resident E identified as alert and oriented by the DON indicated the nasal canula bothered the left ear. The DON assessed his left ear at which time no redness was observed. There was an indentation on his face from the tightness of the tubing on his face on both the left and right side of his nose. Oxi-ears were not present on the tubing for padding over the ears.</p> <p>3. Resident F was observed lying in bed with the nasal canula in place. The DON assessed around both ears and no redness was observed. Oxi-ears were not present on the tubing for padding.</p> <p>4. Resident G was walking around the room with her oxygen tubing off at this time. She was identified as alert and oriented and indicated no problems with redness nor soreness around her ears. There were no oxi-ears on the oxygen tubing for padding.</p> <p>In interview with the Administrator on 1/19/12 at 9:05 a.m., she indicated there was "no policy and procedure for the use of the oxi-ears".</p> <p>On 1/20/12 at 8:08 a.m. the Administrator provided the "Direction for Use E-Z Wrap" which included, but was not limited to: "Install one E-Z wrap on each</p>			

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	<p>side of the canula headset mid-way between the face piece and the 'Y' piece with slit (cut) in the upward position. Move the E-Z Wrap to the most comfortable position on or behind the ear to alleviate pressure..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure the resident was supervised 1:1 after an elopement as outlined in the facility policy for 1 of 1 resident reviewed with an elopement from the facility thru the window in the resident room in a sample of 15. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/17/12 at 1 p.m. The resident's diagnoses included, but were not limited to: senile dementia, toxic metabolic encephalopathy and anxiety The resident was admitted to the facility on 12/26/11. Progress Notes included, but were not limited to the following:</p> <p>12/29/11 1 am "...Res has slept all shift except i (one) time and Res wandering in hallway and trying to undress. Res redirected back into room. Speech clear. Very slow to respond to questions and answers inapro (inappropriately) @ times. No S/S (signs/symptoms) of discomfort or</p>	F0323	<p>1.)Resident B no longer resident at the facility.2.) All residents have the potential to be affected. Licensed nurses were re-educated on designating a staff member and documenting it if a resident requires 1:1. There are currently no residents in the building that require 1:1 monitoring.3.)System change: Charge nurse will be responsible to ensure 1:1 documentation is initiated at the time that it occurs. DON/Desingee will review each behavior that requires 1:1 monitoring weekly x 12 weeks then bimonthly x 3 months.4.)Results of the audits will be reviewed at monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012

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	<p>distress @ this time. Res refused supper x 3."</p> <p>12/29/11 1:30 PM "add diagnosis: BPH (Benign Prostatic Hypertrophy), angina, A-fib (atrial fibrillation) 2. PT (protime)/INR ( International Ratio) in AM 3. start coumadin (blood thinner) 5 mg (milligram) po (by mouth) once daily. family updated."</p> <p>12/29/11 1:55 PM "new orders received d/c (discontinue) Oxycontin (pain med) 40 mg TID (three times a day) when new order arrives, N/O (New/Order) Oxy continue 30 mg i po TID x &amp; days, then oxycontin 20 mg i po TID x 7 days then Oxycontin 10 mg i po TID x 7 days, then oxycontin 10 mg po BID (two times a day) x 4 days, then oxycontin 10 mg po daily x 3 days, then D/C (discontinue) family notified..."</p> <p>12/29/11 7:45 p.m. "When res. came to his unit he grabbed crash cart &amp; tipped it over. Res. was very agitated (sic) at this point &amp; started trying to find things to throw. LPN #2 came to unit &amp; tried talking with res. to calm him down but no results. Res. became physically abusive by hitting, trying to bite, head butting staff. Res. got behind nurses station &amp; started unplugging machines &amp; picking things up trying to throw them.</p>			

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	<p>Res. entered other res. rooms &amp; staff had to redirect him to hallway. Ambulance members came with stretcher &amp; res. attempted to trip EMT (Emergency Medical Technician). Then res. fought with EMT's so soft gauze were applied to wrists &amp; ankles." The resident was returned to the facility on 12/30/11 at 2:15 A.</p> <p>2:15 A "Res returned to facility @ this time. New order noted to start Levaquin 750 mg 1 tab dly (daily) Total of #10. Hospital staff stated he had pneumonia. Res. family @ bedside res becoming loud @ times but easily redirect. 3 A. Res in room with family members @ bedside. 5 A. Res cont. to be in room family member getting ready to leave. Will cont with frequent monitoring &amp; initiate 24 hr. flow sheet. 5:10 A lab tech here to draw PT (Protime)/INR (International Ratio). res tolerated procedure well. 5:15 A A fax sent to MD to see if res can have PT/INR while on Levaquin, because of medication interaction. No adverse reactions noted to Levaquin that was given @ hospital. 5:30 A. frequent check done and staff noticed that window was open. Staff began checking all rooms and began to go outside &amp; do search. Staff notified that res was in empty dumpster. 4 staff members assisted Res out. 1 staff member went to get w/c (wheelchair) to</p>			

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	<p>take res into facility. When ask why he entered dumpster he stated he though (sic) he was be (sic) shot at....DON &amp; administer (sic) were made aware 911 was dispatched family was made aware of incident.</p> <p>12/30/11 8:30 AM Res noted agitated. Resident not able to calm down. MD. notified. New order received to send resident to ER for eval &amp; treat. 2 EMTs present and police officer present during transfer. POA (Power of Attorney) updated. 12/30/11 11 AM this writer called [named hospital] ER. Nurse in Er stated resident to be admitted to [named behavior hospital]."</p> <p>A 24 Hour Resident Flow Record indicated 15 minute checks with no Reason identified for the "Checks." After the resident eloped through the window between 5:15 a.m. and 5:45 a.m. the 15 minute checks were again started at 5:45 a.m.</p> <p>The Prevention and Reporting policy and procedure provided by the Administrator on 1/17/12 at 4 p.m., included, but was not limited to: "Protection: Provided 1:1 monitoring; Increase amount of resident supervision and Implement discharge process immediately, if the resident is a danger to self or to others. 2. Initiate</p>			

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	<p>behavior crisis management interventions, as applicable (Refer to the "Mood and Behavior Crisis Management:" Procedure in the "Mood and Behavior Program" located in the Clinical Programs Manual.)"</p> <p>An Accident/Incident Report included in the clinical record, indicated the following: Date of Incident 12/30/11 5:40 a.m. Rm 300 A window open Res went out window after family member left facility (window in his room). Facility searched staff performed search around outside of facility. Res found in dumpster behind health department...Dumpster with sliding door...Immediate Action Taken To Prevent Further Incidents: Cont. with 1:1..." Documentation was lacking of 1:1 being implemented.</p> <p>The Elopement Plan of Care: Assessment, Prevention and Management signed and dated 12/30/11 included, but was not limited to: "Exit Seeking Behavior Described - lacked explanation: Intervention 1 - 1 with resident [named hospital] contacted for eval 6:45 a.m."</p> <p>In interview with the Administrator on 1/19/12 at 9:25 a.m., she indicated the 1:1 was "family the wife."</p> <p>In interview with the Social Worker at</p>			

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	<p>10:05 a.m., she indicated after the resident returned from the hospital on 12/30/11 he was placed on 1:1 checks. At 10:08 a.m., she indicated the 1:1 started after he went out the window. Documentation was lacking of the resident being monitored 1:1.</p> <p>This federal tag relates to Complaint(s) IN00101919 and IN00102017.</p> <p>3.1-45(a)(2)</p>				

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>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"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <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"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <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 and record review the facility failed to follow their procedure for posting the daily nurse staffing data for 1 of 4 survey days. (January 19th, 2012) This had the potential to affect all 58 residents residing</p>	F0356	1.)All residents have the potential to be affected.2.)Education was provided to the ADON regarding filling out the daily staff form correctly by the HFA. 3.)System change: The ADON/Designee will be responsible to ensure the daily	02/17/2012			

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	<p>in the facility and their visitors.</p> <p>Findings include:</p> <p>On 1/19/12 upon entrance to the facility at 5:00 a.m., the posted "Daily Nurse Staffing Form" for 01/19/12, listed only the hours for the day shift. The night and evening shifts were blank.</p> <p>On 01/23/12 at 12 noon the administrator provided the procedure titled "Daily Nurse Staffing" was provided and indicated the following:</p> <p>Procedure: 1. "Initiate the Daily Nurse Staffing (Copy Form) at the start of the Night shift.</p> <p>2. Post the following information on a daily basis at the beginning of each shift:</p> <ol style="list-style-type: none"> <li>Facility name</li> <li>Current date</li> <li>Resident census</li> <li>Categories of nurse staff:</li> </ol> <p>Licensed and unlicensed nursing staff includes registered nurses, licensed practical nurses., licensed vocational nurses and nurses aides.</p> <p>e. Actual time worked for the specified categories of direct cared nursing staff: Enter the actual number and shift</p>		<p>staffing forms are completed daily. The DON/Designee will conduct weekly audits q week x 12 weeks then bimonthly x 3 months to ensure they are filled out correctly.4.)Results of the audits will be reviewed at monthly QA metings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	

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	<p>(including split shifts) of licensed and unlicensed staff directly responsible for the care of residents for that particular day on each shift.</p> <p>Post each shift staff numbers very close to the beginning of the shift in order to ensure that eh posted numbers are actual staff working the shift.</p> <p>If any changes to the information posted are needed, they must be made as soon as possible.</p> <p>f. Staffing totals: Enter the shift totals (including split shifts) of licensed and unlicensed nursing staff directly responsible for the care of the residents for that particular day on each shift using Full Time Equivalents (FTEs)"</p> <p>3.1-13(a)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review and interview the facility failed to ensure equipment was clean and in good repair on 1 of 2 dietary observations. This deficient practice had the potential to affect 58 of 58 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>On 01/17/12 at 2:40 p.m., the following was observed:</p> <ol style="list-style-type: none"> <li>1. The inner surface of a large Teflon skillet was heavily marred.</li> <li>2. The can opener blade was soiled with a dried black substance. In interview with the evening cook she indicated she had not used the can opener since coming on duty at 12:30 p.m.</li> <li>3. Eight steam table pans stored as clean were wet on the inner surfaces and soiled with food debris. (Six 1/4 pans and 2 1/2 pans).</li> </ol>	F0371	<p>1.)The large Teflon skillet, can opener, 8 steam table pans, 3 quart pan were cleaned. The trash container lid was placed back on the trash can. The 2 dietary aides were trained on how to check the sanitizer levels.2.)Re-education was provided to ensure items are clean and in good working order and staff members know how to check the sanitizer levels.3.)System change: Cook to make rounds at the beginning of each shift to ensure equipment is clean and in good repair and staff members know how to check the sanitizer levels. Dietary manager/designee will perform rounds 5x/week x 12 weeks, then bimonthly x 3 months to ensure equipment is clean and in good working order and staff are aware of how to check the sanitizer levels.4.)Results of the audits will be reviewed at monthly QA meetings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012

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	<p>4. One 3 quart pan stored as clean was soiled with food debris.</p> <p>5. The trash container lid was on the floor behind the container. The container was 3/4 filled with trash.</p> <p>6. The evening cook and dietary aide when asked to check the sanitizer levels in the containers of solution indicated they lacked knowledge on how to check the levels.</p> <p>3.1-21(i)(3)</p>			

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview the facility failed to follow the pharmacy Medication disposal and destruction policy/procedure for 2 of 15 sampled resident records reviewed. (Resident B, C)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/17/12 at 1 p.m. The resident's diagnoses included, but were not limited to; senile dementia, toxic metabolic encephalopathy and diabetes mellitus type II. The resident was</p>	F0425	<p>1.)Resident B &amp; C no longer reside at the facility.2.)Re-education ws provided to the Licensed nurses to ensure method of destruction is marked and a RN signature must be obtained for all meds that are returned to the pharmacy. A one time audit was completed fo the medication rooms to ensure meds were sent back timely and according to facility policy.3.)System change: Licensed nurse will review medication rooms each shift to ensure meds are sent back to the pharmacy per policy. DON/Designee will audit medication returns 3x/week x 12</p>	02/17/2012

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	<p>discharged from the facility on 12/30/11. Review of the Disposition of Unused Medication included, but was not limited to:</p> <p>A. Oxycotin (sic) 40 mg (milligram) 30 tabs Disposition Date 1/8/12 ; Method of Disposition Flushed/Incinerate, Other, Released to resident or responsible party not identified as to which method was used.</p> <p>B. Norco 5/325 mg 29 tablets Disposition Date 1/8/12 Discontinued on 12/27/11.</p> <p>C. Oxycotin (sic) 40 mg 22 tablets Disposition Date 1/8/12 Discontinued on 12/27/11.</p> <p>D. Lorazepam 1 mg 22 tablets Disposition Date 1/8/12 Discontinued on 12/27/11.</p> <p>2. The clinical record for Resident C was reviewed on 1/17/12 at 5:55 p.m. The resident's diagnoses included, but were not limited to; pneumonia, schizophrenia, acute renal failure and congestive heart failure. The resident was discharged to the local hospital on 1/7/12 and expired at [named] hospital on 1/9/12. A Drug Disposition Form dated 1/10/12 which identified 13 medications as having been</p>		<p>weeks, then bimonthly x 3 months to ensured the policy is being followed. 4.)Results of the audits will be reviewed at monthly QA metings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>		

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	<p>returned to the pharmacy and 1 medication Valproic Acid 10 ml (milliliters) Flushed. One staff member signature was present and no pharmacy signature was available.</p> <p>On 1/20/12 at 8:08 a.m., the Administrator provided the Pharmacy policy/procedure related to medication disposal and destruction which included, but was not limited to: "Procedure: 1. Facility staff should destroy and dispose of medications in accordance with Facility policy and Applicable Law. 2. Once an order to discontinue a medication is received, the Facility staff is to remove this medication from the resident's drug supply..5. The Facility destroys non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with facility policy or applicable law..."</p> <p>3.1-25(o) 3.1-25(r) 3.1-25(s)(4) 3.1-25(s)(6) 3.1-25(s)(8)</p>			

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F0513 SS=D	<p>483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.</p> <p>Based on record review and interview the facility failed to ensure the final report of diagnostic tests for 1 of 1 supplemental resident records reviewed with a moderate barium swallow study in a supplemental sample of 5 and a sample of 15 residents reviewed for diagnostic tests. (Resident C )</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 1/17/12 at 5:55 p.m. The resident diagnose's included, but were not limited to; schizophrenia, diabetes mellitus and acute renal failure. A Physician Telephone Order dated 12/5/11 indicated "MBSS (Modified Barium Swallow Study ) R/O (Rule/Out) aspiration and determine safe and appropriate po (by mouth) diet." On reviewed the lab/xray section of the record the result of the MBSS was not available.</p> <p>On 1/19/12 at 7:40 a.m., the Administrator provided the results of the MBSS performed on 12/13/11 at [named hospital] which included, but was not</p>	F0513	<p>1.)Resident C no longer resides at the facility.2.)A one time chart review was conducted on all current resident to ensure Barium Swallows were present on the active charts for orders obtained within the last 30 days. Licensed nurses were re-educated on ensureing Barium Swallow results were obtained and put on the clinical record.3.)System change: DON/Designee will review MD orders for Barium Swallows and ensure the are properly placed on the resident chart. DON/Designee will aduit MR of residents who receive Barium Swallows weekly x 12 weeks, then bimonthly x 3 months to ensure results are on the medical record.4.)Results of the audits will be reviewed at monthly QA metings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012

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	<p>limited to "Impression: 1. Aspiration with thin liquids. 2. Deep penetration with the nectar taken by straw. Please refer to the speech therapist notes for a detailed report." The report was faxed to the facility on 1/18/12 at 12:37 p.m.</p> <p>3.1-49(j)(4)</p>			

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F0514 SS=D	<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 the clinical record was complete and accurately documented for a resident with behavior changes was monitored closely for 1 of 4 residents reviewed for behaviors in a sample of 15. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/17/12 at 1 p.m. The resident's diagnoses included, but were not limited to: senile dementia, toxic metabolic encephalopathy and anxiety The resident was admitted to the facility on 12/26/11.</p> <p>Progress Notes included, but were not limited to the following:</p>	F0514	<p>1.)Resident B no longer resides at the facility.2.)A one time chart review was conducted to ensure if the resident was having behavior changes the MD was notified for the last 30 days prior. Licensed nurses were re-educated to notify MD with behavior changes.3.)System change:DON/Designee to review behavior logs 5x/week x 12 weeks, then bimonthly x 3 months to ensure no changes in behaviors that would require MD notification. 4.)Results of the audits will be reviewed at monthly QA metings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012			

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	<p>12/26/11 11:50 p.m. ..."Res resting abed. Resp even &amp; unlabored no acute distress. No verbal complaints. Res. takes meds whole without diff (difficulty). F/C (foley/cath) to BSD (bedside), clear yellow urine noted. Abd. (abdomen) soft non-distended. Speech slurred @ times. Res. alert to self. Call light with in reach."</p> <p>Next entry.</p> <p>12/27/11 8:30 a.m., "Res. (resident) ref'd (refused) meds this AM. Pulled out tube connector to F/C (foley/cath). Ref'd to let it be re-attached. Res seeing 'a little girl under my chair.' Documentation was lacking of the physician being notified of the hallucination.</p> <p>Next entry:</p> <p>2:45 P "Family aware of N.O.'s (New Orders)."</p> <p>Next entry.</p> <p>12/28/11 12:50 a.m. "Res. refused to take HS meds. Res not making eye contact &amp; pushing staffs hand with meds in it away. Went in @ 10 p and gave 10 pm meds and res. took them but I had to spoon meds into mouth. Res sleeping sideways(sic) in bed and refusing to keep covers on...."</p> <p>Next entry:</p>						

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	<p>12/29/11 1 am "...Res has slept all shift except i time and Res wandering in hallway and trying to undress. Res redirected back into room. Speech clear. Very slow to respond to questions and answers inapro (inappropriately) @ times. No S/S (signs/symptoms) of discomfort or distress @ this time. Res refused supper x 3."</p> <p>Next entry.</p> <p>12/29/11 1:30 PM "add diagnosis: BPH ( ), angina, A-fib (atrial fibrillation) 2. PT (protime)/INR ( Reactor) in AM 3. start coumadin (blood thinner) 5 mg (milligram) po (by mouth) once daily. family updated."</p> <p>12/29/11 1:55 PM "new orders received d/c (discontinue) Oxycontin (pain med) 40 mg TID (three times a day) when new order arrives, N/O (New/Order) Oxy continue 30 mg i po TID x &amp; days, then oxycontin 20 mg i po TID x 7 days then Oxycontin 10 mg i po TID x 7 days, then oxycontin 10 mg po BID (two times a day) x 4 days, then oxycontin 10 mg po daily x 3 days, then D/C (discontinue) family notified..."</p> <p>Next entry</p> <p>12/29/11 7:45 p.m. "When res. came to his unit he grabbed crash cart &amp; tipped it over. Res. was very agitated (sic) at this point &amp; started trying to find things to</p>			

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	<p>throw. LPN #2 came to unit &amp; tried talking with res. to calm him down but no results. Res. became physically abusive by hitting, trying to bite, head butting staff. Res. got behind nurses station &amp; started unplugging machines &amp; picking things up trying to throw them. Res. entered other res. rooms &amp; staff had to redirect him to hallway. Ambulance members came with stretcher &amp; res. attempted to trip EMT (Emergency Medical Technician). Then res. fought with EMT's so soft gauze were applied to wrists &amp; ankles."</p> <p>12/30/11 2:15 A "Res returned to facility @ this time. New order noted to start Levaquin 750 mg 1 tab dly (daily) Total of #10. Hospital staff stated he had pneumonia. Res. family @ bedside res becoming loud @ times but easily redirect. 3 A. Res in room with family members @ bedside. 5 A. Res cont. to be in room family member getting ready to leave. Will cont with frequent monitoring &amp; initiate 24 hr. flow sheet. 5:10 A lab tech here to draw PT (Protime)/INR (International Ratio). res tolerated procedure well. 5:15 A A fax sent to MD to see if res can have PT/INR while on Levaquin, because of medication interaction. No adverse reactions noted to Levaquin that was given @ hospital. 5:30 A. frequent check done and staff noticed</p>			

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	<p>that window was open. Staff began checking all rooms and began to go outside &amp; do search. Staff notified that res was in empty dumpster. 4 staff members assisted Res out. 1 staff member went to get w/c (wheelchair) to take res into facility. When ask why he entered dumpster he stated he though (sic) he was be (sic) shot at...DON &amp; administer (sic) were made aware 911 was dispatched family was made aware of incident.</p> <p>12/30/11 8:30 AM Res noted agitated. Resident not able to calm down. MD. notified. New order received to send resident to ER for eval &amp; treat. 2 EMTs present and police officer present during transfer. POA (Power of Attorney) updated. 12/30/11 11 AM this writer called [named hospital] ER. Nurse in Er stated resident to be admitted to [named behavior hospital]."</p> <p>This federal tag relates to Complaint(s) IN00101919 and IN00102017.</p> <p>3.1-50(a)(2)</p>			

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F0518 SS=D	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>Based on record review and interview the facility failed to ensure dietary personnel were trained on how to turn off the gas valve to the stove in the kitchen in an emergency for 2 of 3 dietary employees observed on 1 of 2 dietary observations. (Cook #1 and dietary aide #1)</p> <p>Findings include:</p> <p>On 01/17/12 at 2:46 p.m., cook #1, and dietary aide #1, lacked knowledge of how to turn off the gas in an emergency. During interview on 01/17/12 at 2:46 p.m., cook #1 and dietary aide #1 indicated they did not know where the gas shut off valve was in case of emergency.</p> <p>On 1/23/12 at 9:10 a.m., the "Dining Services Aide Competencies" checklist for the cook with hire date of 5/25/11 was reviewed and for the dietary aide with hire date of 11/21/11 the list failed to indicate the employees had been trained in how to shut off the gas in an emergency. The checklists were provided</p>	F0518	<p>1.)Cook #1 and aide #1 were retrained on how to turn off gas valve.2.)Dietary staf were re-trained on how to turn off the gas valve to the stove.3.)System change: The gas shut off valve was added to the new hire checklist for all new dietary staff. Dietary manager/desingee will complete 1 staff interview 5x/week x 12 weeks then bimonthly x 3 months to ensure they are able to probide and return demonstration on how to turn off the gas valve.4.)Results of the audits will be reviewed at monthly QA metings for at least 6 months. Any further incidents will result in re-education and/or disciplinary action by the HFA/DON.</p>	02/17/2012	

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	by (name of person) responsible for employee records.  3.1-51(b)			