

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 6, 7, 8, 9, 20, 13, 14, and 16, 2012</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Sheila Sizemore, RN - TC Kelly Sizemore, RN (August 6, 7, 8, 9, 2012) Marcia Mital, RN Regina Sanders, RN (August 6, 7, 8, 9, 10, 2012)</p> <p>Census bed type: SNF/NF: 146 Total: 146</p> <p>Census payor type: Medicare: 15 Medicaid: 109 Other: 22 Total: 146</p> <p>Sample: 24 Supplemental sample: 6</p> <p>These deficiencies also reflect state</p>	F0000		
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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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	findings cited in accordance with 410 IAC 16.2. Quality review 8/20/12 by Suzanne Williams, RN			

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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 a resident's physician of a significant weight gain and refusal of a chest x-ray for 2 of 24 residents reviewed for physician</p>	F0157	F157 <i>It is the practice of this facility to inform the resident; consult with the resident's physician; and if known , notify the resident's legal representative ...when there is a change in the</i>	09/12/2012	

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	<p>notification in a total sample of 24. (Residents #25 and #56)</p> <p>Findings include:</p> <p>1. Resident #56's record was reviewed on 08/07/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to, end stage kidney disease, dialysis, and hypertension.</p> <p>The resident's weight on 06/07/12 was 212 pounds. The resident's weight on 07/02/12 was 225 pounds (6.13% gain) and on 07/10/12 the weight was 228 pounds (7.5% gain in one month).</p> <p>There was a lack of documentation to indicate the resident's physician had been notified of the significant weight gain in one month.</p> <p>During an interview on 08/08/12 at 9:05 a.m., the C-Unit Manager indicated the physician was notified of lab results that day, but not about the weight gain.</p> <p>A facility policy, titled, "Weight Monitoring", dated 2011, and received from the Administrator as current, indicated, "...When weight change is significant or severe, the licensed nurse will notify the patient's physician, and obtain and carry out treatment orders if</p>		<p><i>resident's physical...status.</i> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i> · The physician for resident #56 was notified on 8-7-12 of weight gain/fluctuations for the month of July. MD stated that he is aware of resident being on dialysis which causes wt fluctuations and had no new orders. · Resident # 25 actually had received her chest x-ray prior to admission to facility. A copy of this x-ray was presented to the surveyors at the time of survey. Order received to discontinue order for Chest X-ray due to having already been obtained. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <p>·All residents have the potential to be affected by the same alleged deficient practice.</p> <p>·All residents who had a significant wt gain in July or August have had their records reviewed to ensure that physician was notified of that wt gain was completed.</p> <p>·All residents progress notes were reviewed for July and August to ensure that any other resident who may have refused a chest x-ray, had appropriate notification of the physician.</p> <p>·Nurses Notes will be</p>				

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	given..."		<p>reviewed daily 7 days a week during clinical start up to ensure that notification has been made to physicians and family.</p> <ul style="list-style-type: none"> · Any resident who has any weight change or any resident who may repeatedly refuse care as ordered will have the resident's physician notified. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i> · Re-education of nurses will be completed regarding need for follow through on notification of physician for any changes in resident's status. · Resident's weights will be reviewed monthly by the RD and the IDT team and weekly by the IDT team. Any wt change of 3 pounds in one week or 5% in one month or 7.5% in 90days will have MD notified. · The "Daily Start Up Change of Condition/Physician Order Audit" form will be used daily by Unit Manager/member of nursing management to ensure that any resident with a change in condition(which would include a wt gain or loss) or a refusal to comply with a physician's order has follow up which includes notification of physician for change or refusal. · Review of use of "Daily Start Up Change of Condition/Physician Order Audit" form will be completed with the Unit Managers to ensure that use of Log is completed including 	

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	<p>2. Resident #25's record was reviewed on 8/6/12 at 1:12 p.m. Resident #25's diagnoses included but were not limited to, dementia and anxiety.</p> <p>A physician's order, dated 7/13/12, indicated obtain a chest x-ray.</p> <p>The resident's nurses' notes indicated:</p>		<p>verification of timely physician notification. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · An audit of the "Daily Start Up Change of Condition/Physician Order Audit" form will be completed by the DNS/ADNS during morning clinical review to assure that follow through on physician notification has been completed.</p> <ul style="list-style-type: none"> o These audits will be completed 5 times a week for 4 weeks and then o 3 times a week for 4 weeks and then o Weekly as an ongoing process. <p>· Results of audits will be presented to the QA&A meeting each month x 3 months and then quarterly as an ongoing process and trends or patterns noted will have an action plan written and interventions implemented.</p> <p>· The Executive Director and the Director of Nursing will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>		

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	<p>7/13/12 at 10:59 p.m., "X-ray to be completed 7/14/12..."</p> <p>7/14/12 at 6:35 p.m., "...was here to take an x-ray of the chest. Resident refused x (times) 3. MD was called and answering service stated they will page him and have him return the call. Staff will continue to inform MD."</p> <p>The nurses' notes dated 7/14/12 through 8/6/12 lacked documentation to indicate the physician had been notified of the resident's refusal of the chest x-ray.</p> <p>During an interview on 8/7/12 at 9:45 a.m., the B Wing Unit Manager indicated no one had followed up and notified the physician of the resident's refusal of the chest x-ray.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure a resident was transported to the shower room in a manner that maintained their dignity related to a CNA pulling a resident backward in a wheelchair and the resident's body parts being exposed for 1 resident in a sample of 24 residents. (Resident #96)</p> <p>Findings include:</p> <p>Resident #96 was observed on 8/13/12 at 9:45 a.m., being transported in a shower chair in front of the nurses' station. The resident was being pulled backwards in the shower chair by CNA #6 and the front of the resident was covered by a thin blanket. The resident's buttocks were exposed on the backside of the shower chair.</p> <p>During an interview on 8/13/12 at 9:46 a.m., CNA #6 indicated she could not get the blanket around the resident. CNA #6 indicated she knew she was not supposed to pull residents backwards in the shower</p>	F0241	<p>F241 <i>It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances reach resident's dignity and respect in full recognition of his or her individuality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. · The C.N.A who provided care for resident # 96 on 8-13-12 received written disciplinary education on maintaining a resident's dignity and respect while providing care to this and all residents. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · All residents will be provided care in a dignified and respectful manner · Nursing staff will be re-educated on providing care to all resident's in a dignified and respectful manner. This will include how to transport a resident to the shower room. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p>	09/12/2012	

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	<p>chair.</p> <p>During an interview on 8/13/12 at 9:50 a.m., the D-wing Unit Manager indicated she would talk with the CNA. The Unit Manager indicated the resident should have been pushed forward in the shower chair and her buttocks should not have been exposed.</p> <p>3.1-3(t)</p>		<p>· Nursing staff will be re-educated on providing care to all resident's in a dignified and respectful manner. This will include how to transport a resident to the shower room. · Observation audits will be completed for transport of residents to shower rooms. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · Observation audits of residents being transported to shower rooms will be completed Daily (Monday thru Saturday, no showers are given on Sundays) x 4 weeks. o The audits will then be completed 3 times a week x 4 weeks. o The audits will then be completed weekly x 4 weeks or until 30 days of compliance with dignified transport is documented. (Ex... No one is observed to be transporting a resident not covered appropriately or pulling resident backwards during transport) · Results of audits will be reviewed at the QA&A monthly meeting · The Executive Director and the Director of Nursing will oversee this process. <i>By what date the systemic changes will be completed. September 12, 2012</i></p>		

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure comprehensive assessments were completed for pressure sore risk, elopement risk, and fall risk for 1 of 24 residents reviewed for assessments in a total sample of 24.</p>	F0272	F 272 <i>It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. What corrective action(s) will be accomplished for those residents</i>	09/12/2012

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	<p>(Resident #82)</p> <p>Findings include:</p> <p>Resident #82's record was reviewed on 08/08/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>The resident's current Quarterly MDS (Minimum Data Set) Assessment was dated 05/22/12.</p> <p>The last pressure sore risk, elopement risk, and fall risk assessment, which are included in the Clinical Health Status form, in the record was dated 06/10/11.</p> <p>During an interview on 08/08/12, the C-Unit Manager indicated there were no other assessments completed.</p> <p>During an interview on 08/08/12, MDS Nurse #2 indicated they use the Clinical Health Status form to fill out the MDS, but will use the information in the resident's record if a Clinical Health Status form had not been completed.</p> <p>During an interview on 08/08/12 at 12:35 p.m., the Director of Nursing indicated the Clinical Health Status forms are to be completed when the resident is admitted and quarterly. She indicated the resident</p>		<p><i>found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> ·A Clinical Health Status Assessment form for Resident #82 was completed on 8-27-12. <p>This assessment includes the pressure sore risk, elopement risk and fall risk assessments as a part of this form.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the same alleged deficient practice. ·All residents had their medical record reviewed to ensure that a Clinical Health Status Assessment has been completed which includes the pressure sore risk, elopement risk and fall risk assessments. Any resident found to be out of compliance has had A Clinical Health Status completed. ·All resident will have a Clinical Health Status Assessment which includes the assessment for pressure sore risk, elopement risk and fall risk, completed upon admission/readmission and quarterly thereafter. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>The list of resident's with upcoming scheduled quarterly/annual MDS will be</p>				

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	<p>should have had assessments completed. She indicated the assessments were supposed to be done with the MDS assessments.</p> <p>3.1-31(c)(1)</p>		<p>provided to nursing management by the MDS Coordinator. This list will be reviewed at the morning clinical start up and verification will be made that the Clinical Health Status Assessment has been completed by the ARD date. · During review of resident records for completion of the quarterly/annual MDS if any resident is found to not have a completed Health Assessment, the MDS nurse will notify the Nursing Management at that time so that assessment can be completed. This will be an ongoing process. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · An ongoing list will be maintained x 3 months of resident's ARD date and completion date of their Clinical Health Status Assessment. · This list will be reviewed at the QA&A monthly meeting for the next 3 months and then will be completed Quarterly as an ongoing process. · The MDS coordinator/Designee will review resident's medical records with each MDS ARD and will report to DNS if any discrepancies are noted in completion of the Clinical Health Status Assessment. She will report to each monthly QA&A if any records were found to be out of compliance</p>		

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			and an action plan will be implemented if indicated. · The Executive Director and the Director of Nursing will oversee this process. <i>By what date the systemic changes will be completed.</i> September 12,201		

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F0280 SS=E	<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 ensure residents' care plans were developed and updated, related to activities of daily living, cognition, communication, incontinency, pressure ulcers, respiratory status, dialysis, sleep apnea, seizures, hydration, anticoagulants, pain, falls, and psychotropic drug use for 12 of 24 residents reviewed for care plans in a total sample of 24. (Residents #14, #25, #30, #56, #66, #84, #90, #94, #96, #98, #111, and #117)</p> <p>Findings include:</p>	F0280	<p><i>F 280 It is the practice of this facility to develop a comprehensive care plan for each resident within 7 days after the completion of the comprehensive assessment.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # 66 had care plan completed on 8-27-12 for communication and urinary incontinence. Also had care plan related to pressure ulcer updated to indicate that area was healed. · Resident #56 had care plan completed on 8-7-12 for triggered care areas of urinary 	09/12/2012

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410			
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	<p>1. Resident #66's record was reviewed on 08/08/12 at 8 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, severe behavioral disturbance, and chronic renal failure.</p> <p>A) A significant change MDS (Minimum Data Set) Assessment CAA (Care Area Assessment) Summary, dated 05/11/12, indicated communication and urinary incontinence had triggered from the MDS assessment. The CAA indicated the facility was going to care plan the triggered care areas of communication and urinary incontinence.</p> <p>The care plans, dated 05/15/12, lacked documentation of care plans for communication and urinary incontinence.</p> <p>During an interview on 08/08/12 at 9:15 a.m., MDS Nurse #1 indicated the resident did not have a care plan for communication and urinary incontinence.</p> <p>B) A care plan, dated 07/10/12, indicated the resident had a pressure ulcer present on the coccyx.</p> <p>The Wound Evaluation Flow Sheet, dated 07/17/12, indicated the pressure ulcer on the coccyx had healed.</p> <p>During an interview on 08/08/12 at 9:30 a.m., the ADoN (Assistant Director of Nursing) indicated the resident's care plan should have been revised since the area had healed.</p> <p>2. Resident #56's record was reviewed on 08/07/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to, end stage kidney</p>		<p>incontinence, falls and pain.</p> <ul style="list-style-type: none"> · Resident # 84 had care plans completed on 8-7-12 for communication, seizures, and sleep apnea. · Resident # 14 care plan was updated on 8-7-12 for "...Potential for alteration in Hydration related to Diuretic use..." · Resident # 111 had care plan updated on 8-9-12 for urinary incontinence and ADL's. · Resident # 30 has discharged from facility. · Resident # 25 had care plan completed on 8-7-12 for communication, cognition and urinary incontinence. · Resident # 117 had care plan completed on 8-30-12 communication. · Resident # 96 had care plan updated on 8-13-12 for use of psychotropic drug use. · Resident # 90 had care plan updated on 8-7-12 for ADL's and skin integrity · Resident # 94 had care plan updated on 8-13-12 for urinary incontinence. · Resident # 98 had care plan updated on 8-31-12seizures. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · Every active resident's most recent Comprehensive Assessment was reviewed to 				

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	<p>disease, dialysis and hypertension. The resident was admitted into the facility on 06/05/12 from the hospital.</p> <p>The Nurses' Admission Assessment, dated 06/05/12, indicated the resident required oxygen, was occasionally incontinent of bladder, and had pain to her left leg.</p> <p>The admission/5 day MDS Assessment, dated 06/12/12, indicated the resident was always incontinent, received an anticoagulant (blood thinner), had pain almost constantly and received scheduled pain medication.</p> <p>The CAA, dated 06/12/12, indicated urinary incontinence, falls, and pain were triggered care areas and the facility were going to care plan these triggered areas.</p> <p>A physician's order, dated 06/07/12, indicated the resident received dialysis three times a week.</p> <p>The resident's care plans, indicated the care plans for bowel and bladder incontinence, risk for complications related to anticoagulant use, falls, pain, alteration in hydration, alteration in respiratory status, and dialysis were not initiated until 08/07/12, which was over two months since the resident had been admitted into the facility.</p> <p>During an interview on 08/07/12 at 2:13 p.m., the C-Unit Manager indicated she had looked at the care plans in the computer, and the care plans had not been initiated until 08/07/12.</p> <p>3. Resident #84's record was reviewed on 08/07/12 at 8:25 a.m. The resident's diagnoses included, but were not limited to, Down's syndrome, sleep apnea and</p>		<p>ensure each CAA trigger was addressed on the resident's care plan if indicated as such on the CAA</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> The Clinical Assessment and Reimbursement Specialist (CARS) will train each member of the IDT team that completes CAAs on the CAA process. RNAC will complete audit tool for each Comprehensive Assessment validating that each CAA that indicated the need to proceed and had a care plan completed. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> The DNS/Designee/CARS will review 100% of the Comprehensive Assessments monthly x 3 months , then a sample of 50% of total Comprehensive Assessments completed during a quarter x 3 quarters to ensure care plans are completed if indicated as such on that resident' CAA. The results of the DNS/Designee/CARS reviews will be brought through the QA&A process monthly x 3 months and then Quarterly x 3 Quarters and trends or patterns noted will have 				

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	<p>epilepsy.</p> <p>A) The significant change MDS Assessment, dated 06/07/12, indicated the resident was cognitively impaired, had unclear speech, sometimes could understand communication, and could be sometimes understood.</p> <p>The CAA, dated 06/07/12, indicated communication was triggered as a care area and the facility was going to proceed with a care plan for communication.</p> <p>The resident's care plan, revised 08/02/12, lacked documentation to indicate a communication care plan had been initiated for the resident.</p> <p>B) The resident's care plan, revised 08/02/12, lacked documentation to indicate a care plan had been initiated for the resident's seizures and sleep apnea.</p> <p>During an interview on 08/07/12 at 11:25 a.m., the MDS Nurse #1 indicated there were no care plans initiated for the resident's communication, seizures, and sleep apnea.</p> <p>4. Resident #14's record was reviewed on 8/9/12 at 10:20 a.m. Resident #14's diagnoses included, but were not limited to, dementia, congestive heart failure</p>		<p>an action plan written and interventions implemented.</p> <p>The Executive Director and the Director of Nursing will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>		

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	<p>(CHF), and hypertension.</p> <p>A care plan, dated 5/20/11, updated 7/8/12, indicated "I have a potential for alteration in Hydration related to Diuretic use..."</p> <p>The physician's orders recapitulation, dated 7/30/12 indicated the resident was not on a diuretic medication.</p> <p>During an interview on 8/9/12 at 11:50 a.m., the B Wing Unit Manager indicated the resident was not on a diuretic and the care plan needed to be updated.</p> <p>5. Resident #111's record was reviewed on 8/9/12 at 2:10 p.m. Resident #111's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and bi-polar disease.</p> <p>A significant change MDS, dated 6/18/12, indicated the resident had triggered for care plans for ADL's (activities of daily living) and urinary incontinence and they were proceeding to care plan.</p> <p>The resident's care plans, dated 5/11/11 and updated 8/9/12, lacked documentation of care plans for urinary incontinence and ADL's.</p> <p>During an interview on 8/9/12 at 2:45</p>				

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	<p>p.m., the Assistant Director of Nurses indicated there were no care plans for ADL's or urinary incontinence.</p> <p>6. Resident #30's record was reviewed on 8/8/12 at 9:20 a.m. Resident #30's diagnoses included, but were not limited to, hypertension, dementia, and schizophrenia.</p> <p>A significant change MDS assessment, dated 2/24/12, indicated the resident had triggered for a care plan for communication and they were proceeding with a care plan.</p> <p>The resident's care plans, dated 8/9/11 and updated 8/6/12, lacked documentation of a care plan for communication.</p> <p>During an interview on 8/8/12 at 12:30 p.m., the B Wing Unit Manager indicated there was not a care plan for communication.</p> <p>7. Resident #25's record was reviewed on 8/6/12 at 1:12 p.m. Resident #25's diagnoses included, but were not limited to, dementia and anxiety.</p> <p>An admission MDS assessment, dated 7/19/12, indicated the resident triggered for cognition, communication, and urinary incontinence and the facility was</p>						

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	<p>proceeding with care plans.</p> <p>The resident's care plans, dated 7/13/12 and updated 7/16/12, lacked documentation of care plans for cognition, communication, and urinary incontinence.</p> <p>During an interview on 8/7/12 at 9:47 a.m., the B Wing Unit Manager indicated there were no care plans for communication, cognition or urinary incontinence.</p> <p>8. Resident #117's record was reviewed on 8/13/12 at 1:15 p.m. Resident #117's diagnoses included, but were not limited to end stage dementia, hypertension, and diabetes mellitus.</p> <p>A significant change MDS assessment, dated 6/30/12, indicated the resident had triggered for communication and they were proceeding with a care plan.</p> <p>The resident's care plans, dated 12/28/10 and updated 7/6/12, lacked documentation of a care plan for communication.</p> <p>During an interview on 8/13/12 at 2:20 p.m., MDS Coordinator #1 indicated there was not a care plan for communication.</p> <p>9. Resident #96's record was reviewed on</p>				

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	<p>8/13/12 at 10:05 a.m. Resident #96's diagnoses included, but were not limited to, anxiety, depression, and Parkinson's disease.</p> <p>Resident #96's physician's orders indicated the resident was receiving Celexa (antidepressant) and perphenazine (antipsychotic) daily.</p> <p>An admission MDS assessment, dated 7/13/12, indicated the facility would proceed to care plan the resident for the use of psychotropic drugs.</p> <p>Resident #96's care plan lacked documentation of a care plan for the use of psychotropic drug use.</p> <p>An interview on 8/13/12 at 11:40 a.m., the D-wing Unit Manager indicated she could not find a care plan for the psychotropic drug use in the resident's record.</p> <p>10. Resident #90's record was reviewed on 8/7/12 at 11:50 a.m. Resident #90's diagnoses included, but were not limited to, senile dementia, hypertension, and congestive heart failure.</p> <p>An annual MDS assessment, dated 11/15/11, indicated the facility would proceed to care plan the resident for</p>						

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	<p>activities of daily living and pressure sores.</p> <p>Review of the resident's care plans lacked documentation of care plans for activities of daily living and pressure sores.</p> <p>An interview on 8/7/12 at 1:50 p.m., the D-wing Unit Manager indicated she could not find care plans for activities of daily living and pressure sores in the resident's record.</p> <p>11. Resident #94's record was reviewed on 8/13/12 at 8:50 a.m. Resident #94's diagnoses included, but were not limited to, depression and urinary tract infections.</p> <p>A significant change MDS assessment, dated 2/1/12 indicated the facility would proceed to care plan the resident for urinary concerns.</p> <p>The resident's record lacked documentation of a care plan for urinary concerns in the resident's care plans.</p> <p>An interview on 8/13/12 at 9:55 a.m., MDS #2, indicated there was no care plan for the urinary concern in the resident's care plans.</p> <p>12. Resident #98's record was reviewed on 8/10/12 at 9:05 a.m. Resident #98's</p>			

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	<p>diagnoses included, but were not limited to, Epilepsy and infantile cerebral palsy.</p> <p>Resident #98's record indicated a physician's order for the use of dilantin (anti-seizure) with the diagnosis of epilepsy and seizures.</p> <p>A significant change MDS assessment, dated 5/15/12, indicated the resident had an active diagnosis of seizures.</p> <p>The resident's care plans lacked documentation of a care plan for seizure or dilantin use.</p> <p>An interview on 8/10/12 at 10:15 a.m., MDS #2 indicated there was not a care plan for seizure and dilantin use.</p> <p>3.1-35(c)(1) 3.1-35(d)(2)</p>			

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F0282 SS=E	<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 observation, record review and interview, the facility failed to ensure physician's orders were followed related to medications, weights, and removal of an indwelling catheter for 6 of 24 residents reviewed for following physician's orders for a total sample of 24. (Residents #8, #38, #58, #100, #117 and #148)</p> <p>Findings include:</p> <p>1. Resident #117's record was reviewed on 8/13/12 at 1:15 p.m. Resident #117's diagnoses included, but were not limited to, end stage dementia, diabetes mellitus, and anxiety.</p> <p>A nurses' note, dated 7/28/12 at 7:57 a.m., indicated "...Received new order for foley x (times) 2 weeks and change in treatment to right ischium [lower portion of the hip bone] (pressure ulcer)." The end of the 2 weeks was 8/11/12.</p> <p>Resident #117 was observed on 8/14/12 at 9:20 a.m., sitting in her wheel chair outside the beauty shop. The resident's</p>	F0282	<p><i>F282 It is the practice of this facility to ensure services are provided by qualified persons in accordance with each resident's written plan of care.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <ul style="list-style-type: none"> · Resident # 117 received order from MD on 8-14-12 to continue with foley catheter for diagnosis of wound healing. No stop date was given at this time. · Resident # 38 MD was notified of discrepancy in potassium order. Verification order received. Medication Error report was completed. · Resident # 8 MD was notified that medication ordered on 7-3-12 was not started until 7-4-12. No new orders received . Medication Error report was completed. · Resident # 148 was closed record and no further action can be taken. · Resident # 100 MD was notified of discrepancy in Lactelose order. Order received to continue with medication BID as it was being given. Medication Error report was completed. 	09/12/2012			

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	<p>catheter had yellow urine with sediment in the tubing.</p> <p>During an interview on 8/13/12 at 2:10 p.m., the MDS Coordinator #1 indicated someone should have called the physician to clarify if he wanted to continue the catheter or removed the catheter before now it was only ordered for 2 weeks.</p> <p>2. Resident #38's record was reviewed on 8/9/12 at 9:15 a.m. Resident #38's diagnoses included, but were not limited to, dementia, atrial fibrillation, and hypertension.</p> <p>Resident #38 was re-admitted to the facility on 7/23/12.</p> <p>The physician's orders, dated 7/23/12, indicated potassium chloride 10 meq (milliequivalents) give 2 capsules daily.</p> <p>The hospital discharge orders, dated 7/23/12 indicated potassium chloride 10 meq daily.</p> <p>The resident's MAR (medication administration record), dated 7/12, indicated the resident received two 10 meq capsules of potassium chloride 7/25/12 through 7/31/12.</p> <p>The resident's MAR, dated 8/12, indicated</p>		<ul style="list-style-type: none"> · Resident # 58 has been discharged from facility and no further action can be taken. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · All resident's have the potential to be affected by the the alleged deficient practice. · Nurses notes since September 1, 2012 have been reviewed to ensure that a corresponding physicians order is in place if applicable. · All new admits since September 1 have had their admission orders reviewed to ensure that all orders were transcribed correctly into PCC. · All residents physicians orders will be entered into PCC (computerized medical record) correctly and medications will be administered in a timely manner when a new order is received. · Licensed nursing staff will be re-educated on inputting of physicians' orders into PCC. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i> · Licensed nursing staff will be re-educated on inputting of physicians' orders into PCC. · Licensed staff will be re-educated on utilizing medication from the EDK when 				

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	<p>the resident received two capsules of 10 meq of potassium chloride 8/1/12 through 8/9/12.</p> <p>During an interview on 8/9/12 at 3 p.m., the B Wing Unit Manager indicated she was making a medication error form out for the potassium chloride. She indicated the resident's physician only wanted the resident to receive 10 meq daily.</p> <p>3. Resident #8's record was reviewed on 8/13/12 at 9 a.m. Resident #8's diagnoses included, but were not limited to, history of DVT (deep vein thrombosis), dementia, and stroke.</p> <p>The nurses' notes indicated:</p> <p>7/3/12 at 3:32 p.m., "Resident's PT/INR (blood clotting tests) results in. Coumadin (medication which thins the blood) currently remains on hold. MD has been notified via message to office awaiting response..."</p> <p>7/3/12 at 3:50 P.M., "MD responded to PT/INR results received new orders to resume with 3 mg (milligrams) (Coumadin) qd (every day)."</p> <p>The resident's MAR, dated 7/12, indicated the Coumadin was not administered on 7/3/12 at 5 p.m.; it was not started until</p>		<p>new order received , so as to administer medication in a timely manner.</p> <ul style="list-style-type: none"> · Physician's orders will be reviewed daily by the Unit Manager utilizing the "Daily Start Up Change of Condition/Physician Order Audit" tool. · New admissions physician's orders will be reviewed within 24 hours by a member of nursing management utilizing the "New Admission Audit" tool. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · An audit of the "Daily Start Up Change of Condition/Physician Order Audit" form and "New Admission Audit" form will be completed by the DNS/ADNS during morning clinical review to assure that new orders have been reviewed. <ul style="list-style-type: none"> o These audits will be completed daily x 4 weeks and then o 3 times a week x 4 weeks and then o Weekly as an ongoing process. · Results of audits will be presented to the QA&A meeting each month x 3 months and then quarterly as an ongoing process and patterns or trends noted will have an action plan written and interventions implemented. 				

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	<p>7/4/12 at 5 p.m.</p> <p>During an interview on 8/13/12 at 10:07 a.m., the B Wing Unit Manager indicated the Coumadin should have been given on 7/3/12. She indicated she was making a medication error form.</p> <p>A "Medication Error Reporting Form" , dated 8/13/12, indicated the medication of Coumadin had been not been resumed on 7/3/12 as ordered.</p> <p>4. Resident #148's record was reviewed on 8/10/12 at 10:15 a.m. Resident #148's diagnoses included, but were not limited to, failure to thrive, hypertension, and chronic obstructive pulmonary disease.</p> <p>A hospice order, dated 6/19/12, indicated "start Roxanol 5 mg (milligrams) BID (twice a day) & Q 2 o (every two hours) prn (as needed)..."</p> <p>The resident's MAR, dated 6/12, indicated Roxanol 5 milligrams bid, every 2 hours prn. The medication had not been administered twice daily. The MAR indicated a lack of documentation of the times to administer the Roxanol. The MAR had prn next to the medication only.</p> <p>During an interview on 8/10/12 at 11:08</p>		<p>The Executive Director and the Director of Nursing will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>				

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	<p>a.m., the Director of Nurses indicated the nurse had not transcribed the order correctly. She indicated she had made the Roxanol just prn not routine.</p> <p>5. Resident #100's record was reviewed on 8/13/12 at 1:00 p.m. Resident #100 diagnoses included, but were not limited to, alcoholism, dementia, and stroke.</p> <p>A physician's order wrote on an ammonia level laboratory result, dated 7/20/12, indicated "Lactulose 30 ml (milliliters) BID (twice a day) x (times) 3 days then daily. Recheck ammonia level in one week."</p> <p>The resident's record indicated the resident was sent out to the hospital on 7/24/12 and returned to the facility on 7/27/12.</p> <p>The July and August MARS (Medications Administration Records) indicated the resident had received the 20 grams of lactulose twice a day at 9:00 a.m. and 5:00 p.m., from 7/27/12 until 8/12/12.</p> <p>An interview on 8/13/12 at 1:50 p.m., the D-wing Unit Manager indicated she would have to check with Medical Records as the resident's admission orders were not in the record.</p> <p>The physician's admission orders dated</p>						

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	<p>7/27/12, indicated an order for lactulose 20 grams by mouth nightly.</p> <p>An interview on 8/14/12 at 9:10 a.m., the D-wing Unit Manager indicated there had been a medication error and she had contacted the resident's physician. She indicated the resident should have only received the lactulose at night.</p> <p>6. Resident #58's record was reviewed on 8/7/12 at 9:10 a.m. Resident #58's diagnoses included, but were not limited to, stroke, dementia, and seizures.</p> <p>A physician's order, dated 7/6/12 indicated "monthly weights to be obtained and entered into the PCC (computer program) by the 10th. Once a day on day shift for 10 days, starting 7/6/12."</p> <p>There was a lack of documentation in the resident's record to indicate daily weights were completed for the 10 days.</p> <p>An interview on 8/7/12 at 10:20 a.m., the ADoN indicated they did not complete the weights for the 10 days.</p> <p>3.1-35(g)(2)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to ensure residents who required assistance for showers received their showers for 1 of 24 residents reviewed for showers in a total sample of 24 (Resident #84)</p> <p>Findings include:</p> <p>Resident #84's record was reviewed on 08/07/12 at 8:25 a.m. The resident's diagnoses included, but were not limited to, Down's syndrome and epilepsy.</p> <p>The significant change Minimum Data Set (MDS) Assessment, dated 06/07/12, indicated the resident was cognitively impaired and was totally dependent for personal hygiene and bathing.</p> <p>The C-Wing Shower List, received as current from the C-Unit Manager on 08/08/12 at 11:25 a.m., indicated the resident's showers were scheduled for Tuesdays and Fridays on the evening shift.</p>	F0312	<p><i>F312 It is the practice of this facility to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # 84 is scheduled to receive shower/full bed bath on Tuesday and Friday evening shift. Unit Manager will oversee the completion of this each week. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · Nursing staff will be re-in serviced on providing showers to all residents as scheduled and on documenting of showers/bed baths given per the Care-Tracker. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the</i></p>	09/12/2012			

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	<p>The record indicated the resident was in the hospital on 06/29/12 through 07/03/12.</p> <p>The Bathing Type Detail indicated the resident received a full bed bath on 06/01/12 and 06/08/12 (6 days without a shower).</p> <p>The Bathing Type Detail indicated the resident went from 07/03/12 through 07/13/12 without a shower or complete bedbath.</p> <p>The Bathing Type Detail indicated the resident went from 07/31/12 through 08/07/12 without a shower or complete bedbath.</p> <p>During an interview on 08/07/12 at 11:40 a.m., MDS Nurse #1 indicated the resident had not refused any showers. She indicated the residents are supposed to get two showers a week.</p> <p>A written statement received from the Administrator on 08/08/12 at 3:30 p.m., indicated, "Per the standard of Golden Living it is our practice to offer each resident a shower twice a week."</p> <p>3.1-38(a)(3)(A)</p>		<p><i>deficient practice does not recur</i></p> <ul style="list-style-type: none"> · Nursing staff will be re-in serviced on providing showers to all residents as scheduled and on documenting of showers/bed baths given per the Care-Tracker. · Shower reports will be reviewed/audited weekly by nurse management. · Any staff member identified as not providing and documenting showers will be given written disciplinary action. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · Shower reports will be reviewed /audited weekly by nurse management as an ongoing process. · Results of audits will be presented to the QA&A monthly meeting x 3 months and then quarterly there after or until in substantial compliance. And patterns or trends noted will have action plans written and interventions implemented. · The Executive Director and the Director of Nursing will over see this process. <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>				

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F0315 SS=E	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were accurately assessed for bladder incontinence and provided treatment to restore normal bladder functioning as much as possible for 3 of 11 incontinent residents and failed to ensure foley catheters were positioned correctly to prevent infection for 1 of 3 residents with foley catheters in a total sample of 24. (Residents #25, #56, #66, and #96)</p> <p>Findings include:</p> <p>1. Resident #66's record was reviewed on 08/08/12 at 8 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, severe behavioral disturbance, and chronic renal failure. The resident was admitted into the facility on 02/22/12 and readmitted into the facility from a hospital stay on 05/04/12.</p>	F0315	<p><i>F 315 It is the practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. · Resident # 66 Bowel and Bladder Evaluation Tool was completed and it was determined that resident is a poor candidate for a scheduled toileting or retraining program. He had care plan completed for Incontinence Management . · Resident # 56 has been discharged from the facility · Resident # 25, Bowel and Bladder Evaluation Tool was</i></p>	09/12/2012			

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	<p>A significant change MDS (Minimum Data Set) Assessment CAA (Care Area Assessment) Summary, dated 05/11/12, indicated the resident was always incontinent of urine, and a trial toileting program had not been attempted on admission or reentry into the facility.</p> <p>There was a lack of documentation to indicate a Bowel and Bladder Record Data Collection Tool had been completed on the resident upon admission and/or reentry into the facility.</p> <p>During an interview on 08/08/12 at 9:40 a.m., the ADoN (Assistant Director of Nursing) indicated a three day void and urinary incontinence assessment had not been completed on the residents.</p> <p>2. Resident #56's record was reviewed on 08/07/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to, end stage kidney disease, dialysis, and hypertension.</p> <p>The Nurses' Admission Assessment, dated 06/05/12, indicated the resident was occasionally incontinent of bladder.</p> <p>The admission/5 day MDS Assessment, dated 06/12/12, indicated the resident's cognition was intact, had no</p>		<p>completed. Care plan completed for occasional urinary incontinence. · Resident # 96 is being provided care to help maintain her catheter tubing in such a way as to prevent infection. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <p>·All resident's have the potential to be affected by the alleged deficient practice.</p> <p>·The facility will implement the use of the Bowel and Bladder Evaluation Tool which includes a 3 Day Bowel and Bladder Record.</p> <p>·All residents who have been admitted since 9-1-12 have had the Bowel and Bladder Evaluation Tool completed as per protocol.</p> <p>· Any resident who does not have an evaluation tool in place will have the Bowel and Bladder Evaluation Tool completed with their next upcoming MDS assessment (quarterly, change of condition or annual). This will bring the facility up to compliance within 90 days. (As per protocol each resident will have evaluation completed with each admission, re-admission and annual or change of condition assessment following their next upcoming assessment)</p> <p>·All resident's who have an indwelling catheter has the</p>		

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	<p>communication problems, was totally dependent on two or more staff for toilet use, and was always incontinent of bowel and bladder.</p> <p>There was a lack of documentation to indicate a Bowel and Bladder Record Data Collection had been completed on the resident upon admission into the facility.</p> <p>During an interview on 08/08/12 at 9:40 a.m., the ADoN (Assistant Director of Nursing) indicated a three day void and urinary incontinence assessment had not been completed on the residents.</p> <p>A facility policy, dated 01/11, received from the Administrator as current, titled, "Bowel and Bladder Record Data Collection Tool", indicated, "This tool is used as part of the analysis for determining a resident's bowel and bladder status and for developing a toileting plan..."</p> <p>A facility policy, dated 01/11, received from the Administrator as current, titled, "Incontinence Management/Bladder function Guideline", indicated, "...1. Upon admission (if the resident has a history of incontinence) complete the Bowel and Bladder Tracking Tool. Completed to identify any trends or</p>		<p>potential to be affected by the same alleged deficient practice.</p> <ul style="list-style-type: none"> · All residents who have urinary catheters will have tubing maintained in such a way as to prevent infection. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i> · All residents who are admitted or re-admitted into the facility will have a Bowel and Bladder Evaluation Tool completed with in 72 hours of admitting into facility. Also this tool will be completed annually or with any significant change. The resident will then be care planned for the appropriate toileting program according to the results of the evaluation tool. · Licensed nursing staff will be in-serviced on completion of the Bowel and Bladder Evaluation Tool. · Nursing staff will be re-in-serviced on care and placement of tubing for resident's who have urinary catheters. · Observation audits will be completed by Nursing Management / designee on each unit, daily on all three shifts and by ACE (guardian angels) members during routine weekly rounds for resident's with urinary catheters to ensure that catheter placement is correct. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · Residents admitted or re-admitted to facility 				

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	<p>patterns that the resident may have in relation to incontinence. 3 full days completed...2. Complete the Bladder Assessment form and the Bowel Assessment Form...Upon completion of this assessment/evaluation as well as the Tracking Tool, the toileting /bladder program can be determined..."</p> <p>3. Resident #25's record was reviewed on 8/6/12 at 1:12 p.m. Resident #25's diagnoses included, but were not limited to, dementia and anxiety.</p> <p>An admission, nurses note, dated 7/12/12 at 1:06 p.m., indicated "...continent of b/b (bowel and bladder)..."</p> <p>An admission MDS, dated 7/19/12, indicated the resident had sever cognitive impairment, required limited assistance of one staff member for toilet use, and was occasionally incontinent of bladder.</p>		<p>will have medical record reviewed per facility policy to ensure that all assessments, including the Bowel and Bladder Evaluation tool, have been completed as per protocol.</p> <ul style="list-style-type: none"> · Audit tool will be completed by the Unit Manger with each new admission/re-admission to validate that all assessments are completed for each resident. · Results of Admission audit tool will be present to the QA&A each month. This will be an ongoing process. · Results of observation audits for catheter placement will be present to the QA&A monthly meeting x 3 months and then quarter x 3 months · The Executive Director and the Director of Nursing will oversee this process. <p><i>By what date the systemic changes will be completed.</i> <i>September 12, 2012</i></p>	

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	<p>The CAA (care area assessment(dated 7/30/12, for urinary incontinence indicated "...Urinary incontinence triggered due to this resident is occasionally incontinent. She recognizes the urge to void and sometimes is unable to make it to the bathroom in time. Will proceed to care plan."</p> <p>The resident's care plans, dated 7/13/12 and updated 7/16/12, lacked documentation of a care plan for urinary incontinence.</p> <p>There was a lack of documentation of any further assessment for the resident's urinary incontinence.</p> <p>During an interview 8/7/12 at 9:35 a.m., the B Wing Unit Manager indicated there was not an assessment for the resident's urinary incontinence and no three day voiding pattern for the incontinence.</p> <p>During an interview on 8/7/12 at 9:47 a.m., the B Wing Unit Manager indicated there was not a care plan for the resident's urinary incontinence.</p> <p>4. During the initial tour on 8/6/12 beginning at 10:00 a.m. with the D-wing Unit Manager, Resident #96's was observed sitting up in her wheelchair in her room. The resident's foley catheter</p>			

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	<p>tubing was laying on the floor. The D-wing Unit Manager indicated the resident's catheter tubing should not be on the floor.</p> <p>Resident #96 was observed on 8/14/12 at 9:18 a.m., laying in her bed. The resident's foley catheter bag was hanging on the top siderail above the resident's head and the top siderail was in the up position.</p> <p>An interview on 8/14/12 at 9:20 a.m., the D-wing Unit Manager indicated that was not a good position for the foley catheter. The Unit Manager was observed to reposition the foley catheter bag to the bed frame below the resident's bladder.</p> <p>Resident #96's record was reviewed on 8/13/12 at 10:05 a.m. Resident #96's diagnoses included, but were not limited to, anxiety, depression, and Parkinson's disease.</p> <p>The resident's record indicated the foley catheter use was for urinary retention.</p> <p>3.1-41(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. Based on record review and interview, the facility failed to ensure a resident with a known history of exit seeking behavior was supervised to prevent elopement from the facility, resulting in the resident being found by staff outside of the facility for 1 of 24 residents reviewed for elopement in a total sample of 24. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66's record was reviewed on 08/08/12 at 8 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, severe behavioral disturbance, and chronic renal failure. The resident was admitted into the facility on 02/22/12 and readmitted into the facility from a hospital stay on 05/04/12.</p> <p>The record indicated the resident was transferred from the facility to a specialty hospital on 03/29/12 and returned to the facility on 05/04/12.</p> <p>A care plan, initiated 03/24/12, indicated</p>	F0323	<p><i>F323 It is the practice of this facility to 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.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident #66 is care planned for elopement. He does have a wander guard in place. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i> · Any residents who have been identified as "Elopement Risk" have been reviewed. All care plans and protocols are in place. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i> · All new admits/re-admits to the facility will have an Elopement Risk Assessment completed at the time of 	09/12/2012			

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	<p>the resident exhibited behaviors of wandering and poor safety awareness. The interventions included, "check wanderguard placement and functioning..."</p> <p>A hospital History and Physical, dated 03/29/12, indicated, "...neurocognitive decline with severe behavioral disturbance...impulsive..."</p> <p>The return nursing admission assessment, risk for elopement assessment, dated 05/04/12, indicated, " 1. is resident physically able to leave the building on their own?... (checked no). 2. Is the resident cognitively impaired?... (checked yes). 3. Does the resident have impaired decision making skills? (checked yes)...5. Is there a history of wandering or elopement? if yes, implement Elopement IPOC (individual plan of care)... if 'YES' is marked for #1 and #2 and any other...consider a prevention plan of care for elopement..."</p> <p>A significant change MDS (Minimum Data Set) Assessment, dated 05/11/12, indicated the resident responded adequately to simple, direct communication only, was cognitively impaired, had difficulty focusing attention and disorganized thinking, had no behaviors, required extensive assistance</p>		<p>admission. Any resident found to be "at risk" will be care planned for possible elopement.</p> <ul style="list-style-type: none"> Social Services and Nurse Managers will review residents' charts at time of admission/re-admission into facility and will ensure that elopement preventive protocols have been put into place as per facility policy and procedure for identified residents. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> Social Services will maintain oversight of resident's who are identified as "at risk for elopement" following the facilities policy and procedure. (Social Services will review each resident chart upon admission and with each quarterly assessment or change in condition to identify any resident who may be identify as "at risk for elopement. They are responsible to maintain the "Elopement Risk" protocol which includes binder and pictures of all residents identified, ongoing list of resident's with wanderguards, and Plans of care for each identified resident.) Social Services will review at the monthly QA&A meeting the resident's who have been 				

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	<p>of two or more staff for transfers and locomotion and used a wheelchair for mobility.</p> <p>The care plan for wandering and poor safety awareness was brought forward from before the readmission, dated 03/24/12, which included the intervention to check the wanderguard for placement and functioning.</p> <p>A Nurses' Note, dated 05/26/12 at 10:21 a.m., indicated, "resident (sic) alert oriented to self only, numerous attempts to open exit doors, easily redirected..."</p> <p>A Nurses' Note, dated 05/28/12 at 1:01 p.m., indicated, "...resident exit facility through the front lobby doors and was found sitting under the awning to the entrance (sic) of the building Background: resident has hx (history) of exit seeking with hx of dementia with behavioral disturbances Assessment: staff noticed resident sitting outside of front doors of facility under the front door awning...resident stated he wanted 'to go to Broadway (sic) street to go home' staff member brought resident into facility...Response: writer contacted resident doctor...apply wander guard (sic) to resident ankle..."</p> <p>During an interview on 08/08/12 at 9:45</p>		<p>admitted each month, who are at risk for elopement and verify that all interventions have been put into place to prevent elopement as per our policy and procedure. This will be completed monthly as an ongoing process.</p> <p>The Executive Director and the Director of Nursing will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> September 12,2012</p>		

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	<p>a.m., the C-Unit Manager indicated the resident had a wanderguard on prior to his hospitalization and had been removed sometime during his hospitalization. She indicated there was an order for the wanderguard written on 03/14/12.</p> <p>During an interview on 08/08/12 at 10:10 a.m., the DoN (Director of Nursing) indicated she did not consider the resident being out of the building an elopement. She indicated they believed someone had left the door open and the resident did not go anywhere except just right outside the door. She indicated she was unaware of the exit attempts on 05/26/12.</p> <p>A facility policy, dated 01/11, titled, "Elopement Policy and Procedure Guide", received from the Administrator as current, indicated, "...Elopement...is defined as the situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for injury outside the confines...has left the living center without knowledge of staff...residents at risk of elopement are assessed quarterly and as needed..."</p> <p>3.1-45(a)(2)</p>			

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to identify a resident with significant weight loss in a timely manner and failed to follow up with dietary interventions in a timely manner for 1 of 6 residents with weight loss in a total sample of 24 (Resident #30)</p> <p>Findings include:</p> <p>Resident #30's record was reviewed on 8/8/12 at 9:20 a.m. Resident #30's diagnoses included, but were not limited to, hypertension, dementia, and schizophrenia.</p> <p>A care plan, dated 8/9/11 and updated 8/6/12, indicated "...At risk for predicted suboptimal (sic) energy intake related to dx (diagnosis) Alzheimers disease as evidenced by fluctuation PO (oral) intake and hx (history) of significant weight loss...Monitor weights..."</p>	F0325	<p><i>F 325 It is the practice of this facility to ensure that a resident: maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # #30 no longer resides at this facility. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · The RD has reviewed all resident's weights and ensured that appropriate interventions and follow up are in place. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> · All resident monthly 	09/12/2012			

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	<p>The resident's weights indicated: 5/10/12 155 pounds 6/3/12 144 pounds (This is a 7.5% weight loss in one month) 7/6/12 139 pounds 7/11/12 143 pounds 7/18/12 144 pounds 7/24/12 141 pounds 7/28/12 140 pounds 8/6/12 141 pounds</p> <p>A RD (Registered Dietician) note, dated 6/24/12, indicated the resident had significant weight loss in one month and recommendations for fortified foods at breakfast and with her evening and bed time snacks. (This was 3 weeks after the resident's weight had been obtained with a significant weight loss in one month.)</p> <p>The physician's order recapitulation, dated 7/30/12, indicated on 7/6/12 orders for "fortified foods with breakfast to aid with weight stability....add fortified foods as PM and HS (bedtime) snacks to aid with weight stability. (This was over a month since the resident had a 7.5 % weight loss in one month. The resident had continued to lose 5 more pounds since 6/3/12 before the RD recommendations had been followed.)</p> <p>A dietary requisition, dated 7/6/12 at</p>		<p>weights will be reviewed each month by the IDT team and the RD. Any resident with a 5% wt loss in one month will be placed on weekly wts and monitored and documented on for nutritional needs.</p> <ul style="list-style-type: none"> · All resident weekly weights will be reviewed weekly by the IDT team and further recommendations will may be made at that time. · All recommendations from RD or IDT team will be followed up on within 72 hours of nursing receiving the recommendation. · Completion of dietary recommendations will be overseen in the daily clinical meeting. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · RD will audit weekly completion of recommendations Results of these audits will be presented to the QA&A monthly meeting x 3 months and then quarterly there after as an ongoing process. · RD will report significant wt changes to the QA&A monthly meeting. This is an ongoing process. · The Executive Director and the Director of Nursing will oversee this process. <p><i>By what date the systemic</i></p>				

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	<p>11:32 a.m., indicated "...fortified foods at breakfast, dinner and HS snack for wt (weight) stability."</p> <p>An IDT (Interdisciplinary Team) note, dated 7/31/12 at 2:14 p.m., indicated "...weight review: current weight 140. Res (Resident) has dx (diagnosis) of breast cancer and has shown slight weight declines weekly. She also has dx of dementia...wanders out of dining room before finishing her meals. current diet regular with fortified foods with breakfast, and at pm and hs snacks. po (oral) intake last 7 days 75%. Recommend 2 cal (supplement) 60 ccs (cubic centimeters) tid (three times a day) and ice cream with dinner. Will continue weekly weights for close monitoring and verification."</p> <p>During an interview on 8/8/12 at 9:43 a.m., the B Wing Unit Manager indicated no one had caught the resident's significant weight loss until 6/24/12 when the RD made recommendations. She indicated RD recommendations are supposed to be followed up within 72 hours. The resident was supposed to start on weekly weights in June but they did not start them until July. She indicated she had not followed up with the recommendations from 7/31/12 yet.</p>		<p><i>changes will be completed.</i> September 12, 2012</p>				

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	<p>During an interview on 8/8/12 at 10:30 a.m., the B Wing Unit Manager indicated she had called the physician with the RD recommendations on 7/2/12 but had not gotten the orders until 7/6/12. She indicated she had not received the recommendation from 7/31/12 for the 2 cal and the ice cream at dinner to follow up on.</p> <p>A facility policy, dated 2011, titled "Weight Monitoring" provided by the Administration as current on 8/8/12, indicated "...Weight is recorded by the Nursing department upon admission, monthly and more often if risk is identified. All weights will be reviewed by the DSM (Dietary Service Manager) and the RD will be notified of any significant weight changes or trends...significant weight loss one month 5 percent sever loss greater than 3 percent...When weight change is significant or severe, the licensed nurse will notify the patient's physician, and obtain and carry out treatment orders...Each Living Center will have a Nutrition Risk Committee. This committee should meet regularly to determine possible reasons for weight loss...and should make recommendations to prevent further unplanned changes..."</p> <p>3.1-46(a)(1)</p>						

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor a resident on Coumadin as ordered by the physician for 1 of 3 residents on Coumadin in a total sample of 24. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's record was reviewed on 8/13/12 at 9 a.m. Resident #8's diagnoses included, but were not limited to, history of DVT (deep vein thrombosis), dementia, and stroke.</p>	F0329	<p><i>F329 It is the practice of this facility to maintain each resident's drug regimen free from unnecessary drugs. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <p>No further action can be taken at this time for resident # 8. Physician made aware of lag time for restarting of Coumadin 7-4-12. Nursing staff involved in not following through with order for PT/INR and for not starting medication on 7-3-12 as ordered</p>	09/12/2012

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	<p>A laboratory test, dated 6/25/12, indicated Prothrombin time (PT) was high at 53.8 and INR (International normalized ratio) [blood clotting time tests] was critical at 5.45. Hand written on the form was 6/25/12 currently on Coumadin (blood thinner) 4 milligrams daily. Hold times 2 days.</p> <p>A physician's order, dated 6/25/12, indicated "HOLD COUMADIN X (times) 2 DAYS REPEAT PT AND INR ON WEDNESDAY 6-27-12 REPORT RESULTS STAT (immediately)."</p> <p>The resident's record lacked documentation of a PT/INR laboratory test result for 6/27/12.</p> <p>The nurses' notes indicated:</p> <p>6/25/12 at 7:25 p.m., "COAGULATION results received...new order noted and received to hold Coumadin x 2 days then repeat PT/INR 6-27-12 and notify with results stat...No abnormal bleeding or bruising notes..."</p> <p>6/27/12 at 7:03 a.m., "...Coumadin remains on hold..."</p> <p>6/27/12 at 10:23 a.m., "Coumadin remains on hold..."</p>		<p>have been educated. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · Audit of all residents receiving Coumadin has been completed and no discrepancies were found. · <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i> · Unit Managers were re-educated on the use of the "Lab Tracking Form" Log book. This form will be used by each Unit Manger or a member of Nurse Management team to review all orders for labs (PT/INR) and will include documentation of date lab was ordered, date lab completed, date lab results received by facility and date physician was notified of lab results. · Review/audit of use of the Lab Tracking Log Book will be completed weekly with the Unit Managers during the clinical start up to ensure that use of Log is completed. · Licensed Nursing staff were re-educated on follow through for physician orders and completion 		

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	<p>6/27/12 at 10:49 p.m., "Res (Resident) continues with Coumadin on hold..."</p> <p>6/28/12 at 10:55 a.m., "Coumadin remains on hold..."</p> <p>6/28/12 at 1:32 p.m., "Received labs PT 53.8 INR 5.45, MD made aware and gave new orders to repeat pt/inr on 6-30-12, and hold Coumadin until MD receives new lab results..." This was the laboratory results of the PT/INR, dated 6/25/12. There was not a laboratory report for the PT/INR to be drawn on 6/27/12.</p> <p>Another laboratory test result, dated 6/25/12, indicated handwritten on the bottom of the form, dated 6/28/12, was MD made aware gave new orders to hold until next PT/INR.</p> <p>The resident's record lacked documentation of the laboratory results of the PT/INR for 6/30/12.</p> <p>The next PT/INR laboratory test result was dated 7/2/12, the results were PT low at 11.3 and INR low at 1.11. Hand written on the form was resume Coumadin 3 milligrams.</p> <p>The nurses' notes indicated:</p>		<p>of lab requests as ordered.</p> <ul style="list-style-type: none"> Coumadin audit book will be maintained by the DNS/ADNS and residents will be monitored and reviewed at the clinical start up. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> Weekly review/audit of Lab Tracking Log book will be an ongoing process. Results of the audits will be presented to the QA&A monthly meeting x 3 months and then quarterly thereafter this will be monitored for trends or patterns and an action plan will be implemented as indicated. The Executive Director and Director of Nursing Services or designee are responsible to ensure compliance. <p><i>By what date the systemic changes will be completed</i> September 12, 2012</p>				

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	<p>7/3/12 at 3:32 p.m., "Resident's PT/INR results in. Coumadin (medication which thins the blood) currently remains on hold. MD has been notified via message to office awaiting response..."</p> <p>7/3/12 at 3:50 P.M., "MD responded to pt/inr results received new orders to resume with 3 mg (milligrams) (coumadin) qd (every day)."</p> <p>The resident's MAR, dated 7/12, indicated the coumadin was not administered on 7/3/12 at 5 p.m. it was not started until 7/4/12 at 5 p.m.</p> <p>During an interview on 8/13/12 at 9:45 a.m., the B Wing Unit Manager indicated the PT/INR was not drawn on 6/27/12 as ordered. She indicated the next PT/INR was drawn on 6/30/12.</p> <p>During an interview on 8/13/12 at 10 a.m., the B Wing Unit Manager indicated the results of the 6/30/12 PT/INR were not in the resident's record. She indicated she was not sure why the PT/INR was not drawn on 6/27/12.</p> <p>During an interview on 8/13/12 at 11:12 a.m., the B Wing Unit Manager indicated the nurse had not put in the laboratory order for the 6/27/12 PT/INR. She</p>						

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	<p>indicated when another nurse came in on 6/28/12 she saw the 6/25/12 laboratory results with the critical results and called the physician with the laboratory results from 6/25/12. and he gave her the order to hold the Coumadin but she didn't write the order. She indicated the coumadin should have been started on the Coumadin 3 milligrams on 7/3/12.</p> <p>3.1-48(a)(3)</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 Based on observation, record review and interview, the facility failed to distribute and serve food under sanitary conditions related to, open, undated, and unlabeled food, an opened beverage can in a cabinet, dirty food processor and bowls for 1 of 1 Kitchen. This had the potential to affect 137 of 137 residents who consumed food prepared in the kitchen out of a total population of 146.</p> <p>Findings include:</p> <p>1. Kitchen</p> <p>During the initial tour on 8/6/12 beginning at 9:45 a.m., with Cook #3 , the following was observed in the kitchen:</p> <p>A. In the freezer, there was a bag of opened ground meat not labeled or dated when opened.</p> <p>B. In the walk in cooler, there was a container of fruit covered with plastic which was not dated, there was a container of "soup" covered with foil</p>	F0371	<p><i>F371 It is the practice of this facility to (1)procure food from sources approved or considered satisfactory by the federal, state or local authorities and (2) store, prepare, distribute and serve food under sanitary conditions.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · The opened ground meat in the walk-in freezer as discarded immediately · The uncovered/unlabeled fruit and soup in the walk-in refrigerator was discarded immediately. · The food processor was cleaned immediately · The Bowls were cleaned immediately · The personal beverage was discarded immediately <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · Audit of kitchen was completed by the Regional 	09/12/2012			

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	<p>which was not labeled or dated, and there were two containers covered with foil labeled "soup dinner" which were not dated. During an interview with Cook #3 at the time of the observation, she indicated she would throw it all away.</p> <p>C. In a cabinet, next to the utensil drawers, there was an opened beverage can. During an interview with Cook #3 at the time of the observation, she indicated it was not suppose to be there.</p> <p>D. A food processor, stored and ready to use, was dirty and had a red substance on it. During an interview at the time of the observation, Cook #3 indicated it would be rewashed.</p> <p>E. There were 2 of 8 bowls, stored and ready to use, dirty with food debris.</p> <p>An undated facility policy titled "Storing Prepared Foods," received as current from the Administrator on 8/9/12 at 3:35 p.m., indicated "...Containers for extra portions...Items are labeled with product name, and 'use by' date and placed in the refrigerator...Labeling...Label each item with product name and "use by" date..."</p> <p>3.1-21(i)(3)</p>		<p>Director of Health Services which is the contracted dietary company for this facility. No other issues were noted.</p> <ul style="list-style-type: none"> · Regional and District professionals from Health Services Dietary monitored kitchen throughout the survey process. · New Dietary Director is in training at this time. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> · New Dietary Manager (DSM) has been put into place · Dietary staff were in-serviced 8-8-12 on labeling and dating and personal beverages not allowed in kitchen area. · Dietary staff will be re-in-serviced on policy for Storing Prepared Foods and proper cleaning and storage of dishes and equipment . · Food and equipment storage procedures will be monitored daily (at least 5 times per week) by the DSM and /or the RD during consultation visits. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · The Dietary Manger will report a summary of audits with any trends of deficiencies found to the QA&A committee on a monthly basis for 		

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			<p>recommendations and resolutions. This will be an ongoing process.</p> <p>The Executive Director and the Golden Living Dietary Director will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</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. Based on observation and record review, the facility failed to ensure multidose vials of insulin were dated when opened and were discarded when expired for 1 of 3 medication carts on D Wing (B hall medication cart). The facility also failed to discard a vial of tuberculin (medication for tuberculosis skin testing) for 1 of 3 medication rooms (C Wing Medication Room) for 1 resident in a supplemental of 6. (Resident #116)</p> <p>Findings include:</p> <p>During an observation on 8/8/12 at 11:10</p>	F0425	<p><i>F425 It is the practice of this facility to provide pharmaceutical service (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # 116 multidose vial of Novolog Mix 70/30 (insulin) was discarded on 8-8-12 and a new vial was provided for resident. · Multidose vial of tuberculin 	09/12/2012
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	<p>a.m., with LPN #4 of the D Wing B hall medication cart, the following was observed:</p> <p>1. A multidose vial of Novolog Mix 70/30 (insulin) for Resident #116 was opened 6/29/12. During an interview at the time of the observation, LPN #4 indicated it should have been discarded.</p> <p>Resident #116's record was reviewed on 8/8/12 at 1:30 p.m. Resident #116's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>Physician orders for August 2012 indicated an order for Novolog Mix 70/30 10 units subcutaneous daily. The MAR (Medication Administration Record for August 2012 indicated the resident was receiving the Novolog Mix 70/30 daily.</p> <p>During an observation on 8/8/12 at 11:15 a.m., with LPN #5 of the C Wing Medication Room, the following was observed:</p> <p>1. In the refrigerator there was a vial of tuberculin opened 6/27/12. The label indicated to discard after 30 days. During an interview at the time of the observation, LPN #5 indicated she would "get rid of it."</p>		<p>which was dated as opened 6-27-12 was discarded. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · All med carts and medication refrigerators were checked for open vials of multidose medications. No further vials were identified as being past the expiration date. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> · Nursing staff will be re-educated on policy for "Medication Storage in the Facility" which includes the removal of outdated medications. · A log will be kept at each medication refrigerator which will list the multidose vials available in that refrigerator and will include the open date and the expiration date. These logs will be audited weekly by a nurse manager as an ongoing process. · Medication carts will be audited weekly to assure that multidose vials of medication have been dated and not expired. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · Audits will be completed weekly x 8 weeks and then monthly as on going process. 		

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	<p>A facility policy titled "Medication Storage In The Facility," revised June 2005 and received as current from the Administrator, on 8/9/12 at 3:35 p.m., indicated "...Procedure...11. Outdated...medications...are immediately removed..."</p> <p>The facility's pharmacy policy titled "Medications With Special Expiration Date Requirements," dated September 2010 and received as current from the Administrator, on 8/9/12 at 3:50 p.m., indicated "...Novolog Mix 70/30 in use, not refrigerated 28 days...PPD (Tubersol) (medication for tuberculosis skin testing) expiration date 30 days after opening..."</p> <p>3.1-25(m)</p>		<p>Results of audits will be reviewed by the QA&A committee monthly and trends or patterns noted will have an action plan written and interventions implemented.</p> <p>The Executive Director and the Director of Nursing will oversee this process.</p> <p><i>By what date the systemic changes will be completed.</i> Sept 12, 2012</p>		

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview the facility failed to ensure pharmacy recommendations were followed up on in a timely manner for 1 of 24 Residents reviewed for pharmacy recommendations in a total sample of 24. (Resident #90)</p> <p>Findings include:</p> <p>Resident #90's record was reviewed on 8/7/12 at 11:50 a.m. Resident #90's diagnoses included, but were not limited to, senile dementia, hypertension, and congestive heart failure.</p> <p>A physician's order, dated 1/19/12, indicated "Ambien 5 milligrams by mouth at bedtime everyday."</p> <p>A pharmacy recommendation, dated 5/21/12, indicated a recommendation for a decrease in the resident's ambien (hypnotic).</p> <p>The physician's responded on 6/12/12 and</p>	F0428	<p><i>F 428 It is the practice of this facility to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> ·Resident # 90 order for ambien was clarified by the physician on 8-10-12 <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> ·Pharmacist review of all resident records was completed on 8-30-12. This included review for any discrepancies in previous recommendations. ·Nursing will contact the physicians regarding the pharmacy recommendations and will ensure that follow up and implementation is completed. <p><i>What measures will be put into place or what systemic changes</i></p>	09/12/2012			

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	<p>agreed to the recommendation, but did not indicate what his orders were for the dose reduction.</p> <p>An interview on 8/7/12 at 1:50 p.m., the D-wing Unit Manager indicated she was unaware of the pharmacy recommendation in the resident's record.</p> <p>An interview on 8/10/12 at 8:50 a.m., the D-wing Unit Manager indicated the physician had come in and completed the pharmacy recommendation. She indicated she had come to the unit as manager in June.</p> <p>The physician's response on the lower portion of the pharmacy recommendation indicated the physician responded on 8/8/12 and agreed to lower the dose of ambien to 2.5 milligrams. The order was noted by the nurse on 8/10/12.</p> <p>3.1-25(j)</p>		<p><i>will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> ·DNS spoke with physician regarding the completion of pharmacy recommendations. ·Unit Managers will oversee the distribution of pharmacy recommendations to the physicians and will verify the completion and input to PCC of the follow up. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> ·The Pharmacist will give report to DNS monthly related to # of recommendations completed from previous month. The results of this report will be present to monthly QA&A as an on going process. ·The Unit Managers will report to monthly QA&A any problems they may have had in completing the pharmacy recommendations related to poor physician follow through and action will be written and implemented if indicated. ·The DON will speak with any physician that is identified as not responding to recommendations in a timely or complete manner. <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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> <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.</p> <p>A. Based on record review and interview,</p>	F0441	F441 It is the practice of this facility to establish and maintain	09/12/2012			

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	<p>the facility failed to ensure resident's received mantoux tests (testing for tuberculosis) (TB) for 2 of 24 residents reviewed for mantoux tests in a total sample of 24. (Residents #56 and #66)</p> <p>B. Based on record review and interview, the facility failed to ensure staff received mantoux testing for 7 employees reviewed for mantoux testing in a sample of 33 employees. (CNAs #7, #8, #12, #13, and LPNs #9, #10, and #11)</p> <p>Findings include:</p> <p>A.1. Resident #66's record was reviewed on 08/08/12 at 8 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, severe behavioral disturbance, and chronic renal failure. The resident was admitted into the facility on 02/22/12 from the hospital.</p> <p>The TB Screening/Risk Assessment indicated the resident received a first step mantoux test on 02/21/12 at the hospital and the test was completed on 02/23/12 at the facility.</p> <p>There was a lack of documentation to indicate the resident received the second step mantoux testing at the facility.</p> <p>During an interview on on 08/08/12 at 9</p>		<p><i>an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infections.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # 66 had TB test completed · Resident # 56 was discharged from facility on 8-9-12 · Employees CNA # 13, CNA # 7, CNA # 8, CNA # 12, LPN # 9, LPN # 10, and LPN # 11 all received TB testing between August 7 th and August 14 th . Verification of TB testing was given to surveyors before they exited for annual survey. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · All resident records have been audited for 1 st and 2 nd step TB test on admission and for annual TB test. Any resident found out of compliance will have TB test given as per protocol. · All Employee records were audited and TB tests given to those who were out of compliance. <p><i>What measures will be put into</i></p>				

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	<p>a.m., the ADoN (Assistant Director of Nursing) indicated a second step mantoux had not been completed on the resident.</p> <p>2. Resident #56's record was reviewed on 08/07/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to, end stage kidney disease, dialysis and hypertension. The resident was admitted into the facility on 06/05/12 from the hospital.</p> <p>The TB Screening/Risk Assessment form lacked documentation to indicate the resident received a first and second step mantoux test upon admission into the facility.</p> <p>During an interview on 08/08/12 at 8:40 a.m., the C-Unit Manager indicated the hospital had not given the mantoux test. She indicated the resident had not received a first and second step mantoux from the facility.</p> <p>A facility policy, titled, "Tuberculosis Exposure Control Plan", dated 12/98, and received from the Administrator as current, indicated, "...All new admissions...will receive a 2-step Mantoux PPD Test..."</p>		<p><i>place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> · All new admissions will receive 1 st and 2 nd step TB testing upon admission per facility policy. · All resident's will have physician order placed in their medical record indicating when their annual TB test is schedule to be administered. · Annual TB testing will be completed for all resident's per facility policy. · All new employees will receive TB testing upon hire per facility policy. · Annual TB testing will be completed for all employee's per facility policy. · The Director of Clinical Education (DCE) will oversee the monitoring and administration of TB tests for all employees. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · The DCE will report monthly to the QA&A committee the # of staff members who were due for annual TB testing and verification of completion of this process. This will be an ongoing process. · Audit will be completed monthly for resident annual TB tests and results will be presented at the monthly QA&A meeting. This will be an ongoing process. 				

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	<p>B.1. Review of the employee records on 8/10/12 at 8:30 a.m., indicated the following employees did not receive a yearly Mantoux testing or a first and second step Mantoux test upon hire.</p> <p>1. CNA #13's employee record lacked documentation of a first and second step Mantoux test upon her hire. The CNA was hired on 4/12/12.</p> <p>2. CNA #7's employee record lacked documentation of the CNA receiving her yearly Mantoux test.</p> <p>3. CNA #8's employee record lacked documentation of the CNA receiving her yearly Mantoux test.</p> <p>4. CNA #12's employee record lacked documentation of the CNA receiving her yearly Mantoux test.</p> <p>5. LPN #9's employee record lacked documentation of the LPN receiving her yearly Mantoux test.</p> <p>7. LPN #10's employee record lacked</p>		<p><i>By what date the systemic changes will be completed.</i> September 12,2012</p>				

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	<p>documentation of the LPN receiving her yearly Mantoux test.</p> <p>8. LPN #11's employee record lacked documentation of the LPN receiving her yearly Mantoux test.</p> <p>3.1-18(a) 3.1-18(i) 3.1-18(j) 3.1-18(k)</p>			

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>A. Based on observation and interview, the facility failed to ensure safe, sanitary conditions related to dirty floors for 1 of 1 kitchen. This had the potential to affect 137 of 137 residents who consumed food prepared in the kitchen out of a total population of 146.</p> <p>B. Based on observation and interview, the facility failed to ensure housekeeping and maintenance maintained a sanitary and comfortable environment related to pulled back wallpaper, chipped paint, dirty walls, stained ceiling tiles, and dirty mechanical lifts for 3 of 3 Wings. This had the potential to affect 146 of 146 residents who reside in the facility. (ACU, C Wing, and D Wing)</p> <p>Findings include:</p> <p>A. Kitchen</p> <p>During the initial tour on 8/8/12 beginning at 9:25 a.m., with Cook #3, the following was observed in the kitchen:</p> <p>1. The floor behind the steamer had dirt, paper debris, and a paper clip. During an</p>	F0465	<p><i>F 465 It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · The floor in Kitchen area behind steamer was deep cleaned on 8-8-12 . Area is cleaned daily after each meal. · ACU Wing: On 8-8-12 wall paper was repaired in dining room, wall beside bird aviary was cleaned and chipped paint were repaired, ceiling tile was replaced. · C Wing: On 8-8-12 mechanical lift were cleaned, ceiling tiles were replaced. · D Wing: on 8-8-12 mechanical lift was cleaned, areas of chipped pain were repaired. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · Daily rounds by maintenance will be completed daily to assess building for any area that need repair. · Work orders will be used by staff to alert maintenance of 	09/12/2012			

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	<p>interview at the time of the observation, Cook #3 indicated it was dirty. She indicated the floor was to be swept and mopped after each shift.</p> <p>B. ACU Wing</p> <p>During the initial tour on 8/8/12 at 9:25 a.m., with the Maintenance Director, Housekeeping Director and District Manager, the following was observed:</p> <ol style="list-style-type: none"> 1. The entryway to the Dining Room, on the left side, there was pulled back wallpaper and chipped paint. The Maintenance Director indicated he had glue to fix it at the time of the observation. 2. The wall by the Dining Room and bird aviary was dirty and had chipped paint. 3. A ceiling tile by the bird aviary had a big brown stain with mold on it. <p>C Wing</p> <ol style="list-style-type: none"> 1. A mechanical lift in the hallway was dirty. During an interview at the time of the observation, the Housekeeping Director indicated Nursing is suppose to clean them on the midnight shift. 2. On the A hall there was a ceiling tile 		<p>any areas that need attention</p> <ul style="list-style-type: none"> · Kitchen will be monitored daily (M-F) by the DSM for cleanliness. · Health Services Regional Manger will audit kitchen area on routine weekly visits. Report will be given to the Executive Director. · Executive Director will do weekly spot checks of kitchen to ensure cleanliness. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></p> <ul style="list-style-type: none"> · Preventive Maintenance Program will be followed for routine care of building. · Executive Director will make weekly rounds and report any findings to maintenance for follow up and resolution. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · Maintenance will report to monthly QA&A meeting summary of maintenance issues that have been addressed or any areas that need attention. This is an ongoing process. · Dietary Manager will report monthly to the QA& A on the audits for cleanliness of kitchen. This will be an ongoing process. · The Executive Director and the Maintenance Director will oversee this process. <p><i>By what date the systemic</i></p>		

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	<p>with a brown stain.</p> <p>3. There were 3 ceiling tiles by the nurses' station with brown stains. During an interview at the time of the observation, the Maintenance Director indicated they were water stains from condensation from the water line. He indicated he had put new insulation around the line. He indicated he replaces the ceiling tiles a lot.</p> <p>D Wing</p> <p>1. The wall across from the nurses' station had several areas with chipped paint. During an interview at the time of the observation, the Maintenance Director indicated they were from the wheelchairs.</p> <p>2. In the B hall men's shower room there was a mechanical lift that was dirty.</p> <p>3.1-19(f)</p>		<p><i>changes will be completed.</i> September 12, 2012</p>		

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F0514 SS=E	<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 medical records were complete and accurate related to missing and incomplete physician orders for 4 residents in a sample of 24 residents whose records were reviewed. (Resident #8, #90, #98, and #117).</p> <p>Findings include:</p> <p>1. Resident #117's record was reviewed on 8/13/12 at 1:15 p.m. Resident #117's diagnoses included, but were not limited to, end stage dementia, diabetes mellitus, and anxiety.</p> <p>A nurses' note, dated 7/28/12 at 7:57 a.m., indicated "...Received new order for foley x (times) 2 weeks and change in treatment to right ischium {lower portion of the hip</p>	F0514	<p><i>F 514 It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible and systematically organized. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · Resident # 117 had orders for foley catheter clarified and input to PCC. Nurse who input original order received education on order input and documentation. · Resident # 8 no further action can be taken. Nurse who failed to follow through inputting of order, received education on order input and documentation. · Resident #90 order to hold medication was caught the 	09/12/2012			

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	<p>bone} (pressure ulcer)." The end of the 2 weeks was 8/11/12.</p> <p>A physician's order, dated 7/28/12, indicated "insert 16F (French) 5 cc (cubic centimeters) bulb foley." There was a lack of documentation to indicate the catheter was to be for 2 weeks.</p> <p>During an interview on 8/13/12 at 2:02 p.m., the MDS Coordinator #1 indicated the nurse had not put the catheter for 2 weeks on the order.</p> <p>2. Resident #8's record was reviewed on 8/13/12 at 9 a.m. Resident #8's diagnoses included, but were not limited to, history of DVT (deep vein thrombosis), dementia, and stroke.</p> <p>A nurses' note, dated 6/28/12 at 1:32 p.m., indicated "Received labs PT 53.8 INR 5.45, MD made aware and gave new orders to repeat pt/inr on 6-30-12, and hold Coumadin until MD receives new lab results..."</p> <p>During an interview on 8/13/12 at 11:12 a.m., the B Wing Unit Manager indicated the nurse came in on 6/28/12 she saw the 6/25/12 laboratory results with the critical results and called the physician with the laboratory results from 6/25/12. and he gave her the order to hold the Coumadin</p>		<p>following morning during clinical review. Order had been discontinued and then had been input to restart 30 days following the discontinued order. Nurse who received the original order received education on order input and documentation.</p> <ul style="list-style-type: none"> · Resident # 90 order was removed from recapitulation. Order had been discontinued and should not have shown up on the recaps. · Resident # 98 had August recapitulation orders reviewed and corrected. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · All new physicians orders will be reviewed during clinical start up each morning. · Licensed nursing staff to be re-in-serviced on physician's orders, documentation of orders, inputting of orders into PCC and follow through of orders received. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i> · Licensed nursing staff to be re-in-serviced on physician's orders, documentation of orders, inputting of orders into PCC and follow through of orders received. · Physician's orders will be monitored daily at Clinical Start Up to ensure orders are correct. <i>How the corrective action(s) will</i> 				

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	<p>but she didn't write the order.</p> <p>3. Resident #90's record was reviewed on 8/7/12 at 11:50 p.m. Resident #90's diagnoses included, but were not limited to, senile dementia and hyperlipidemia.</p> <p>A nurses' note, dated 7/11/12, indicated to hold the resident's simvastatin (lowers cholesterol) for one month.</p> <p>The resident's record lacked documentation of a physician's order to hold the simvastatin for one month.</p> <p>An interview on 8/7/12 at 1:50 p.m., the D-wing Unit Manager indicated there was no physician's order to hold the simvastatin.</p> <p>4. Resident #98's record was reviewed on 8/10/12 at 9:05 a.m. Resident #98's diagnoses included, but were not limited to, epilepsy and anxiety.</p>		<p><i>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <p>·DNS/Designee will report findings to monthly QA&A meeting any trends or patterns noted will result in an action plan written and implemented.</p> <p><i>By what date the systemic changes will be completed.</i> September 12, 2012</p>		

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	<p>An August 2012 physician recapitulation orders, indicated Restoril (hypnotic) 15 milligrams at bedtime.</p> <p>A physician's telephone order, dated 7/19/12 indicated the Restoril had been discontinued.</p> <p>An interview on 8/10/12 at 10:15 a.m., MDS #2 indicated the Restoril should have been taken off the physician recapitulation orders.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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F9999	<p>State Finding:</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview the facility failed to notify the Indiana State Department of Health (ISDH) of an</p>	F9999	<p><i>F9999</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <p>·Resident #66 had a Wandergard put on and placed on the elopement protocol list on 5-28-12. No further action can be taken at this time.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <p>·All incidence of unusual occurrence will be reported to the Indiana State Department of Health, adhering to the guidelines of the State Department and the Golden Living.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>·Director of Operation did an in-service and education with all management staff to ensure the proper knowledge of the reporting of any unusual occurrences</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <p>·All unusual occurrences will immediately be reported to the</p>	09/12/2012	

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	<p>unusual occurrence, related to an elopement of a cognitively impaired resident, for 1 of 24 residents reviewed for elopements in a total sample of 24. (Resident #66)</p> <p>Findings include:</p> <p>Resident #66's record was reviewed on 08/08/12 at 8 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, severe behavioral disturbance, and chronic renal failure. The resident was admitted into the facility on 02/22/12 and readmitted into the facility from a hospital stay on 05/04/12.</p> <p>A significant change MDS (Minimum Data Set) Assessment, dated 05/11/12, indicated the resident responded adequately to simple, direct communication only, was cognitively impaired, had difficulty focusing attention and disorganized thinking, had no behaviors, required extensive assistance of two or more staff for transfers and locomotion and used a wheelchair for mobility.</p> <p>The care plan for wandering and poor safety awareness was brought forward from before the readmission, dated 03/24/12, which included the intervention to check the wanderguard for placement</p>		<p>ED/DNS and then the DO and CSC, to ensure the proper notification to the State.</p> <p>·All unusual occurrence reports to the State will be brought to QA monthly to monitor as an ongoing process.</p> <p><i>By what date the systemic changes will be completed.</i></p> <p>·9/12/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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	<p>and functioning.</p> <p>A Nurses' Note, dated 05/26/12 at 10:21 a.m., indicated, "resident (sic) alert oriented to self only, numerous attempts to open exit doors, easily redirected..."</p> <p>A Nurses' Note, dated 05/28/12 at 1:01 p.m., indicated, "...resident exit facility through the front lobby doors and was found sitting under the awning to the entrance (sic) of the building Background: resident has hx (history) of exit seeking with hx of dementia with behavioral disturbances Assessment: staff noticed resident sitting outside of front doors of facility under the front door awning...resident stated he wanted 'to go to Broadway (sic) street to go home' staff member brought resident into facility...Response: writer contacted resident doctor...apply wander guard (sic) to resident ankle..."</p> <p>During an interview on 08/08/12 at 10:10 a.m., the DoN (Director of Nursing) indicated she did not consider the resident being out of the building an elopement. She indicated the incident had not been reported to the ISDH. She indicated they believed someone had left the door open and the resident did not go anywhere except just right outside the door.</p>			

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	<p>During an interview on 08/09/12 at 8:55 a.m., the Administrator indicated the resident being outside of the building had not been reported to the ISDH.</p> <p>A facility policy, dated 01/11, titled, "Elopement Policy and Procedure Guide", received from the Administrator as current, indicated, "...Elopement...is defined as the situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for injury outside the confines...has left the living center without knowledge of staff...residents at risk of elopement are assessed quarterly and as needed...The Executive Director shall notify...State agency, as necessary by state requirement..."</p> <p>3.1-13(g)(1)</p>				