

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2012
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F0000	<p>This visit was for the Investigation of Complaint IN00103864.</p> <p>Complaint IN00103864-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F312 and F315.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey.</p> <p>Survey dates: February 13, 14, 15, 16, 17, 19, & 20, 2012</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN, TC February 14, 15, 16, 17, & 20, 2012 Lara Richards, RN February 13, 14, 15, 16, 17, & 20, 2012 Heather Tuttle, RN February 13, 14, 15, 16, 17, & 20, 2012 Kathleen Vargas, RN</p> <p>Census bed type: SNF/NF: 71 Total: 71</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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	<p>Census payor type: Medicare: 21 Medicaid: 37 Other: 13 Total: 71</p> <p>Stage 2 Sample: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/24/12 Cathy Emswiller RN</p>			
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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the residents' physician and/or family member were notified in a timely manner following a condition change</p>	F0157	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: It is the practice of this facility to ensure	03/21/2012	

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	<p>related to a medication allergy, increased lethargy as well as weight loss and decreased appetite for 1 of 3 residents of the 9 who met the criteria for non-pressure skin conditions, for 1 of 3 residents of the 7 who met the criteria for hospitalization within the first 30 days of admission and for 1 of 3 of the 6 residents who met the criteria for nutrition. (Residents #C, #D, and #F)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. and on 2/17/12 at 8:35 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and deep vein thrombosis (blood clot).</p> <p>A Physician's order dated 2/16/12, indicated the resident was to receive Augmentin (an antibiotic) 875 mg (milligrams) twice a day for 3 days due to cellulitis of the right hand.</p> <p>Documentation in the Nursing Progress Notes on 2/16/12 at 5:15 p.m., indicated the pharmacy called and stated the resident was allergic to the prescribed antibiotic. The Physician was notified and staff were waiting for a call back. At 7:00 p.m.,</p>		<p>the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was resident F medical record was reviewed for current allergies and Dr. was notified of res. allergy to Augmentin on 2/17/12 by ADON during the survey. Res. C returned to the facility on 1/29/12 and was reassessed by the DON on 2/21/12 with noted improvement. Resident D was reweighed by CNA on 2/15/12 during the survey and her weight was stable at present. The corrective action for those residents having the potential to be affected by the same deficient practice is DON has audited medical records on 3/2/12 to identify any omitted allergies. ADDENDUM: All residents were audited to determine if there was a decrease in food consumption or change of condition by the ADON to ensure physician/family has been notified in a timely manner. All residents were reweighed during the survey. Residents with a 5 lb wt loss/gain will be reweighed with in 24 hrs and family and physician will be notified by staff nurse. Care plans will be updated to reflect current status. Communication</p>				

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	<p>staff attempted to call the Physician back. A voice message was left with no return call. Documentation at that time, indicated staff would speak with the physician tomorrow. There was no documentation of any attempts to call an alternate Physician or the Medical Director in the above entries.</p> <p>Documentation in the Nursing Progress Notes on 2/17/12 at 12:30 p.m., indicated the resident was seen by the Physician and an order was obtained for a new antibiotic.</p> <p>Interview with LPN #2 on 2/20/12 at 1:55 p.m., indicated if the resident's primary physician did not respond after a few attempts, then the Medical Director should be called.</p> <p>2. The record for Resident #C was reviewed on 2/15/12 at 1:17 p.m. The resident's diagnoses included, but were not limited to, infected decubitus ulcer, hyperactivity, and anxiety.</p> <p>An entry in the Nursing Progress Notes dated 1/22/12 at 9:55 p.m., indicated the resident was found on the floor on his back. The Physician was notified at this time and orders were received.</p> <p>Documentation in the Nursing</p>		<p>slips will be sent to appropriate departments for interventions. The measures put into place and a systemic change made to endure the deficient practice does not reoccur nursing staff have been re-educated relative to appropriate interventions regarding allergies, falls, change of condition and weight loss on 3/2-3/9 by the DON/SDC. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit phone orders, 24 hour report for allergies, falls and any wt loss Monday - Friday to ensure physician/family have been notified timely. Addendum: The Director of Clinical Services/designee will audit 30% of the food consumption records 2 X weekly to verify compliance. DON/designee will monitor results weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution..</p>				

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	<p>Progress Notes dated 1/23/12 at 12:00 a.m., indicated the resident was lethargic at first. Difficult to arouse. When he became more responsive he was confused, inappropriate, unable to follow commands, in answer to questions repeated "Catholic Charities" over and over. Able to move arms, hand grasps weak bilateral. The resident's blood pressure was 100/67 and his pulse was 101.</p> <p>At 2:30 a.m., documentation indicated there was no change in the resident's neurological assessment, he remained confused and was talking to himself. He was orientated to name only.</p> <p>Documentation at 4:15 a.m., indicated the resident remained lethargic. He was speaking in a whisper, and remained confused. At 4:30 a.m., the Physician was notified of the resident's status and orders were received. The resident was admitted to the hospital with the diagnoses of urinary tract infection (UTI), multiple falls, and sepsis secondary to UTI and multiple decubitus.</p> <p>Interview with LPN #1 on 2/20/12 at 1:20 p.m., indicated the physician should have been notified in a more</p>				

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	<p>timely manner related to the resident's lethargy on 1/23/12.</p> <p>3. The record for Resident #D was reviewed on 2/13/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, senile dementia, high blood pressure, convulsions, depressive disorder, and osteoarthritis.</p> <p>The 2011 and 2012 Weight Records indicated the following weights were recorded: 09/10/11 207.10 pounds 10/10/11 203 pounds 11/08.11 204.10 pounds 12/09/11 203 pounds 01/10/12 201.9 pounds 02/07/12 184 pounds 02/15/12 185 pounds</p> <p>The January 2012 Monthly Flow record for food consumption indicated the resident's intakes were as follows: 1/22/12 Breakfast: 0% Lunch: 50% Dinner: not recorded</p> <p>1/23/12 Breakfast: 0% Lunch: 25% Dinner: less than 25%</p>						

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	<p>HS snack: 0%</p> <p>1/24/12 Breakfast: 0% Lunch: 75% Dinner: 0% HS snack: 0%</p> <p>1/25/12 Breakfast: 25% Lunch: 25% Dinner: less then 25% HS snack: 25%</p> <p>1/26/12 Breakfast: 0% Lunch: 0% Dinner: less then 25% HS snack: less then 25%</p> <p>1/27/12 Breakfast: 0% Lunch: 0% Dinner: less then 25%</p> <p>A Nutritional Progress noted dated 2/17/12 indicated the resident had a significant weight loss of 8% in the past 30 days.</p> <p>The resident's current care plans were reviewed. There was no care related to the resident being on any</p>						

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	<p>planned weight loss program during the above months.</p> <p>There was no documentation in the 2/2012 Nurses' Notes related to the resident's family/responsible party receiving notification of the recent weight loss.</p> <p>The 1/2012 Nurses' Notes were reviewed. There was no documentation the physician was notified of the residents decreased food consumption 1/22/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter voiced concerns related to the resident's lethargy. The entry also indicated the resident was moving around very little and not drinking. The next entry was made on 1/27/12 at 8:00 p.m. This entry indicated the resident was being transferred to the hospital for evaluation and treatment.</p> <p>The 1/27/12 hospital Emergency Department notes indicated the resident had decreased oral intake and infection. The note also indicated the resident was asking for something to drink. The note also indicated the Nursing Home staff indicated the resident did not eat or drink water for two days.</p>						

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	<p>The facility policy titled "Changes in Resident's Condition or Status" was received from the Director of Nursing on 2/16/12 at 11:30 a.m. There was no date on the policy. The Director of Nursing indicated the policy was current.</p> <p>The policy indicated the resident, attending Physician, and residents' representative were to be notified of changes in the resident's condition and/or status. The policy indicated Nursing was responsible to notify the attending Physician and the resident and the residents' representative of any significant change in the resident's physical, mental, or emotional status. The policy also indicated the Nursing staff were to notify the Physician of any need to alter the residents treatment or medications significantly. All notifications were to be made as soon as practical and not exceeding twenty-four hours.</p> <p>When interviewed on 2/20/12 at 10:30 a.m., the Director of Nursing indicated the resident's family should have been notified of the weight loss.</p> <p>This Federal tag relates to Complaint IN00103864.</p>						

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	3.1-5(a)(2) 3.1-5(a)(3)				

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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 and/or the plan of care were followed as written related to the use of chair alarms, derma sleeves, elevating an extremity, nutritional supplements, treatments and medications not given as ordered, laboratory tests not done as ordered, the physician not notified of lab results as ordered, the use of non-skid foot wear, and documentation of shower refusals and food consumption for 1 of 3 residents of the 8 who met the criteria for accidents, for 2 of 3 residents of the 9 who met the criteria for non-pressure skin conditions, for 2 of 10 residents who were reviewed for unnecessary medications and for 1 resident of the 1 who met the criteria for activities of daily living. (Residents #B, #D, #F, #G, #H, #J, and #K)</p> <p>Findings include:</p> <p>1. On 2/16/12 at 8:35 a.m., Resident #F was observed in his room in bed.</p>	F0282	<p>The corrective action taken for the resident found to have been affected by the deficient practice was: Res #B is no longer in the facility. Res. #D had a follow up UA C&S with results 2/15 and 2/16. She received showers on 2/15 and 2/18/12, she was seen by the dietician on 2/16 and again on 3/1 with recommendation to add supplements to her POC. Resident F had Geri sleeves placed and arm was elevated by the CNA on 2/20/12. He had a clarification order written on 2/20 for use of a chair alarm and the Daily Care Guide reflects the order. Resident #G had non-skid socks applied. Resident H had restorative therapy initiated on 2/22/12 by the Restorative Nurse. Resident J received a dressing change by the wound care nurse on 2/17/12. Resident K had her dietary card audited to verify that it matches the PO. The Dietary Manager did verify that all items were received per tray card orders on 2/21/12. The corrective action taken for those residents having the potential to be affected by the same deficient practice is an audit was completed by the infection control nurse of physician orders over the last two</p>	03/21/2012			

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	<p>The resident was wearing a short sleeve shirt and he had no derma sleeve (a covering to protect the skin) in place to the left arm. The resident's right arm was wrapped with a gauze dressing. At 9:20 a.m., the resident was seated in a wheelchair in his room. The resident's right hand was red and swollen. The resident's right arm was not elevated at this time. At 12:11 p.m., the resident's right hand remained edematous with redness. The 1/2 lap tray attached to the resident's wheelchair was not in use at this time, nor was the resident's right arm elevated.</p> <p>During observation on 2/17/12 at 8:29 a.m., the resident was seated in his wheelchair in the Restorative Dining Room. The resident's right arm was not elevated. The resident's right hand remained edematous and red in color.</p> <p>During observation on 2/20/12 at 8:30 a.m., 9:30 a.m., and 11:30 a.m., the resident was seated in a wheelchair in his room. The resident's right hand remained red with some edema. The resident's hand was not elevated at this time. Further, the resident did not have on derma sleeves to either arm. The resident's chair alarm was not attached at the above times either.</p>		<p>weeks for UA's to verify they have been processed properly. The dietician to verify that the tray cards matched physician orders for supplements completed a house wide audit. The department heads to completed a house wide audit of the residents to verify that restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered were in proper place. Nursing management competed a house wide audit to verify that the care guides and care plans matched. A audit was completed by the Rehab Service Manager of the last 30 days of recommendations to the restorative services to verify they have been implemented timely. A audit was completed by the DON to verify all dressings had been changed timely. Addendum: All of the residents had their Feb. MAR reviewed by the DON to verify that medications had been given as ordered. The measures put into place and a systemic change made to ensure the deficient practice does not recure is dietary staff has been inserviced by the Dietary Manger on 3/2/2012. Nursing staff and Department Heads have been in-serviced by DON/ SDC on 3/2-3/9/12 on following physician orders for restorative devices and timely dressing changes. Restorative</p>		

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	<p>The record for Resident #F was reviewed on 2/15/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, dementia and Parkinson's disease.</p> <p>A Physician's order dated 1/17/12, indicated the resident was to have derma sleeves to his right and left arm.</p> <p>A Physician's order dated 2/15/12, indicated the resident was to have a right arm half tray on his wheelchair for extremity positioning.</p> <p>The plan of care dated 10/25/11 and reviewed on 1/17/12, indicated the resident was at risk for falls related to the use of psychotropic drugs and unsteady gait. One of the listed interventions was for a wheelchair alarm.</p> <p>The plan of care dated 2/15/12, indicated the resident had a swollen right hand along with cellulitis to the hand. The interventions indicated the resident's hand was to be elevated as needed.</p> <p>Interview with LPN #1 on 2/20/12 at 11:40 a.m., indicated the resident was</p>		<p>Nurse has been by the Rehab Service Manager in regards to timely implementation of restorative services.</p> <p>Addendum: The DON and Medical Records Director will review all residents' MAR Mon – Fri for accuracy of medication administration. They will review all orders for labs Mon. – Fri. in change of condition meeting and verify that all the labs were completed as ordered. The evening supervisor will review all residents' food consumption records Mon. – Fri. to monitor for pattern of decrease of intake looking at three days at a time. To ensure the deficient practice does not recur, the monitoring system established is an audit will be completed on 50% of physician orders Mon – Fri (Weekend orders will be reviewed on Monday) by the DON/designee to verify that they have been processed properly. An audit will be completed 3 times per week (a different meal each time) on 50% of the meal trays by the Dietary Manager /designee to compare the accuracy of the tray to the tray card. The Rehab Service Manager will complete audits 2 times per week of 30% the residents who are on the restorative program to verify they are receiving restorative services and that care plans have been update to reflect services. A audit will be completed two times weekly by the ADON of 25% of</p>				

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	<p>to have derma sleeves on bilaterally at all times except for care. She indicated the resident did not have a derma sleeve on either arm. She then asked CNA #2 to apply the derma sleeves. At that time, there was only one sleeve in the resident's drawer. The CNA indicated that she would have to clarify if the resident was to have a derma sleeve on his right arm due to the swelling.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/20/12 at 1:50 p.m., indicated the resident's half lap tray should have been in use to elevate the resident's right arm. Continued interview at the time, indicated there were conflicting interventions between the care plan and the Daily Care Guide related to the use of a chair alarm. She indicated there was no order for the chair alarm but it was listed as an intervention on the care plan. Continued interview at the time, indicated the order for the chair alarm should have been obtained since it was on the care plan and the chair alarm should have been in use.</p>		<p>the residents who receive dressing changes to verify dressings are being changed as ordered. Addendum: The Director of Clinical Services/designee will audit 30% of the MAR, labs, and food consumption records records 2 X weekly to verify compliance. The Executive Director will review 100% of the Dept. Head's audit of restorative devices such as dema sleeves, lap tables, non-skid foot wear, alarms etc., any assistive devices ordered three times per week. All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed education All audits will be completed weekly for the first month, monthly for the first quarter and quarterly thereafter for three quarters with results forwarded to the facility performance improvement committee for further evaluation or resolution or needed ed</p>		

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	<p>2. On 2/13/2012 at 12:33:41 p.m., Resident #G was observed wearing pink and white socks no non skid material on the bottom of her socks, and she was not wearing shoes.</p> <p>On 2/14/12 at 9:45 a.m., the resident was observed up in her w/c wearing socks with no non skid material and no shoes.</p> <p>On 2/15/12 at 9:10 a.m., 10:40 a.m., and 1:46 p.m., the resident was observed up in her wheelchair sitting by the Nurses' Station. At those times she was observed wearing plain blue striped fuzzy socks with no non skid material on the bottom of them. The resident was not wearing any shoes.</p> <p>The record for Resident #G was reviewed on 2/15/12 at 9:14 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease.</p>			

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	<p>Review of the current plan of care updated on 1/17/12 indicated the resident had the potential for falls related to vertigo(dizziness), cognitive deficit, and impaired safety awareness as evidenced by history of falls. The nursing approaches were to ensure the resident has and wears properly fitting non skid soled shoes for ambulation.</p> <p>Interview with CNA #5 on 2/15/12 at 9:54 a.m., indicated they have care card sheets with all the resident's information on it. She further indicated the resident has always worn those type of socks because that was all the types she had in her drawer. She further indicated there was no information regarding non skid sole socks or shoes on her card regarding resident #G.</p> <p>Interview with LPN #2 on 2/16/12 at 2:31 p.m., indicated the resident was wearing dark purple fuzzy slippery socks and there were no non skid soles on them.</p> <p>3. The record for Resident #H was</p>			

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	<p>reviewed on 2/17/12 at 12:55 p.m.</p> <p>The resident was admitted to the facility on 9/28/11 from the hospital. The resident's diagnoses included, but were not limited to, dementia, hypotension, arthritis, COPD(chronic obstructive pulmonary disease), emphysema, Parkinson disease, and organic brain syndrome.</p> <p>Review of Physician Orders dated 2/2/12 indicated Restorative therapy: AROM (active range of motion) to bilateral upper extremity hand bike times 15 minutes sit to stand 3 minutes times 5 sets, standing tolerances. PROM (passive range of motion) to bilateral upper extremities 20 repetitions times 2 sets.</p> <p>Further review of Physician Orders dated 1/30/12 indicated Restorative therapy: BLE (bilateral lower extremity) leg bike times 20 minutes with 2 pound weights, bed to wheelchair transfers times 5 sets and ambulate 70 feet times 2, gait belt and CNA.</p> <p>Review of the Restorative Nursing</p>						

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	<p>Program Flow Sheet for the week of 1/29-2/4/12 indicated the resident did not receive any therapy 1/29/12 - 1/31/12 and 2/1/12- 2/4/12.</p> <p>Review of the Restorative Nursing Program Flow Sheets for the week of 2/5-2/11/12 and 2/12/12-2/18/12 indicated the resident did not receive therapy on 2/7/12- 2/9/12, 2/11/12-2/14/12, 2/16/12-2/18/12.</p> <p>Interview with the Assistant Director of Nursing on 2/20/12 at 12:17 p.m., indicated the resident did not receive Restorative Therapy as ordered by the Physician.</p> <p>4. On 2/16/12 at 3:15 p.m., the medication drawer for Resident #B was observed. At that time, the medication of Tovaz (a medication used for urinary spasms) was reviewed. The pharmacy had sent the facility a total of 30 pills on 2/10/12. There were 27 pills left in the box on 2/16/12.</p> <p>The record for Resident #B was reviewed on 2/16/12 at 1:19 p.m. The</p>						

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	<p>resident was admitted to the facility on 2/10/12 from the hospital.</p> <p>Review of the Medication Administration Record (MAR) dated 2/10/12 indicated Tovaz 8 mg was only signed out as being given on 2/13/12. The time of administration indicated 8:30 there was no a.m. or p.m. handwritten next to it.</p> <p>Interview with LPN #2 at that time, indicated the medication had only been given three times since the resident had been at the facility. She further indicated the medication had been missed for at least three days.</p> <p>5. The record for Resident #D was reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, knee joint replacement, senile dementia, high blood pressure, depressive disorder, and convulsions.</p> <p>A Physician's order was written on 1/12/12 to obtain a Urinalysis and Culture & Sensitivity to be completed by the laboratory. Another order was</p>				

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	<p>written on 1/17/12 for staff to straight catheterize the resident for the Urinalysis and Culture and Sensitivity test.</p> <p>The 1/2012 Laboratory test results were reviewed. There was no documentation the ordered Urinalysis and Culture and Sensitivity had been completed by the facility.</p> <p>The resident's care plans were reviewed. There was a care plan indicating the resident had an alteration in nutritional status related to decreased oral intake. The care plan was initiated on 5/10/2010 and last updated on 12/20/11. Care plan interventions included to monitor the resident's intake. There was also a care plan indicating the resident was at risk for skin breakdown. The care plan was initiated on 12/20/11. Care plan interventions included for staff to record the resident's food intake percentage at each meal.</p> <p>A care plan initiated on 1/11/12 indicated the resident refused showers at times. Care plan interventions included for staff to call</p>				

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	<p>the resident's sister when showers were refused. A care plan initiated on 8/8/11 indicated the resident refused showers and for staff to wash her clothes. The care plan was last updated on 12/20/11. Care plan interventions included for staff to call the resident's sister to encourage her.</p> <p>The 2/2012 electronic generated Diet Monthly Flow Report was reviewed. The amount of the resident's meal intake was not recorded for the breakfast and lunch meals on 2/1/12 thru 2/3/12 and 2/11/12. The amount of the resident's meal intake was not recorded for the breakfast meals on 2/6/12 and 2/12/12. The amount of the resident's meal intake was not recorded for the lunch meal on 2/8/12.</p> <p>The 1/2012 and the 2/2012 electronic generated Daily Care Monthly Flow Reports were reviewed. The 1/2012 report indicated the resident refused bathing on 1/5/12, 1/6/12, 1/9/12,</p>						

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	<p>1/10/12, 1/17/12, 1/23/12, and 1/27/12. The 2/2012 report indicated the resident refused bathing on 2/7/12.</p> <p>The 1/2012 and the 2/2012 Nurses' Notes were reviewed. There was no indication the staff called the resident's sister related to the refusals as per her plan of care.</p> <p>When interviewed on 2/20/12 at 10:15 a.m., the Assistant Director of Nursing indicated the CNA's write down the intake amount of each meal on the tray card slip and then enter the amount into the computer for each meal. The Assistant Director of Nursing indicated the slips are then thrown away and there is no other area of documentation of the meal intakes.</p> <p>When interviewed on 2/20/12 at 10:30 a.m., the Director of Nursing indicated the resident's plan of care was not followed related to monitoring the resident's oral intakes.</p>				

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	<p>When interviewed on 2/16/2012 at 12:03 p.m., the Director of Nursing indicated if the resident refused the shower staff were to call the resident's sister to come in to attempt to encourage the resident to accept the shower. Nursing staff were to document attempts to call the resident's sister in the Nurses' Notes as per the resident's plan of care.</p> <p>When interviewed on 2/15/12 at 11:07 a.m., the Assistant Director of Nursing indicated an order was obtained for a Urinalysis and Culture and Sensitivity on 1/12/12. The Assistant Director of Nursing indicated the ordered urine specimen had not been collected until the resident was sent to the hospital on 1/27/12.</p> <p>6. Resident #K was observed on 2/16/12 at 12:50 p.m. The resident was in bed, her lunch had been served. The resident did not receive pudding on her lunch tray.</p> <p>The resident was observed on</p>			

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	<p>2/17/12 at 12:48 p.m. in bed. Her lunch tray was served to her in her room. There was no soup served with her lunch</p> <p>On 2/19/12 at 8:36 a.m. the resident's breakfast was served. There was no orange supplement drink on the resident's breakfast tray. Interview with LPN #2 at that time, indicated there was no orange supplement drink served on the resident's breakfast tray.</p> <p>The record for Resident #K was reviewed on 2/15/12 at 9:04 a.m. The resident had diagnoses that included, but were not limited to, congestive heart failure, diabetes, and osteoarthritis.</p> <p>The February 2012 Physician Order Sheet was reviewed, it indicated the resident's diet was: regular, whole milk with all meals and pudding with meals, orange supplement drink at breakfast, super soup at lunch and dinner, 2 Cal (a nutritional supplement) 90 milliliters twice daily.</p> <p>LPN #2 was interviewed on 2/20/12 at 8:46 a.m. She indicated there was no orange supplement available from the kitchen to give to the resident. She also indicated there was a physician's</p>						

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	<p>order that the resident was to receive super soup (a dietary supplement) at lunch and dinner and she was to receive pudding with meals. She indicated the Physician's orders for the dietary supplements were not followed.</p> <p>The Dietary Manager was interviewed on 2/20/12 at 10:25 a.m. She indicated there was no orange supplement drink available in the kitchen for the breakfast meal. She indicated a supply of the orange supplement was ordered and would be coming to the facility at lunch time.</p> <p>7. Resident #J was observed on 2/15/12 at 8:45 a.m. She was seated in a wheelchair in the dining room, there was a dressing on her left lower leg dated 2/15/12.</p> <p>The resident was observed on 2/16/12 at 10:00 a.m. seated in a wheelchair in the Therapy Room. There was a dressing on her left leg dated 2/15/12.</p> <p>The resident was again observed on 2/17/12 at 10:58 a.m. She was seated in her wheelchair in front of the 200 unit nurse's station. There was a dressing on her left leg dated 2/15/12.</p>						

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	<p>On 2/17/12 at 1:15 p.m., the dressing on the resident's left leg was observed. The dressing was dated 2/17/12 and had LPN #2's initials.</p> <p>LPN #2 was interviewed on 2/17/12 at 1:32 p.m., she indicated the resident's dressing was loose and she reinforced the dressing. She stated she did not do a complete dressing change because the Wound Nurse was coming in to complete the treatment. She indicated the dressing she removed was dated 2/15/12.</p> <p>The record for Resident #J was reviewed on 2/17/12 at 12:51 p.m. The resident had diagnoses that included, but were not limited to, hypertension, anemia and coronary artery disease.</p> <p>Review of the Non-Pressure Skin Condition Record indicated the resident had a skin tear that was first noted on 2/3/12 to the left lower leg.</p> <p>There was a Physician's order dated 2/7/12 that indicated, "1) left lateral lower leg, D/C (discontinue) Silvadene cream to area and start 2). Left lateral leg, cleanse area with n/s (normal saline) pat dry and apply Santyl and Calcium Arginate dressing, cover with Kerlix wrap daily</p>						

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	<p>and prn (as needed)."</p> <p>Continued interview with LPN #2 on 2/17/12 at 1:32 p.m., indicated there was a physician's order to change the dressing daily. She indicated the treatment to the skin tear was not completed daily as ordered by the Physician. The LPN also indicated the dressing should have been changed on 2/16/12 and dated 2/16/12.</p> <p>This Federal tag relates to Complaint IN00103864.</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</p> <p>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 observation, record review, and interview, the facility failed to provide the necessary services to maintain nutrition related to not being supervised with meals for 1 of 2 residents reviewed for ADL (Activities of Daily Living) assistance in the Stage 2 sample of 35. (Resident #D)</p> <p>Finding include:</p> <p>On 2/16/12 at 8:38 a.m., CNA #1 was observed passing breakfast meal trays down Resident #D's hall. At 8:44 a.m. the CNA entered the resident's room with her meal tray and placed the tray on the resident's over bed table and left the room. The resident was seated in a wheel chair. The resident picked up the spoon with her left hand and tried to put the spoon into her right hand to eat her yogurt. The spoon was not placed correctly in her right hand. The resident had picked up the carton of yogurt with her left hand and was not able to put the spoon into the yogurt so she put the yogurt container back</p>	F0312	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was resident D is assisted with meals in her room and encouraged to consume meals in the assisted dinning room for closer observation. Physician to be notified with a 3 pound weight loss again. The corrective action taken for those residents having the potential to be affected by the same deficient practice is Medical records of residents with physical impairments will be reviewed for appropriate supervision during meal times. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing staff have been re-educated by DON/SDC on 3/2-3/9 for appropriate supervision and interventions during meal times To ensure the deficient practice does not recur, the monitoring system established is: DON/designee will audit 25% of the residents who remain in rooms 3 times weekly</p>	03/21/2012			

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	<p>on the tray without eating any at this time. After about one minute the resident pushed the overbed table away from her and started propelling herself in the wheel chair towards her bed. At 8:50 a.m., CNA #1 re entered the room and tried to give the resident bites of the yogurt and cereal and the resident told the CNA she did not want any.</p> <p>On 2/16/12 at 9:05 a.m., the Assistant Director of Nursing was observed assessing the resident's movement of her upper extremities. The resident had a spoon in her left hand and had difficulty taking the spoon from her left hand and placing it in her right hand on her own. The fingers of the resident's right hand were bent closed in a fist and the resident pushed the spoon in between the thumb and the right first finger without opening the fingers.</p> <p>On 2/16/12 at 1:07 p.m., the resident was observed in bed eating lunch. There were no staff in the resident's room. The resident was observed picking up carrots with her left hand. At this time the resident was observed using the spoon in her right hand to eat sherbet.</p> <p>The record for Resident #D was</p>		(each meal time to be audited) to ensure they are assisted when needed. DON/designee will monitor the restorative dining room daily at each mealtime to ensure residents have supervision and interventions in place. DON/designee will complete these indicators weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution..				

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	<p>reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, senile dementia, high blood pressure, osteoarthritis, cerebral vascular accident (stroke), and depressive disorder.</p> <p>The 2/2012 Nurses' Notes were reviewed. An entry made on 2/10/12 at 10:00 a.m. indicated the daughter noted the residents right dominant hand was partially clenched and was making it difficult to grasp or hold items. The daughter also indicated even though the resident may say she does not want to eat, she will with encouragement. The entry also indicated a message was left to place the resident in the restorative part of the dining room so the resident would be monitored/encouraged or fed as needed.</p> <p>The 1/2012 Nurses' Notes were reviewed. There was no documentation the physician was notified of the residents decreased food consumption 1/22/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter voiced concerns related to the resident's lethargy. The entry also indicated the resident was moving around very little and not drinking. The next entry was made on</p>						

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	<p>1/27/12 at 8:00 p.m. This entry indicated the resident was being transferred to the hospital for evaluation and treatment.</p> <p>The 1/27/12 hospital Emergency Department notes indicated the resident had decreased oral intake and infection. The note also indicated the resident was asking for something to drink. The note also indicated the Nursing Home staff indicated the resident did not eat or drink water for two days.</p> <p>The resident's care plans were reviewed. There was a care plan indicating the resident had an alteration in nutritional status related to decreased oral intake. The care plan was initiated on 5/10/2010 and last updated on 12/20/11. Care plan interventions included to monitor the resident's intake. There was also a care plan indicating the resident was at risk for skin breakdown. The care plan was initiated on 12/20/11. Care plan interventions included for staff to record the resident's food intake percentage at each meal.</p> <p>The 2011 and 2012 Weight Records</p>						

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	<p>indicated the following weights were recorded:</p> <p>09/10/11 207.10 pounds 10/10/11 203 pounds 11/08.11 204.10 pounds 12/09/11 203 pounds 01/10/12 201.9 pounds 02/07/12 184 pounds 02/15/12 185 pounds</p> <p>When interviewed on 2/16/12 at 9:19 a.m., the Assistant Director of Nursing indicated she asked Therapy to screen the resident on 2/10/12 and the resident refused. The Assistant Director of Nursing indicated on 2/10/12 the resident was noted to have decreased use of her right dominant hand with her meals and was to be placed in the Restorative side of the dining room as the resident could be supervised with her meals.</p> <p>This Federal tag relates to Complaint IN00103864.</p> <p>3.1-38(a)(2)(D)</p>				

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F0315 SS=D	<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 record review and interview, the facility failed to provide the necessary treatment and services related to not obtaining a urine specimen for a urinalysis laboratory test to be completed for a resident with a urinary tract infection in a timely manner which resulted in the delay of treatment for 1 of 3 resident's reviewed for urinary tract infections in the Stage II sample of 35. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 2/15/12 at 9:03 a.m. The resident's diagnoses included, but were not limited to, dysuria (difficulty urinating), senile dementia, depressive disorder, high blood pressure, and convulsions.</p>	F0315	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was resident D's antibiotic treatment continues and a follow up Urinalysis and Culture and Sensitivity has been conducted with no additional treatment indicated. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: A complete review of all residents physicians orders for Urinalysis and Culture and Sensitivity for the last 14 days has been conducted to ensure that no outstanding orders exist and that all specimens have been collected in accordance with orders. The measures put into place and</p>	03/21/2012

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	<p>A Physician's order was written on 1/12/12 to obtain a Urinalysis and Culture & Sensitivity to be completed by the laboratory. Another order was written on 1/17/12 for staff to straight catheterize the resident for the Urinalysis and Culture and Sensitivity test. A Physician's order was written on 1/27/12 to send the resident to the hospital for an evaluation and treatment. An order was written on 1/28/12 for the resident to receive Cipro (an antibiotic) 500 milligrams twice a day for 10 days. An order was written on 1/30/12 to discontinue the Cipro and to start Macrobid (an antibiotic) 100 milligrams twice a day for 7 days.</p> <p>The 1/2012 Laboratory test results were reviewed. There was no documentation the ordered Urinalysis and Culture and Sensitivity had been completed by the facility.</p> <p>The 1/2012 Nurses' Notes were reviewed. An entry made on 1/12/12 at 5:00 p.m. indicated a new order was received to obtain a Urinalysis and Culture and Sensitivity due to a complaint the resident was not feeling well. There was no further documentation related to the ordered urine tests in the Nurses' Notes from</p>		<p>systemic change made to ensure the deficient practice does not recur is: As a portion of Monday through Friday change of condition meeting all physician orders will be reviewed to ensure timely and appropriate follow through and specimen collection. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with the timely collection of specimens and completion of Urinalysis and Culture and Sensitivity in accordance with physician order. The Infection Control Nurse or designee will complete an audit 2 times weekly of 50% of the residents with orders for a UA/C&S. Infection Control Nurse or designee will complete these indicators weekly for the first month, monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution.</p>				

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	<p>1/12/12 thru 1/15/12. An entry made on 1/16/12 at 11:00 a.m. indicated an order was received indicating staff may straight catheterize the resident to obtain the urine specimen for the Urinalysis and Culture & Sensitivity laboratory test. An entry made on 1/17/12 at 7:00 p.m. indicated staff were unable to obtain to catheterize the resident due to redness and irritation. The next entry was made on 1/18/12 at 11:00 p.m. and this entry indicated staff were still awaiting the Urinalysis and Culture and Sensitivity. There were no further entries related the ordered urine laboratory tests in the Nurses' Notes from 1/18/12 thru 1/27/12. An entry made on 1/27/12 at 2:30 p.m. indicated the resident's daughter expressed concerns related to the resident's lethargy and thought the resident may have a urinary tract infection. An entry made on 1/27/12 at 8:00 p.m. indicated the family member preferred the resident be sent to the hospital.</p> <p>An entry made on 1/28/12 at 3:55 a.m. indicated the resident returned to the facility with the diagnoses of urinary tract infection and a prescription for Cipro (an antibiotic) 500 milligrams twice a day for 10 days. An entry was made in the Nurses' Notes on 1/30/12 at 10:50</p>						

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	<p>a.m. This entry indicated the hospital Nurse called the facility to notify then the final results of the Urine Culture and Sensitivity indicated the organism was resistant to Cipro.</p> <p>The 1/27/12- 1/28/12 hospital records were reviewed. A Physical Exam report indicated a urinalysis was positive for nitrates, a small amount of leukocytes.</p> <p>When interviewed on 2/15/12 at 11:07 a.m., the Assistant Director of Nursing indicated an order was obtained for a Urinalysis and Culture and Sensitivity on 1/12/12. The Assistant Director of Nursing indicated the ordered urine specimen had not been collected until the resident was sent to the hospital on 1/27/12. The Assistant Director of Nursing indicated the resident returned from the hospital with a urinary tract infection.</p> <p>This Federal tag relates to Complaint IN00103864.</p> <p>3.1-41(a)(2)</p>				

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