

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2014
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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00157785.</p> <p>Complaint IN00157785 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 30 and 31, 2014 and November 3, 5, 6, and 7, 2014</p> <p>Facility number: 012225 Provider number: 155780 AIM number: 200983560</p> <p>Survey team: Dorothy Plummer, RN-TC Karyn Homan, RN Patsy Allen, SW</p> <p>Census bed type: SNF: 12 NF: 71 Total: 83</p> <p>Census payor type: Medicare: 11 Medicaid: 55 Other: 17 Total: 83</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective December 7, 2014 to the annual licensure survey conducted on October 30, 2014 through November 7, 2014. We respectfully request a paper review and will provide any additional information necessary as requested to confirm that all areas of the plan of correction have been completed.</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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F000279 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 19, 2014; by Kimberly Perigo, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident had a care plan that described the services needed to maintain their highest practicable well-being for 1 of 1 residents reviewed for dialysis in that the resident's</p>	F000279	<p><b>F279</b> It is the practice of this facility to assure that the residents' careplans are developed and address the needs identified by the comprehensiveassessment.</p>	12/07/2014

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	<p>dialysis care plan did not thoroughly explain how often the services this resident needed were to be performed. (Resident #139)</p> <p>Findings include:</p> <p>Resident #139's clinical record was reviewed on 11/06/14 at 11:10 a.m. Diagnoses included, but were not limited to, renal failure with the need for dialysis (medical process of removing wastes from a patient's blood).</p> <p>Resident #139 was admitted 10/14/14.</p> <p>Physician order dated 10/14/14, indicated, "[Name] Dialysis Center Mondays, Wednesday, and Fridays ...."</p> <p>No physician orders were found in regard to assessing the resident, assessing the dialysis site, nor the care the facility was to provide to the resident receiving dialysis.</p> <p>Interim Care Plan dated 10/15/14, did not indicate dialysis as a problem nor have a goal with interventions for this resident.</p> <p>Dialysis care plan initiated 10/31/14, indicated Resident #139, "... needs dialysis r/t [related to] renal disease... Interventions ... Monitor/document for</p>		<p><b>The correction action taken for thoseresidents found to be affected by the deficient practice include:</b></p> <p>Residents #139 care plan has beenupdated to assure that services related to dialysis are addressedappropriately. Physician's orders are inplace related to assessing the dialysis site.</p> <p><b>Other residents that have thepotential to be affected have been identified by:</b></p> <p>All residents have been reviewed toassure that the plan of care addresses pertinent information related to theresidents' current status.</p> <p><b>The measures or systematic changesthat have been put into place to ensure that the deficient practice does notrecur include:</b></p> <p>The policy for dialysis has beenupdated to assure there is no contradiction between the plan of care and thepolicy. All care plan interventions willbe in correlation with the policy as applicable. An in-service has been conducted for nursesrelated to assuring that issues identified at admission or changes in statusare addressed appropriately on the plan of care. In addition, the IDT team will be reviewingnew admissions to assure that the interim care plan addresses pertinentissues. In addition to the MDScoordinator assuring that the care plan is complete related to resident'scurrent condition, the IDT team will be randomly reviewing</p>	

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	<p>peripheral edema. Monitor/document/report to MD [Medical Doctor] s/sx [signs/symptoms] of depression.... Monitor/document/report to MD PRN [as needed] any s/sx of infection to access site: Redness, Swelling, warmth or drainage.... Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP [blood pressure] immediately...."</p> <p>On 11/5/14 at 10:04 a.m., the Director of Nursing (DON) provided the Care of a Resident with End-Stage Renal Disease (ESRD) policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "... 4. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."</p> <p>On 11/07/14 at 2:00 p.m., the DON indicated staff would go to the care plan, physician orders or policy to determine the care of the resident. Resident #139's dialysis care plan and physician orders do not include specific time frames for when to assess the resident or the resident's dialysis catheter. Resident #139's care plan and the dialysis policy contradict themselves when the care plan indicated vitals signs and weights per protocol and the policy indicated to see the care plan.</p>		<p>resident care plans as part of the QA process as indicated below. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to the comprehensive assessment in correlation with the plan of care to assure that pertinent information is identified on the plan of care based on the assessment. The tool also assures that identified changes have been updated on the care plan as indicated. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. <b>The date the systemic changes will be completed:</b> December 7, 2014</p>	

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F000282 SS=D	<p>3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow the written plans of care for a resident on a fluid restriction (Resident #44), for a resident requiring weekly weights (Resident #75), for a resident receiving a laxative medication (a medication used to treat constipation) (Resident #18), and for a resident with physician's orders which indicated no laboratory (lab) testing was to be completed (Resident #64) for 4 of 33 residents who met the criteria for review of services provided in accordance with the written plan of care.</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #44, completed 11/7/13 at 11:42 a.m., indicated the resident had diagnoses including, but not were not limited to, hyponatremia (a low sodium level in the blood).</p> <p>An Annual Minimum Data Set (MDS)</p>	F000282	<p><b>F282</b></p> <p><b>It is the practice of this facility to assure that all services that are provided are completed in a manner that is in accordance with the plan of care.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Resident #44 is having fluid restrictions tracked appropriately to assure fluids not exceeding the physician's ordered restrictions. Resident #75 is receiving weekly weights in accordance with the physician's orders. Resident #18 is receiving medications as ordered related to constipation in accordance with the physician's orders and the bowel movements are being tracked appropriately. Resident #64 is receiving no routine labs per the POA request. Any specific lab order that maybe needed will only be obtained after documented consent from the POA</p> <p><b>Other residents that have the potential to be affected have been</b></p>	12/07/2014			

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	<p>assessment completed 9/26/14, assessed Resident #44 with a 12 out of 15 on the Brief Interview for Mental Status (BIMS). The resident was assessed as being independent with eating after set up assistance was provided.</p> <p>A recapitulation of physician's orders dated 11/1/14 - 11/30/14 included a no added salt diet with a 1500 ml (milliliter) fluid restriction. The orders also included an order for MedPass, a nutritional supplement, 120 ml 3 times a day ( 360 ml/day).</p> <p>Resident #44 had a plan of care dated 10/7/13, indicating the resident had a 1500 ml/day fluid restriction. Interventions included, but were not limited to, encourage allowance of fluids. An intervention, dated 10/8/14, indicated dietary would provide 1000 ml/day, while nursing would provide 500 ml/day divided into 200 ml for the day shift and 150 ml for evenings and night shift.</p> <p>The "Meal Intake Records" for September and October 2014, were reviewed on 11/7/14, at 11:45 a.m.</p> <p>The "Meal Intake Record" for September 2014, lacked documentation of fluid intake for dinner on September 2, 3, 4, 5, 8, 11, 12, 16, 17, 18, 19, 22, 23, 25, 26,</p>		<p><b>identified by:</b></p> <p>All residents have been reviewed to assure that they are receiving services in accordance with the plan of care and where applicable with specialized consent from the POA.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service has been conducted for all nursing staff related to the importance of following the plan of care when providing services to the residents. The in-service includes assuring fluid restrictions are tracked appropriately and totaled, weekly weights are completed as ordered, bowel movement protocol and management is followed, and that labs are drawn only with the consent of the POA if applicable. The CNA assignments sheets have been reviewed to assure that they accurately reflect the services to be provided to the residents in correlation with the plan of care. Nurses will be responsible for assuring that all services provided are completed in accordance with the care plans on their designated shifts via observation. Please see below for monitoring as part of the QA process.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p>	

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	<p>29, and 30.</p> <p>The October 2014, "Meal Intake Record" lacked documentation of fluid intake for lunch on October 27, and lacked documentation of fluid intake for dinner on October 1, 2, 6, 10, 13, and 18, 2014.</p> <p>During an interview with Certified Nursing Assistant (CNA) #3 on 11/6/14 at 10:00 a.m., CNA #3 indicated the resident was able to make wants and needs known and was knowledgeable about the fluid restrictions. The resident did not have a water pitcher at the bedside, because of the restrictions.</p> <p>During an interview with Registered Nurse (RN) #4 on 11/7/14 at 4:55 p.m., RN #4 indicated staff knew the resident was on a fluid restriction and did not offer additional fluids. The resident received 150 ml of fluids with the medications and also received 120 ml of MedPass 3 times a day. Staff did not total the fluid intake for the resident on a daily basis and did not document the amount of fluids given to the resident. "We initial the Medication Administration Record (MAR) for each shift and the initials indicate the fluids were given."</p> <p>During an interview with the Assistant</p>		<p>In addition to nurses assuring that services are provided in accordance to the plan of care on their designated shifts including weekends, a Performance Improvement Tool has been initiated that randomly reviews 5 residents related to providing services in accordance with the plans of care. The tool will specifically look at fluid restrictions, weight monitoring, bowel protocol is followed, and labs are drawn appropriately and with proper consent. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools.</p> <p><b>The date the systemic changes will be completed:</b> December 7, 2014</p>				

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	<p>Director of Nursing (ADON) on 11/7/14 at 5:00 p.m., the ADON indicated the resident should have had flowsheets in the chart where the staff recorded fluid intake for the resident. The ADON looked in the clinical record and was unable to locate an intake flowsheet for July, August, September nor October 2014.</p> <p>2. The clinical record review completed on 11/6/14 at 10:00 a.m., indicated Resident #75 had diagnoses including, but not limited to, congestive heart failure.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 9/10/14, assessed Resident #75 as having a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a moderate cognitive impairment.</p> <p>A plan of care dated 1/9/14, with a focus on the resident having dentures, included an intervention to monitor weight and intake.</p> <p>A recapitulation of physician's orders dated 11/1/14 - 11/30/14, included an order dated 12/31/13 (start date), for the resident to be weighed weekly and to call for a gain of 5 pounds.</p>			

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	<p>A review of the Medication Administration Record (MAR) for 10/1/14 - 10/31/14, included a weight recorded on 10/7/14. No other weights were recorded on the MAR.</p> <p>During an interview with the Director of Nursing (DON) on 11/7/14 at 12:23 p.m., the DON indicated the resident was not followed in the Nutritional at Risk (NAR) meetings and no weekly weights had been completed for the resident.</p> <p>3. The clinical record of Resident #18 completed on 11/5/14 at 10:16 a.m., indicated the resident had diagnoses including, but not limited to, diverticulosis (a condition of the colon).</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/10/14, assessed the resident as having an 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 1 staff person for toileting and personal hygiene. The resident was assessed as frequently incontinent of bowels and urine.</p> <p>A current plan of care dated 11/2/12, with a focus on the resident having a risk for pain due to diagnosis of diverticulosis,</p>			

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	<p>included interventions to administer medications as ordered by the physician and to monitor and document bowel movements.</p> <p>A plan of care dated 11/2/12, with a focus on the resident having a risk for constipation related to medications and immobility, included interventions to observe the consistency of the bowel movements and to report to the physician as needed.</p> <p>A recapitulation of physician's orders dated 11/1/14 - 11/30/14, included an order dated 11/25/14 (start date), for the resident to receive polyethylene glycol (Miralax, a laxative) 1 capful dissolved in 8 ounces of water or juice by mouth once daily on Monday, Wednesday, and Friday.</p> <p>A review of the Medication Administration Record (MAR) for 9/1/14 - 9/30/14 indicated the resident received polyethylene glycol once a day each day of the month. A review of the MAR for 10/1/14 - 10/31/14 indicated the resident received polyethylene glycol each day from 10/1/14 through 10/10/14.</p> <p>A review of the "BM Monitoring" record for the month of September 2014, indicated the resident had large loose</p>			

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	<p>stools September 1, 2, 5, 6, 8, 13, 15, 18, 20, and 28, 2014. A small loose stool was documented on September 11, 2014. Eleven shifts lacked any documentation.</p> <p>During an interview with the Director of Nursing (DON) on 11/5/14 at 12:30 p.m., the DON indicated she was not aware of the medication being given each day from September 1, 2014 through October 10, 2014, and indicated a medication error report, including physician notification, had not been completed.</p> <p>On 11/5/14 at 10:05 a.m., the Administrator provided the undated policy "Medication Administration-General Guidelines" and indicated the policy was the one currently used by the facility. The policy indicated, "...B. Administration...2. Medications are administered in accordance with written orders of the attending physician...."</p> <p>4. The clinical record review for Resident #64, completed on 11/5/14 at 3:49 p.m., indicated the resident had diagnoses including, but not limited to, dementia with delusional disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/22/14, assessed the resident as having a 3 out of 15 on the Brief Interview for Mental Status (BIMS)</p>			

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	<p>indicating the resident had a severe cognitive impairment.</p> <p>A review of physician's orders included an order written on 3/7/14, to discontinue all scheduled laboratory (lab) testing as requested by the power of attorney (POA, a legal representative) for Resident #64.</p> <p>A nurse's note dated 3/7/14 at 4:05 p.m., indicated the POA was contacted and had given a request to discontinue all routine labs for the resident.</p> <p>A physician's progress note dated 3/10/14, indicated no labs were to be done as requested by the POA for the resident.</p> <p>A physician's order dated 5/16/14, indicated routine orders for valproic acid level (VPA, a lab to check the medication level), basic metabolic panel (BMP, a lab to check electrolytes in the blood), and complete blood count (CBC) every 4 months were discontinued.</p> <p>A nurse's note dated 5/16/14 at 12:00 p.m., indicated the POA had requested all routine labs to be discontinued.</p> <p>A review of completed lab testing indicated the resident had a hemoglobin A1C (a blood test to check blood sugar</p>			

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F000329 SS=D	<p>averages) completed 7/9/14. The clinical record lacked a consent from the POA for the lab testing.</p> <p>A review of the recapitulation of physician's orders dated 10/1/14 - 10/31/14 and 11/1/14 - 11/30/14, indicated the resident had routine orders for VPA, BMP, and CBC every 4 months and a hemoglobin A1C every 3 months.</p> <p>During an interview with the Director of Nursing (DON) on 11/5/14 at 4:30 p.m., the DON indicated she was not aware of the lab test being completed and would have to check on it.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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>						

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	<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 interview and record review, the facility failed to ensure residents who received antipsychotic medications received gradual dose reductions (GDR) and failed to ensure targeted behavior monitoring was completed for 2 of 5 residents who met the criteria for review of unnecessary medication use. (Resident #64 and Resident #18)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The clinical record review for Resident #64, completed on 11/5/14 at 3:49 p.m., indicated the resident had diagnoses including, but not limited to, dementia with delusional disorder.</li> </ol> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/22/14, assessed the resident as having a 3 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a severe</p>	F000329	<p><b>F329</b></p> <p><b>It is the practice of this facility to assure that medications are reviewed for appropriateness, reduced as indicated, and in accordance with the physician's order.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Residents #64 and #18 have been reviewed and requests have been submitted to the physician for a gradual dose reduction for the psychotropic medications.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents could potentially be affected. All residents receiving psychotropic medications have been reviewed to assure that reductions have been made appropriately in accordance with the physician's orders.</p> <p><b><i>The measures or systematic changes that have been put</i></b></p>	12/07/2014

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	<p>cognitive impairment.</p> <p>Resident #64 had a plan of care dated 11/9/2012, with a focus indicating the resident had a risk for side effects of medications related to the use of antipsychotic medications. Interventions included, but were not limited to, medications as ordered by the physician and quarterly review by behavior management committee including consultant pharmacy review.</p> <p>A review of the recapitulation of physician's orders dated 11/1/14 - 11/30/14, indicated the resident had orders for olanzapine (Zyprexa, an antipsychotic medication) 2.5 mg (milligrams) every day and divalproex sprinkles (Depakote, used as a mood stabilizer) 375 mg two times a day. Clinical record documentation indicated the medications have been prescribed and taken since 11/9/12.</p> <p>A request for a GDR in 2014, was not found in the clinical record of Resident #64.</p> <p>During an interview with the Director of Nursing (DON) on 11/7/14 at 12:10 p.m., the DON indicated a GDR had not been attempted for any medication since 10/8/13.</p>		<p><b><i>intoplace to ensure that the deficient practice does not recur include:</i></b></p> <p>The nurses have been in-serviced related to the use of medications and their appropriateness. Their service includes assuring that psychotropic medications are reviewed appropriately for possible reduction. In addition, the IDT team will be reviewing all residents on psychotropic medications a minimum of quarterly for possible reduction based on documentation of behaviors. In addition, the pharmacy consultant will be reviewing residents on psychotropic medications with recommendations not to exceed every 6 months.</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents who receive psychotropic medications to assure that there have been reduction attempts or that there is documentation that the physician has refused request for reduction based on clinical indicators. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for</p>	

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	<p>During an interview with the Social Services Director (SSD) on 11/7/14 at 11:37 a.m., the SSD indicated the resident was removed from behavior tracking due to a lack of behaviors. The SSD indicated the resident had behaviors on 11/1/14 and 11/2/14, and would have a behavior management tracking sheet initiated.</p> <p>2. The clinical record of Resident #18 completed on 11/5/14 at 10:16 a.m., indicated the resident had diagnoses including, but not limited to, dementia with behaviors.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/10/14, assessed the resident as having an 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a moderate cognitive impairment.</p> <p>Resident #18 had a current plan of care dated 11/9/2012, with a focus indicating the resident had a risk for side effects of medications related to the use of antidepressant and antipsychotic medications. Interventions included, but were not limited to, medications as ordered by the physician and quarterly reviews by the behavior management committee including consultant pharmacy</p>		<p>new interventions as needed based on the outcome of the tools. <b>The date the systemic changes will be completed:</b> December 7, 2014</p>				

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	<p>review.</p> <p>A review of the recapitulation of physician's orders dated 11/1/14 - 11/30/14, indicated the resident received quetiapine (Seroquel, an antipsychotic medication) 25 mg (milligrams) in the morning and 50 mg in the evening for a diagnosis of dementia with behaviors. The start date for the Seroquel was 4/23/13. The resident had divalproex sprinkles (Depakote Sprinkles, a medication used as a mood stabilizer) 125 mg twice a day for dementia. The start date for the Depakote was 2/28/12.</p> <p>During an interview with the Director of Nursing (DON) on 11/5/14 at 12:10 p.m., the DON indicated the resident was not currently reviewed or monitored quarterly by the behavior committee as the resident was not currently having behavior issues.</p> <p>During an interview with the Social Services Director (SSD) on 11/7/14 at 11:35 a.m., the SSD indicated the resident had not been reviewed or monitored by behavior management for some time, as the resident had not had any behavior issues.</p> <p>During an interview with the DON on 11/7/14 at 12:25 p.m., the DON indicated a GDR had not been attempted since</p>			

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F000431	<p>1/29/14, when the physician declined a dosage reduction.</p> <p>On 11/5/14 at 10:05 a.m., the Administrator provided a policy "Psychoactive Medications" dated 05/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. For the purposes of this policy a psychotropic medication is defines as: Any antipsychotic, antianxiety, antidepressant, sedative or hypnotic medication prescribed for the treatment of mental illness or behavioral manifestation... 8...a. Daily behavior tracking shall be completed for those residents receiving psychoactive medication with the exception of those residents receiving prn [as needed] medications...11...a. Antipsychotic Medication: GDR [Gradual Dose Reduction] should be attempted within the first year in which a resident is admitted on medication(s) or after medication is initiated. A second GDR should be attempted in a separate quarter at least one month following the initial GDR then annually thereafter unless clinically contraindicated...."</p> <p>3.1-48(b)(2)</p> <p>483.60(b), (d), (e)</p>						

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SS=E	<p><b>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure medications were disposed of as indicated by expiration date for 2 of 4 medication carts reviewed on the West</p>	F000431	<p><b>F431</b></p> <p>It is the practice of this facility to assure that residents' medications are dated when opened as applicable and disposed of based on the date of expiration in</p>	12/07/2014

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	<p>hall in that insulin vials were kept beyond the expected timeframe after being opened. (400 hall medication cart, 600 hall medication cart) (Residents #15, #81, #28, and #9)</p> <p>B. Based on record review and interview, the facility failed to maintain complete records for controlled medications, as indicated by facility policy for 4 of 4 medication carts reviewed on the West hall in that the facility Narcotic/Controlled Substance Shift to Shift Count Sheets had missing signatures. (400 hall med cart, 500 hall med cart, 600 hall med cart, and 700 hall med cart)</p> <p>Findings include:</p> <p>A. On 11/7/14 from 11:25 a.m. to 11:40 a.m., the West hall medication carts were observed.</p> <p>1. During observation of the 600 hall medication cart a NovoLog insulin vial belonging to Resident #28, with the open date of 9/25/14 and a dispense date of 9/16/14, was found in the drawer. Dates indicated the vial had been in use for 43 days.</p> <p>The 600 hall cart also contained a Humalog insulin vial belonging to</p>		<p><b>correlation with the manufacturer's guidelines. In addition, the facility protocol is for controlled medications to be counted with appropriate signatures at the change of shifts.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Residents #15, #81, #28, and #9 had expired insulin destroyed and new insulin obtained from pharmacy. Since it would not be prudent to go back and obtain signatures on the controlled count sheets, please see the systems below to correct the issue to prevent reoccurrence.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All resident medications have been reviewed to assure that they are all dated as to when opened and are within the time limits of expiration in accordance with the manufacturer's guidelines.</p> <p>All resident controlled substance sheets are being reviewed on a routine basis to assure that appropriate signatures are in place in accordance with facility protocol. See below for system implementation.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>Nurses have been in-serviced related to dating certain medication such as</p>	

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	<p>Resident #9, with an open date of 10/5/14 and a dispense date of 9/24/14. Dates indicated the vial had been in use for 33 days.</p> <p>On 11/7/14 at 11:27 a.m., LPN #2 indicated, Humalog and NovoLog insulin vials are good for 28 days after being opened.</p> <p>2. During observation of the 400 hall cart a Humalog insulin vial belonging to Resident #81, with an open date of 9/27/14 and a dispense date of 9/26/14, was found in the drawer. Dates indicated the vial had been in use for 41 days.</p> <p>The 400 hall cart also contained a Levemir insulin pen belonging to Resident #15, with an open date of 9/15/14 and a dispense date of 9/15/14. Dates indicated vials had been in use for 53 days.</p> <p>On 11/17/14 at 11:35 a.m., LPN #1 indicated, insulin was good for 28 days after the open date.</p> <p>On 11/7/14 at 12:21 p.m., the Director of Nursing (DON) indicated, "The insulin vials should have been disposed of. Insulin is only good for 28 days after the container is opened."</p>		<p>insulin when opened and assuring that they are only used within the expiration period per the manufacture's guidelines. The in-service also included the proper protocol related to signatures when counting controlled substances. Nursing Administration will be observing controlled medication count sheets for appropriate signatures as they make daily rounds as well as spot checking medications for dates and expirations. Please see below for systems for monitoring.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement tool has been established related to auditing medication control count sheets on each medication cart on a routine basis. In addition, this tool will review the medication refrigerators and medication carts to assure that medications have dates as to when opened and that they are not expired in accordance with the manufacturer's guidelines. The sample for audit will include a minimum of 5 residents related to insulin and 5 controlled medication sheets on each hall. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at</p>	

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	<p>On 11/7/14 at 12:00 p.m., the DON provided the Medication Storage in the Facility policy Section 21: Storage of Medications Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "... Procedures ... M. Outdated, ... are immediately removed from stock, disposed of according to procedures for medication disposal...."</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, indicated NovoLog insulin, "... open vials and cartridges of NovoLog are stable at room temperature for 28 days..." and Levemir insulin, "... After initial use, a cartridge or prefilled syringe may be used for up to 42 days if kept at room temperature...."</p> <p>"Patient Information Humalog" (November 2013) was retrieved on 11/7/14 at 4:00 p.m., from the Humalog website (<a href="http://pi.lilly.com/us/humalog-pen-ppi.pdf">http://pi.lilly.com/us/humalog-pen-ppi.pdf</a>). The website indicated, "... How should I store HUMALOG? ... Throw away an opened vial after 28 days of use, even if there is insulin left in the vial...."</p> <p>B. On 11/7/14 from 11:25 a.m. to 11:40 a.m., the West hall medication carts were observed.</p>		<p>the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools.</p> <p><b>The date the systemic changes will be completed:</b> December 7, 2014</p>	

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	<p>During the medication cart observations, November 2014 and October 2014 Narcotic/Controlled Substance Shift to Shift Count Sheets were reviewed.</p> <p>1. The signature sheets lacked the following signatures for the 400 hall medication cart:</p> <p>October 5th, 3rd shift oncoming nurse October 6th, 1st shift off going nurse October 20th, 1st shift off going nurse October 22nd, 2nd shift oncoming nurse October 22nd, 3rd shift off going nurse</p> <p>2. The signature sheets lacked the following signatures for the 500 hall medication cart:</p> <p>October 1st, 1st shift off going nurse October 1st, 1st shift oncoming nurse October 1st, 2nd shift off going nurse October 2nd, 2nd shift oncoming nurse October 2nd, 3rd shift off going nurse October 2nd, 3rd shift oncoming nurse October 3rd, 1st shift off going nurse October 10th, 1st shift oncoming nurse October 10th, 2nd shift off going nurse October 10th, 3rd shift oncoming nurse October 14th, 1st shift oncoming nurse October 14th, 2nd shift off going nurse October 17th, 1st shift oncoming nurse October 17th, 2nd shift off going nurse October 20th, 3rd shift oncoming nurse</p>			

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	<p>October 21st, 1st shift off going nurse October 21st, 3rd shift oncoming nurse October 22nd, 1st shift off going nurse October 24th, 1st shift oncoming nurse October 25th, 1st shift off going nurse October 29th, 1st shift off going nurse October 31st, 1st shift off going nurse</p> <p>3. The signature sheets lacked the following signatures for the 600 hall medication cart:</p> <p>October 2nd, 3rd shift oncoming nurse October 3rd, 1st shift off going nurse October 7th, 3rd shift oncoming nurse October 8th, 1st shift off going nurse October 9th, 2nd shift oncoming nurse October 9th, 3rd shift off going nurse October 10th, 2nd shift oncoming nurse October 12th, 3rd shift oncoming nurse October 13th, 1st shift off going nurse October 16th, 3rd shift oncoming nurse October 17th, 1st shift off going nurse October 17th, 3rd shift oncoming nurse October 18th, 1st shift off going nurse October 21st, 2nd shift oncoming nurse October 21st, 3rd shift off going nurse October 22nd, 1st shift oncoming nurse October 22nd, 2nd shift off coming nurse October 24th, 2nd shift oncoming nurse October 24th, 3rd shift off going nurse October 25th, 3rd shift oncoming nurse October 26th, 1st shift off going nurse October 27th, 1st shift oncoming nurse</p>			

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	<p>October 27th, 2nd shift off going nurse October 29th, 2nd shift oncoming nurse October 29th, 3rd shift off going nurse November 2nd, 2nd shift oncoming nurse November 2nd, 3rd shift off going nurse November 2nd, 3rd shift oncoming nurse November 3rd, 1st shift off going nurse November 4th, 1st shift oncoming nurse November 4th, 2nd shift off going nurse November 6th, 1st shift oncoming nurse November 6th, 2nd shift off going nurse</p> <p>4. The signature sheets lacked the following signatures for the 700 hall medication cart:</p> <p>October 19th, 2nd shift off going nurse October 20th, 3rd shift off going nurse October 23rd, 2nd shift off going nurse October 28th, 1st shift oncoming nurse October 28th, 2nd shift off going nurse October 30th, 1st shift oncoming nurse October 30th, 2nd shift off going nurse October 31st, 1st shift oncoming nurse October 31st, 2nd shift off going nurse November 3rd, 1st shift oncoming nurse November 3rd, 2nd shift off going nurse</p> <p>On 11/7/14 at 11:29 a.m., LPN #2 indicated at the beginning and end of every shift the narcotics are counted. After counting the narcotics each nurse (on coming and off going nurse) signs the shift signature sheet.</p>			

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F000514 SS=E	<p>On 11/07/2014 at 2:00 p.m., the DON indicated each staff member should count the narcotics and sign the signature sheet at the beginning and end of their shift with the oncoming and off going staff member.</p> <p>On 11/7/14 at 12:00 p.m., the DON provided the Medication Storage in the Facility policy Section 23: Controlled Medication Storage Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "... Procedure ... D. At each shift change, a physical inventory of all controlled medications, including emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record per facility procedure...."</p> <p>3.1-25(e)(3) 3.1-25(o)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that</p>			

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	<p>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 interview and record review, the facility failed to ensure clinical records were complete including documentation of food and fluid intake and daily documentation of the provision of Activities of Daily Living (ADL's) for 5 of 5 residents who met the criteria for review of ADL's. (Resident #75, Resident #18, Resident #44, Resident #64, and Resident #7)</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #44, completed 11/7/13 at 11:42 a.m., indicated the resident had diagnoses including, but not limited to, hyponatremia (a low sodium level in the blood).</p> <p>An Annual Minimum Data Set (MDS) assessment completed 9/26/14, assessed Resident #44 with a 12 out of 15 on the Brief Interview for Mental Status (BIMS) and assessed the resident as requiring total assistance of 1-2 staff members for</p>	F000514	<p><b>F514</b></p> <p><b>It is the practice of this facility to assure resident medical records are present, organized, and stored appropriately.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Residents #75, #18, #44, #64, and #7 are receiving appropriate documentation related to food/fluid consumption and daily documentation of the provision of Activities of Daily living.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents are potentially affected. All residents have been reviewed and are now receiving appropriate documentation related to food/fluid consumption and daily documentation of the provision of Activities of Daily living.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The nursing staff has been</p>	12/07/2014

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	<p>bed mobility, transfers, toileting, and personal hygiene. The resident was assessed as being independent with eating after set up assistance was provided and always incontinent of urine and bowels.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for dinner September 2, 3, 4, 5, 8, 11, 12, 16, 17, 18, 19, 22, 23, 25, 26, 29, and 30.</p> <p>The October 2014, "Meal Intake Record" lacked documentation of food or fluid intake for dinner on October 1, 2, 6, 10, 13, and 18, 2014, and lacked documentation of lunch on October 27, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the night shift for September 1, 16, 20, 23, and 24, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the day shift for September 3, 8, 11, 13, 14, 22, and 30, 2014.</p>		<p>in-serviced on the properdocumentation related to fluid/meal intake records as well as assuring that thedaily provision of Activities of Daily Living are daily on each of theirdesignated shifts. The nurse will beresponsible for assuring that this documentation occurs appropriately on theirdesignated shifts.</p> <p><b>The corrective action taken to monitor performance to assurecompliance through quality assurance is:</b></p> <p>In addition to the nurses being responsible for reviewing thedocumentation related to fluid/meal consumption as well as ADL documentation ontheir designated shifts and audit tool has also been initiated which will becompleted as part of the QA process. APerformance Improvement Tool has been initiated that randomly reviews 5residents to assure that fluid/meal consumption is documented appropriately aswell as ADL documentation on each shift. The Director of nursing, or designee,will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediatelycorrected. The Quality AssuranceCommittee will review the tools and the results at the scheduled meetings withrecommendations/interventions based on the outcome of the tools.</p> <p><b>The date the systemic changes will</b></p>	

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	<p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the evening shift for September 3, 4, 5, 14, 15, 17, 18, 25, 26, and 30, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the night shift for October 17, 18, 23, 24, 25, 26, 27, 29, 30, and 31, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the day shift for October 20 and 26, 2014, and lacked evening shift documentation for October 28, 2014.</p> <p>2. The clinical record review completed on 11/6/14 at 10:00 a.m., indicated Resident #75 had diagnoses including, but not limited to, congestive heart failure.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 9/10/14, assessed Resident #75 as having a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a moderate cognitive impairment. The</p>		<p><i>be completed:</i> December 7, 2014</p>	

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	<p>resident was assessed as requiring extensive assistance of 1 staff person for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident was assessed as being independent with eating after set up assistance was provided and always incontinent of urine and bowels.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for dinner on September 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 17, 18, 19, 22, 23, 25, 26, 29, and 30, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the night shift for September 23 and 24, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the day shift for September 22, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the evening shift for September 25 and</p>			

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	<p>26, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the night shift for October 4, 5, 16, 17, 18, 19, 23, 24, 25, 26, and 30, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the evening shift for October 2, 3, 4, 5, 6, 7, 15, 30, and 31, 2014.</p> <p>3. The clinical record of Resident #18 completed on 11/5/14 at 10:16 a.m., indicated the resident had diagnoses including, but not limited to, diverticulosis (a condition of the colon).</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/10/14, assessed the resident as having an 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a moderate cognitive impairment. The resident was assessed as requiring extensive assistance of 1 staff person for bed mobility, dressing, toileting, and personal hygiene. The resident was assessed as independent with eating after set up assistance and frequently</p>						

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	<p>incontinent of urine and bowels.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for dinner on September 2, 3, 4, 5, 8, 9, 10, 11, 12, 16, 17, 18, 19, 22, 23, 25, 26, 29, and 30, 2014.</p> <p>A review of the "Meal Intake Record" for October 2014, lacked documentation of food or fluid intake for breakfast on October 7, 2014 and lunch on October 22 and 27, 2014.</p> <p>A review of the "Meal Intake Record" for October 2014, lacked documentation of food or fluid intake for dinner on October 1, 2, 6, 7, 13, and 18, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the night shift for September 1, 15, 16, 20, 23, and 24, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the night shift for October 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, and 31, 2014.</p>			

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	<p>4. The clinical record review for Resident #64, completed on 11/5/14 at 3:49 p.m., indicated the resident had diagnoses including, but not limited to, dementia with delusional disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 7/22/14, assessed the resident as having a 3 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had a severe cognitive impairment. The resident was assessed as requiring total assistance of 2 staff members for bed mobility, toileting, transfers, and personal hygiene. The resident was assessed being independent with eating after set up assistance was provided and always incontinent of urine and bowels.</p> <p>A review of the "Meal Intake Record" for August 2014, lacked documentation of food or fluid intake for breakfast and lunch on August 1, 2, 3, 8, 17, 19, 20, 26, 30, and 31, 2014.</p> <p>A review of the "Meal Intake Record" for August 2014, lacked documentation of food or fluid intake for dinner on August 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 28, 2014.</p> <p>A review of the "Meal Intake Record" for</p>			

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	<p>September 2014, lacked documentation of food or fluid intake for lunch on September 7, 8, 9, 10, 11, 12, 28, and 30, 2014.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for dinner on September 3, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25, 27, 28, 29, and 30, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the night shift for October 4, 5, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2014.</p> <p>5. The clinical record review, completed on 11/6/14 at 3:41 p.m., indicated Resident #7 had diagnoses including, but not limited to, osteoarthritis.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 10/8/14, assessed the resident as having a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident had no cognitive impairment. The resident was assessed as requiring extensive assistance of 1 staff member for bed mobility, toileting, dressing, and personal hygiene.</p>			

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	<p>The resident was assessed being independent with eating after set up assistance was provided and always incontinent of urine and bowels.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for breakfast and lunch on September 2, 3, and 29, 2014 and lunch on September 8, 9, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 28, 29, and 30, 2014.</p> <p>A review of the "Meal Intake Record" for September 2014, lacked documentation of food or fluid intake for dinner on September 2, 3, 4, 5, 6, 7, 8, 12, 13, 14, 19, 20, 21, 22, 23, 24, 25, and 27, 2014.</p> <p>A review of the "Meal Intake Record" for October 2014, lacked documentation of food or fluid intake for lunch on October 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for September 2014, lacked documentation of care delivery on the night shift for September 1, 15, 16, 20, 23, and 24, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming</p>			

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	<p>Documentation" for September 2014, lacked documentation of care delivery on the evening shift for September 3, 11, 12, 16, and 18, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the night shift for October 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, and 31, 2014.</p> <p>A review of the "Urine Output/Bathing/Grooming Documentation" for October 2014, lacked documentation of care delivery on the day shift for October 20, 21, and 30, 2014.</p> <p>During an interview with the Director of Nursing (DON) on 11/5/14 at 11:59 a.m., the DON indicated, "The expectation is to have the CNA [certified nursing assistant] documentation completed each shift each day. There shouldn't be any holes [blank] in the documentation."</p> <p>On 11/6/14 at 4:29 p.m., the Director of Nursing (DON) provided the "Charting and Documentation" policy, dated March 2010, and indicated the policy was the one currently used by the facility. The policy statement indicated, "All services</p>			

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	provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical record..."  3.1- 50(a)(1)				