

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2011
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY ROAD LAWRENCEBURG, IN47025		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 11, 12, 13, 14, and 15, 2011</p> <p>Facility number: 000022 Provider number: 155061 AIM number: 100274510</p> <p>Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN</p> <p>Census bed type: SNF/NF: 56 SNF: 7 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 46 Other: 10 Total: 63</p> <p>Sample: 15 Supplemental sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending July 15, 2011. Due to the low scope and severity of the survey findings, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please contact me.</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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F0279 SS=D	<p>Quality review 7/22/11 by Suzanne Williams, RN 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). Based on interview and record review, the facility failed to develop care plans to address Resident #107's youthful age and discharge plans. This deficient practice affected 1 of 15 residents reviewed for care plans in a sample of 15. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's clinical record was reviewed on 7-14-11 at 4:45 p.m. Her diagnoses included, but were not limited to, type I diabetes mellitus, diabetic ketoacidosis (dangerously high blood sugar levels), bipolar disorder, anorexia</p>	F0279	F279 Requires that the facility develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and socosocial needs that are identified in the comprehensive assessment. The care plan describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required. Any services that otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.The	07/29/2011

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	<p>(eating disorder in which one does not eat), and right foot drop. The clinical record indicated this resident was a youthful age at the time of her admission.</p> <p>In interview with the Social Services Designee on 7-15-11 at 10:20 a.m., she indicated she had not care planned anything relating to Resident #107's age. She indicated, "I will be real honest with you, I did not care plan anything about her age. I know her situation was unique because of her age but I didn't give it a thought to care plan."</p> <p>Review of the care plans indicated a lack of care plans related to her youthful age.</p> <p>Review of Resident #107's clinical record indicated a "Social Services Progress Note," dated 4-28-11 at 11:00 a.m. which indicated, "IDT (interdisciplinary team) reviewed res (resident) care plan + (sign for and) overall health. CP (care plan) updated. (Sign of a zero with a line through it to indicate 'no' followed by another sign of a triangle to indicate 'change')." The note continued, "SW (social worker) to work on transferring res (resident) to facility in (name of another community in the state) d/t (due to) having relatives living there per res (resident) req (request)."</p>		<p>facility will ensure this requirement is met through the following.1. Resident #107 was not harmed. Resident is a discharged resident.2. All resident s have the potential to be affected. Care plans reviewed for all residents 55 years and younger to ensure pschosocial needs are being met and care plans implemented as applicable. All residents with the intent to discharge back to the community have been reviewed to ensure a discharge care plan is in place.3. Social Service Job description reviewed with no changes made. Socail Service Director re-educated on Job Description (See attachment A)4. THE administrator or designee will audit 5 resident's charts weekly times 4 weeks, then every 2 weeks times 1 month, then monthly times 3 months then quarterly to ensure social services is addressing psychosocial related issues as they pertain to a resident's youthful age and discharge planning. (see attachment B) The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and above plan will be altered accordingly.5. The above plan of correction will be completed on or before July 29, 2011.</p>				

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	<p>Another Social Services progress note, dated 5-3-11 at 3:39 p.m. indicated the Social Services Designee had contacted a facility in the area referred to in the 4-28-11 notation. The notation indicated that facility's admissions person would be contacting the Social Services Designee regarding making a visit to consider admitting Resident #107. The notes reflected no further information regarding this other facility or what happened in regard to a possible transfer. The last entry on the "Social Services Progress Note," dated 6-20-11 at 10:30 a.m. indicated the resident had been discharged "to another nursing facility."</p> <p>In an interview with the Social Services Designee on 7-15-11 at 10:55 a.m., she indicated, "I know I wrote things down about (resident's name) plans to move closer to (name of family member). I'll have to look for it. (Name of family member) was the one who really pushed this and had facilities calling me about getting her transferred." No further documentation was provided.</p> <p>Review of the care plans indicated a lack of documentation related to plans for transfer to a facility closer to family.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				

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F0283 SS=D	<p>3.1-35(b)(2)</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>Based on record review, the facility failed to adequately summarize the resident's stay in regard to the complexity of the resident's health status prior to the resident's transfer to another facility. This deficient practice affected 1 of 2 residents reviewed for discharge or transfer in a sample of 15. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's clinical record was reviewed on 7-14-11 at 4:45 p.m. Her diagnoses included, but were not limited to type I diabetes mellitus, diabetic ketoacidosis (dangerously high blood sugar levels), bipolar disorder, anorexia (eating disorder in which one does not eat), and right foot drop. The clinical record indicated this resident was a youthful age at the time of her stay at the facility.</p> <p>Review of the "Discharge Summary",</p>	F0283	F283 Requires the facility to adequately summarize the resident's stay in regards to the complexity of the resident's health status prior to the transfer to another facility.1. Resident #107 was not harmed.2. All residents have the potential to be affected. All residents that are being discharged from the facility will have a discharge summary filled out and sent with the resident during transfer. The DON or her designee will review all discharge summaries to ensure that the complexity of the resident's health status is addressed prior to transfer. See below for corrective measures.3. The Facility Discharge Summary policy and procedure was reviewed with no changes made. (See attachment C) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool (See attachment D) to review all discharge summaries to ensure resident who are being discharged have appropriate documentation listed on the form	07/29/2011	

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	<p>dated 6-27-11 indicated the reason for transfer as "location." The "Description of resident's stay" indicated the date of admission, that she was a "type II very brittle" (indicating fluctuating blood sugars) diabetic which required having her blood sugars checked four times daily with a sliding scale insulin coverage based on the results of the blood sugars. It indicated she was alert. It indicated she had osteoporosis of her back. It indicated she had a physician's order for Tramadol (pain medication) that can be given every four hours as needed. It indicated she had no skin issues.</p> <p>The section indicated as "Status at time of discharge," indicated "VSS" (vital signs were stable), she was alert, she gets about the facility in a wheelchair, her 11:00 a.m. blood sugar reading was 147, she had eaten 100% of her breakfast, she was receiving physical therapy for back pain, and she had received a dose of Tramadol at 9:00 a.m. Additionally, it indicated the social worker and a certified nursing assistant from the receiving facility were present and report had been called to a nurse at the receiving facility.</p> <p>The discharge summary did not indicate any issues related to her age or her multiple behavioral issues, which included bipolar disorder, anorexia,</p>		<p>to ensure the complexity of the resident's health status is addressed prior to the transfer to another facility daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before July 25, 2011.</p>		

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	<p>non-compliance with her diabetic care needs or limited family support. Although the summary indicated the resident was a "brittle diabetic" it did not allude to issues such as refusing multiple meals and being found at the snack machine multiple times eating poor food choices and the general ranges of her blood sugars. The discharge summary did not indicate her weight as being less than 90 pounds. Review of the discharge summary did not indicate any reference to a week-long inpatient stay in March 2011 for behavioral issues.</p> <p>Review of the "Nursing Progress Notes" indicated on the day of discharge, 6-27-11 at 1:00 p.m., that a report was called to a nurse at the receiving facility. No indication was made as to the content of the report.</p> <p>A policy entitled, "Facility Discharge Summary Policy," with an activation date of 7/05 was provided by the Director of Nursing on 7-15-11 at 11:44 a.m. This policy indicated its purpose as "To provide discharge information to include, but not limited to, admission date, date of discharge, reason transferred, where transferred to, recapitulation of the resident's stay, resident status at time of discharge and post-discharge plan of care."</p>						

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F0284 SS=D	<p>3.1-36(a)(1) 3.1-36(a)(2)</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p> <p>Based on interview and record review, the facility failed to adequately plan for transfer and summarize the resident's stay in regard to the complexity of the resident's health status prior to the resident's transfer to another facility. This deficient practice affected 1 of 2 residents reviewed for discharge or transfer in a sample of 15. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's clinical record was reviewed on 7-14-11 at 4:45 p.m. Her diagnoses included, but were not limited to type I diabetes mellitus, diabetic ketoacidosis (dangerously high blood sugar levels), bipolar disorder, anorexia (eating disorder in which one does not eat), and right foot drop. The clinical record indicated this resident was a youthful age at the time of her stay at the</p>	F0284	F284 Requires the facility to adequately summarize the resident's stay in regards to the complexity of the resident's health status prior to the transfer to another facility. 1. Resident #107 was not harmed. 2. All residents have the potential to be affected. All residents that are being discharged from the facility will have a discharge summary filled out and sent with the resident during transfer. The DON or her designee will review all discharge summaries to ensure that the complexity of the resident's health status is addressed prior to transfer. See below for corrective measures. 3. The Facility Discharge Summary policy and procedure was reviewed with no changes made. (See attachment C) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool (See attachment D) to review all discharge summaries to ensure	07/29/2011	

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	<p>facility.</p> <p>Review of the "Discharge Summary", dated 6-27-11 indicated the reason for transfer as "location." The "Description of resident's stay" indicated the date of admission, that she was a "type II very brittle" (indicating fluctuating blood sugars) diabetic which required having her blood sugars checked four times daily with a sliding scale insulin coverage based on the results of the blood sugars. It indicated she was alert. It indicated she had osteoporosis of her back. It indicated she had a physician's order for Tramadol (pain medication) that can be given every four hours as needed. It indicated she had no skin issues.</p> <p>The section indicated as "Status at time of discharge," indicated "VSS" (vital signs were stable), she was alert, she gets about the facility in a wheelchair, her 11:00 a.m. blood sugar reading was 147, she had eaten 100% of her breakfast, she was receiving physical therapy for back pain, and she had received a dose of Tramadol at 9:00 a.m. Additionally, it indicated the social worker and a certified nursing assistant from the receiving facility were present and report had been called to a nurse at the receiving facility.</p> <p>The discharge summary did not indicate</p>		<p>resident who are being discharged have appropriate documentation listed on the form to ensure the complexity of the resident's health status is addressed prior to the transfer to another facility daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 25, 2011.</p>		

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	<p>any issues related to her age or her multiple behavioral issues, which included bipolar disorder, anorexia, non-compliance with her diabetic care needs or limited family support. Although the summary indicated the resident was a "brittle diabetic" it did not allude to issues such as refusing multiple meals and being found at the snack machine multiple times eating poor food choices and the general ranges of her blood sugars. The discharge summary did not indicate her weight as being less than 90 pounds. Review of the discharge summary did not indicate any reference to a week-long inpatient stay in March 2011 for behavioral issues.</p> <p>Review of the "Nursing Progress Notes" indicated on the day of discharge, 6-27-11 at 1:00 p.m., that a report was called to a nurse at the receiving facility. No indication was made as to the content of the report.</p> <p>In interview with the Social Services Designee on 7-15-11 at 10:20 a.m., she indicated she had not care planned anything relating to Resident #107's age. She indicated, "I will be real honest with you, I did not care plan anything about her age. I know her situation was unique because of her age but I didn't give it a thought to care plan."</p>						

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	<p>Review of the "Social Services Progress Note," dated 4-28-11 at 11:00 a.m. which indicated, "IDT (interdisciplinary team) reviewed res (resident) care plan + (sign for and) overall health. CP (care plan) updated. (Sign of a zero with a line though it to indicate 'no' followed by another sign of a triangle to indicate 'change')." The note continued, "SW (social worker) to work on transferring res (resident) to facility in (name of another community in the state) d/t (due to) having relatives living there per res (resident) req (request)."</p> <p>Another Social Services progress note, dated 5-3-11 at 3:39 p.m. indicated the Social Services Designee had contacted a facility in the area referred to in the 4-28-11 notation. The notation indicated that facility's admissions person would be contacting the Social Services Designee regarding making a visit to consider admitting Resident #107. The notes reflected no further information regarding this other facility or what happened in regard to a possible transfer. The last entry on the "Social Services Progress Note," dated 6-20-11 at 10:30 a.m. indicated the resident had been discharged "to another nursing facility."</p> <p>In an interview with the Social Services</p>				

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	<p>Designee on 7-15-11 at 10:55 a.m., she indicated, "I know I wrote things down about (resident's name) plans to move closer to (name of family member). I'll have to look for it. (Name of family member) was the one who really pushed this and had facilities calling me about getting her transferred." No further documentation was provided.</p> <p>Review of the care plans indicated a lack of documentation related to plans for her youthful age nor for a transfer to a facility closer to family.</p> <p>A policy entitled, "Facility Discharge Summary Policy," with an activation date of 7/05 was provided by the Director of Nursing on 7-15-11 at 11:44 a.m. This policy indicated its purpose as "To provide discharge information to include, but not limited to, admission date, date of discharge, reason transferred, where transferred to, recapitulation of the resident's stay, resident status at time of discharge and post-discharge plan of care."</p> <p>3.1-36(a)(3)</p>						

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F0387 SS=D	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure one resident's initial physician visit was conducted within the first 30 days of admission. This deficient practice affected 1 of 13 residents reviewed for timeliness of physician visits in a sample of 15. (Resident #81)</p> <p>Findings include:</p> <p>Resident #81's clinical record was reviewed on 7-14-11 at 9:47 a.m. He was admitted to the facility on 5-19-11. His current diagnoses included, but are not limited to mild mental retardation, impulse control disorder, depression, chronic pain, osteoarthritis, diabetes mellitus, and hypertension (high blood pressure).</p> <p>Review of physician visits indicated Resident #81 was seen for an initial physician visit on 7-14-11 in the physician's office. This was 56 days after admission.</p>	F0387	F387 Requires the facility to ensure initial physician visits are conducted within the first 30 days of admission.1. Resident #81 was not harmed.2. All residents have the potential to be affected. All resident's physician visits were reviewed to ensure that visits were timely. If the resident needed to be seen, the physician was notified and arrangements were made to have the physician visit the resident. See below for corrective measures.3. The Physician's Visits policy and procedure was reviewed with no changes made. (See attachment E) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool to ensure that the physicians are aware of the residents needing to be seen that month per fax and if no response a phone call will be made to set up appointments so residents are seen timely daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. (See attachment F) The audits will be reviewed during the facility's quarterly quality assurance	07/29/2011	

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F0428 SS=D	<p>In interview with the facility's Administrator on 7-15-11 at 1:40 p.m., he indicated he was surprised by the lateness of the initial physician visit and was unsure how this happened. He indicated he would check to see if any additional visits were available. No additional information was provided.</p> <p>3.1-22(d)(1)</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the consultant pharmacist failed to review the drug regimen of each resident monthly. This affected 1 of 13 residents in a sample of 15 reviewed for monthly pharmacy reviews. (Resident #62)</p> <p>Findings include:</p> <p>Resident #62's record was reviewed on 7/13/11 at 4:47 p.m. The record indicated Resident #62 was admitted on 1/26/11 with diagnoses that included, but were not limited to, anemia, depression, diabetes mellitus, high blood pressure, and anxiety.</p>	F0428	<p>meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before July 25, 2011.</p> <p>F428 Requires the facility to ensure that a consultant pharmacist reviews the drug regimen of each resident monthly. 1. Resident #62 was not harmed.2. All residents have the potential to be affected. See below for corrective measures.3. The Consultant Pharmacist Responsibilities procedure was reviewed with no changes made. (See attachment G) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool to ensure residents are seen by the consultant pharmacist monthly daily times four weeks, then weekly times four weeks, then</p>	07/29/2011	

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	<p>No documentation could be located in the clinical record that indicated the Consultant Pharmacist had completed a monthly drug review.</p> <p>On 7/15/11 at 6:14 p.m., the Director of Nurses provided a "Consultation Report" that indicated the pharmacist had reviewed Resident #62's drug regimen on 5/31/11. During an interview at that time, the Director of Nurses indicated this was the only document she could find to show the Consultant Pharmacist had done a review.</p> <p>No other documentation could be provided to indicate pharmacy reviews had been completed between 1/26/11 and 2/26/11, between 2/26/11 and 3/26/11, and between 3/26/11 and 4/26/11, for a total of three required monthly visits.</p> <p>A policy and procedure for "CONSULTANT PHARMACIST RESPONSIBILITIES" was provided by the Administrator on 7/15/11 at 5:46 p.m. The policy indicated, but was not limited to: "POLICY: Consultant pharmacist services are provided through written agreement for the performance of responsibilities consistent with the expectation of the facility and the requirements of state, federal and local pharmacy law. The facility will assure</p>		<p>every two weeks times two months, then quarterly thereafter. The DON or her designee will meet with the pharmacist prior to leaving the facility and ensure per the census sheet that all resident's medication regimens were reviewed. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 25 2011.</p>		

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	<p>that the consultant pharmacist has access to all necessary facility and resident records to enable implementation of consultant pharmacist services.</p> <p>CONSULTANT PHARMACIST RESPONSIBILITIES The consultant pharmacist shall be responsible for the general supervision of the facility's pharmaceutical services. These responsibilities include but are not limited to...3. Drug Regimen reviews for all residents as required, utilizing federally mandated standards of care. Notations, comments, suggestions and irregularities will be compiled in the Drug Regimen Review report presented to the administrator and director of nursing for follow-up...."</p> <p>3.1-25(h)</p>				

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to maintain an infection control program to help prevent the potential development and transmission of disease and infection, in that residents</p>	F0441	F441 Requires the facility to maintain an infection control program to help prevent the potential development and transmission of disease and infection. 1. Resident #7 and #81	07/29/2011	

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	<p>were not administered first step Mantoux skin tests timely for 2 of 13 residents reviewed in a sample of 15. (Residents #7 and 81)</p> <p>Findings include:</p> <p>1. Resident #7's record was reviewed on 7/13/11 at 3:45 p.m. The record indicated Resident #7 was admitted on 3/15/11 with diagnoses that included, but were not limited to, high blood pressure, kidney failure, anemia, and congestive heart failure.</p> <p>An "IMMUNIZATION/MANTOUX RECORD" indicated the first step Mantoux had been administered on 3/27/11, twelve days after admission, and was read on 3/3/11.</p> <p>Medication Administration Records (MAR) also indicated the first step Mantoux had been administered on 3/27/11 and read on 3/30/11.</p> <p>During an interview on 7/15/11 at 12:30 p.m., the Director of Nurses indicated the facility gives the Mantoux upon admission.</p> <p>2. Resident #81's clinical record was reviewed on 7-14-11 at 9:47 a.m. He was admitted to the facility on 5-19-11. His current diagnoses included, but are not</p>		<p>were not harmed.2. All residents have the potential to be affected. All resident's mantoux administrations were reviewed. The Mantoux was administered to the resident if needed. See below for corrective measures.3. The TB/Mantoux test policy was reviewed with no changes made. (See attachment H) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool to ensure residents are given the first and second step Mantoux per policy daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. (See attachment F) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 25, 2011.</p>				

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	<p>limited to mild mental retardation, impulse control disorder, depression, chronic pain, osteoarthritis, diabetes mellitus, and hypertension (high blood pressure).</p> <p>The clinical record indicated he received his initial TB (tuberculosis)/Mantoux test on 5-20-11, one day after admission.</p> <p>A policy provided by the Assistant Director of Nursing (ADON) on 7-15-11 at 9:00 a.m. with an activation date of 9/05 indicated the TB/Mantoux test should be administered to all employees and residents annually, unless contraindicated. It indicated if the employee or resident did not have a documented negative skin test, then the two-step method should be utilized. The policy did not indicate within what time frame the initial TB/Mantoux test should be administered to newly admitted residents.</p> <p>3.1-18(e) 3.1-18(f)</p>				

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation related to drug disposition/destruction records for 3 of 15 residents reviewed for drug disposition/destruction records in a sample of 15. (Residents #107, 30, and 57)</p> <p>Findings include:</p> <p>1. Resident #107's clinical record was reviewed on 7-14-11 at 4:45 p.m. Her diagnoses included, but were not limited to, type I diabetes mellitus, diabetic ketoacidosis (dangerously high blood sugar levels), bipolar disorder, anorexia (eating disorder in which one does not eat), and right foot drop.</p> <p>Resident #107's clinical record indicated she was transferred to another facility on 6-27-11. The "Home Discharge Instructions" document, dated 6-27-11,</p>	F0514	F514 Requires the facility to ensure complete and accurate documentation related to drug disposition/destruction records. 1. Resident #107, #30 and #57 were not harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The medication destruction policy was reviewed with no changes made. (See attachment I) Nursing staff was inserviced on the above procedure. 4. The DON or her designee will utilize the nursing monitoring tool to ensure that the nursing staff fills out the drug disposition/destruction form correctly. If a medication is destroyed, two nurse's signatures will be obtained, how the medication was destroyed, date and time. If a medication is returned to the pharmacy, the nursing staff will fill out the form to include all necessary documentation for return. This audit will be conducted daily times four weeks, then weekly times four weeks, then every two weeks	07/29/2011	

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	<p>indicated a listing of all current medication orders the resident had at the time of discharge. The medication list indicated how many of each medication were sent with the resident to the other facility. The listing included a pain medication that was sent with the resident. The listing indicated 16 tablets of Tramadol 50 mg (milligrams) was sent to the receiving facility. The "Controlled Substances Record" for Tramadol 50 mg indicated 30 tablets were originally received, with no date or signature listed on the form for receipt. The first dose indicated as given was signed out on 6-24-11 at 8:00 a.m. The last entry on the record indicated a dose of medication was signed out on 6-27-11 at 8:50 a.m. with 16 doses remaining. In the upper right hand portion of the form, it indicated, "16 doses transferred to disposal record." This information was followed by the date, "6-27-11," and three nurses' signatures.</p> <p>In an interview with the Director of Nursing on 7-15-11 at 12:25 p.m., she indicated the facility's policy is to have three signatures [on the Controlled Substance Record] for any destructions. She indicated, "If my name is on the form with the two other nurses, then that means it was destroyed." She indicated, "The form doesn't specifically say if the medication was destroyed, sent with a</p>		<p>times two months, then quarterly thereafter. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 25, 2011.</p>				

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	<p>patient or what, does it? Maybe we need to clarify that." She indicated, "Now if a form has the three nurse signatures, but not mine, then something else happened. Like with (Resident #107's name)'s Tramadol, it lists 16 remaining, but none of the three signatures are mine. I remember (name of nurse) telling me she sent those with her. She should have documented that on the transfer form and I believe she did." She indicated, "I see where it says, 'doses transferred to disposal record,' that does make it sound like it is recorded on another form, but this is the only one we use."</p> <p>2. Review of Resident #30's clinical record on 7/11/2011 at 2:00 p.m., indicated the resident was admitted with diagnoses that included, but were not limited to, end stage renal disease, dementia, diabetes, hypertension, right femur fracture with wound infection, and coronary artery disease.</p> <p>A "PRN Pharmaceutical, LP Controlled Substance Record", dated 3/23/11 Time: 23:30:06, for Alprazolam 0.5 mg, indicated quantity 30 sent for Resident #30. This same record indicated from 5/28-6/7/11 resident received one at 9 p.m. each day. Documentation on the record indicated "Dc'd" at bottom of the page, no date or signature, and blank for doses transferred to disposal record, Qty [quantity]19 Date 6/17. There were three</p>						

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	<p>nurses' signatures, but no indication if destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "PRN Pharmaceutical, LP Controlled Substance Record", dated 3/23/11 Time: 19:42:21, for Alprazolam 1 mg, indicated quantity 30 sent for Resident #30. This same record indicated, "D'cd" at the bottom of the page, with no date or signature. There were three nurses' signatures, but no indication if destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "PRN Pharmaceutical, LP Controlled Substance Record", dated 3/25/11 Time: 11:27:30, for Alprazolam 1 mg, quantity indicated 30 sent for Resident #30. This same record indicated, "D'cd" at the bottom of the page, with no date or signature. There were three nurses' signatures at top with Qty 28, but no indication if destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "Drug Disposition Record" for Resident #30 dated 3/27/11, indicated Ranitidine 150 mg - Qty 73 returned to pharmacy, Vitamin C 250 mg - Qty 49 returned to pharmacy, Reno Caps Softgel - Qty 34 returned to pharmacy, Loperamide 2 mg - Qty 27 returned to pharmacy, Loperamide 2 mg - Qty 30 returned to pharmacy, and Promethazine 25 mg - Qty 10 returned to pharmacy. There was no reason code, no</p>			

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	<p>time and one nurse signature at the bottom of the page.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 4/24/11 Time 4:38, for Oxycodone-APAP 5-325 mg, indicated quantity 30 sent for Resident #30. This same record indicated order changed 5/3/11, resident received 26 tablets from 5/5-5/29, leaving 4 tablets on 5/29/11. Documentation indicated Qty 4 on 5/31/2011 with three nurses' signatures at the top, but no indication if destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "Drug Disposition Record" for Resident #30 dated 5/4/11 at 10 a.m., indicated Cozaar Qty 3, Cozaar Qty 8, Vitamin C Qty 24, Malccylin Qty 4, Pepcid Qty 4, Pepcid Qty 30 returned to pharmacy. Reason code was discontinued, with one nurse signature.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 5/4/11 Time: 13:14:27, for Oxycodone HCL 5 mg, indicated quantity 20 sent for Resident #30. This same record contained three nurses' signatures at the top with Qty 20 on 5/5/11, none of the medication documented as given, no indication if destroyed, and another nurse's signature with date 5/16/11, with no other information.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 5/4/11 Time:</p>				

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	<p>16:03:10, for Alprazolam 1 mg, indicated quantity 60 sent for Resident #30. This same record indicated, "D'cd" at the bottom of the page. Qty 60 with 5/5/11 date at top with 3 nurses' signatures. "60" was documented with one nurse's signature, and the date 6/17/11, about half-way down page. There was no indication if destroyed and no date and time "D'cd", and no "Drug Disposition Record" found for this medication.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 5/6/11 Time: 15:23:16, for Oxycodone-APAP 5-325 mg, indicated quantity 30 sent for Resident #30. This same record contained the signatures of three nurses at the top with Qty 30, date 5/7/11, and no indication any of meds given. The date 5/31/11 was documented, with RN signature, no indication if medication was destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "Drug Disposition Form" dated 5/11/11 at 10 a.m., indicated Dextrose 50 ml and Emla Cream 30 ml, discontinued and returned to pharmacy, with one nurse signature.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 5/12/11 Time: 11:06:16 for Oxycodone-APAP 5-325 mg, give 1 tablet every 6 hours as needed for pain times 2 days, indicated quantity 8 sent for Resident #30. This same record</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated at the top, Qty 8 on 5/31/2011 with three nurses' signatures, no indication if destroyed and no "Drug Disposition Record" found for this medication.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record", dated 5/12/11 Time: 15:17:44 for Alprazolam 1 mg, indicated quantity 60 sent for Resident #30. This same record indicated, "D'cd", no date, time, signature with "D'cd" or indication if destroyed, and no "Drug Disposition Record" found for this medication. There were three nurses' signatures at top with QTY 60 and date 6/17/11.</p> <p>3. During an interview on 7/11/2011 at 3:50 p.m., the Director of Nursing indicated nursing staff is to sign, date, and time orders to discontinue medications. "They are to transfer discontinued medications to a Drug Disposition Record with date, time, reason, and signature of nurse, and witnesses. They cannot send narcotics back, we destroy in the facility, by flushing." "They are to send other medications back to pharmacy for credit." "Liquids are destroyed by flushing down the sink, if they have been opened." "They have to have at least one licensed nurse and QMA sign for destruction of non-narcotics and two licensed staff for narcotics, one can be the pharmacy consultant." "I sign all of the destruction</p>				

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	<p>records for narcotics, too."</p> <p>4. On 7/15/11 at 5:46 p.m. the policy for, "MEDICATION DESTRUCTION " "Policy Number: 3.08 Original Date: 01/01/05 was received from the Administrator who indicated this was their policy before 7/1/11. "Policy: Discontinued medications and medications left in the facility after a resident's discharge if not returned for credit are destroyed in the facility." PROCEDURE: 1. Unused portions of any medication/treatment which cannot be returned to the pharmacy are to be destroyed in the facility when the medication is discontinued, expired, or the resident has been discharged without medication or the resident has expired. 2. Controlled substances are destroyed and documented as outlines in the policy, "Managing Controlled Medications" # 4.06. 3. Ointments, creams, and similar substances are placed in a trash receptacle in the medication room. 4. Drug destruction should be carried out in accordance with the policies of the facility and recommendations of the local environmental agencies. 5. "Destruction occurs in the presence of two licensed nurses or one licensed nurse and a pharmacist or licensed nurse and a QMA in Indiana." 6. "The nurses or pharmacist witnessing the destruction ensures that the</p>						

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	<p>following information is entered on the medication disposition form within seven (7) days of the discontinuation: A. Date of Destruction B. Resident's Name C. Name and strength of medication D. Prescription Number E. Amount destroyed F. Signatures of witnesses G. Reason for disposal H. Method of disposal." 7.8. "The Medication Disposition Form is stored with the resident's chart."</p> <p>On 7/13/2011 at 10:00 A.M. received, "DESTRUCTION OF MEDICATIONS" POLICY from the Director of Nursing and Assistant Director of Nursing who indicated this policy is effective as of 7/1/2011. POLICY - "Any medication for which there is no active order shall be destroyed at the nursing facility as soon as possible, but no later than within seven (7) days of becoming active. Appropriate records of drug disposition shall be maintained in each resident's clinical record. Such medications include discontinued drugs, outdated drugs, drugs for residents who are deceased, or for residents who have been discharged. Unused portions of prescription medications may be sent home with a discharged resident only on written order of a physician. PROCEDURE-A For those residing in the facility, deceased, or permanently discharged residents: 1. As soon as a medication becomes inactive,</p>						

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	<p>the unit charge nurse or designee should remove all supplies of the drug from stock, count the remaining doses, fill out the Drug Disposal Log, and destroy the medication. If a medication cannot be destroyed at the time it becomes inactive, all of the above steps will be performed except that the drug will be placed in a secure, designated area to await destruction. Drugs should not be routinely stockpiled for mass destruction. 2. A separate Drug Disposition Log is maintained for each resident on his or her clinical record. 3. Schedule II controlled drugs are handled in a similar fashion except that: a. C-II drugs must remain in the narcotic locker until they are to be destroyed. b. The quantity to be destroyed and the persons performing the destruction must sign and date the Controlled Accountability Record as well as the Drug Destruction Sheet. c. Destruction must be performed by two (2) licensed personnel (i.e. two (2) nurses or one (1) licensed nurse and the consultant pharmacist). 4. Oral solid dosage forms should be flushed down a toilet. Oral liquid may be flushed or rinsed down a sink. Injectable forms must be withdrawn from the ampule or vial and rinsed down a sink."</p> <p>5. On 7/13/2011 at 8:06 a.m. record review of Resident #57, indicated the</p>						

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	<p>resident was admitted with diagnoses that included, but were not limited to, dementia with vascular disturbance, hypertension, mood disorder, depression, and behaviors due to personality.</p> <p>The "Drug Disposition Form" for Resident #57, dated 5/25/11 at 7 p.m., indicated Trazadone Qty 12 and Diphenhydramine Qty 27 were returned to the pharmacy, signed by one nurse.</p> <p>The "PRN Pharmaceutical, LP Controlled Substances Record" for Resident #57 for Zolpidem Tartrate 5 mg, Qty 30 received 5/24/11 Time: 21:25:02 and d/c 5/2011, 3 nurses' signatures, date 6/9/11, with no indication if destroyed and no Drug Disposition Form found for this medication and no date and time for destruction.</p> <p>A "PRN Pharmaceutical, LP Controlled Substances Record" for Resident #57 for Zolpidem Tartrate 5 mg, Qty received on 5/25/11 Time: 19:05:07 3 nurses' signatures with Qty 30, date 6/9/11, with no indication if destroyed, no d/c date, time, and no Drug Disposition Form for this medication found.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011

FORM APPROVED

OMB NO. 0938-0391

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