

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/09/2013
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 2, 3, 4, 7, 8, 9, 2013</p> <p>Facility number: 000269 Provider number: 155400 AIM number: 100267720</p> <p>Survey Team: Ginger McNamee, RN, TC Betty Retherford, RN Karen Lewis, RN</p> <p>Census bed type: SNF: 9 SNF: 72 Total: 81</p> <p>Census payor type: Medicare: 14 Medicaid: 59 Other: 8 Total: 81</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN on 1/14/13.</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance</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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F0156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to notify 2 of 6 residents reviewed for the discontinuance of Medicare coverage in a timely manner of the change in their pay status and the charges that could be incurred due to the lack of Medicare coverage benefits. [Resident #'s 72, 16]</p> <p>Findings include:</p> <p>The review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 72, 16, 82, 61, 59, and 35 was completed on 1/7/13 at 9:47 a.m. There was no information for Resident #72 and Resident #16.</p> <p>During an interview with the Business Office Manager on 1/7/13 at 9:47 a.m., she indicated she did not have</p>	F0156	<p>1. Resident # 72 has been made aware of the discontinuance of Medicare coverage, the changes in pay status, and the charges that could be incurred due to lack of Medicare coverage of benefits. Resident # 16 is no longer a resident at the facility.2. All Residents who have recently been discontinued from Medicare coverage have the potential to be affected. Their clinical records have been reviewed and notification has been made to them regarding a change in their pay status, and charges that could be incurred due to the lack of Medicare coverage of benefits, as indicated.3. The facility's policy for notifying residents upon Medicare coverage discontinuation has been reviewed and no changes are indicated at this time (See Attachment A). The Business Office Manager has been</p>	02/08/2013			

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	any information related to Resident #72 and Resident #16 being notified of the discontinuance of Medicare coverage.  3.1-4(f)(3)		educated on the policy (See Attachment B). An ABN Expedited Determination Notices form has been implemented (See Attachment C).4. The Business Office Manager or designee will be responsible to complete the Change in Medicare Coverage form on scheduled work days as follows: daily for two weeks then two times weekly thereafter for a minimum of 6 months to ensure timely documented notification of discontinuation of Medicare benefits. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff obtained a laboratory test in a timely manner for 1 of 3 residents reviewed for laboratory testing in a sample of 10.</p> <p>Findings include:</p> <p>The clinical record for Resident #57 was reviewed on 1/7/13 at 9:20 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, osteoarthritis, osteoporosis, congestive heart failure, chronic obstructive pulmonary disease, and coronary artery disease.</p> <p>The clinical record indicated the resident was hospitalized from 11/22/12 to 12/27/12 related to shortness of breath and congestive heart failure.</p> <p>A physician's progress note, dated 12/10/12, indicated the resident was having problems with edema, excessive weight gain, cough, and required oxygen therapy. The</p>	F0282	<p>1. The current lab orders for Resident # 57 have been reviewed and all labs have been drawn per MD orders.2. All residents have the potential to be affected. Their lab orders have been reviewed. If results were not found, the MD was updated and orders were followed, as indicated.3. The facility's policy for Physician's Orders (See Attachment D) has been reviewed and no changes are indicated at this time. The nurses have been re-educated regarding following physician's orders (See Attachment E). Lab Monitoring form has been implemented (See Attachment F).4. The DON or designee will be responsible for completing the form on scheduled work days on an ongoing basis for a minimum of 6 months to ensure labs are being drawn as ordered. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	02/08/2013	

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	<p>resident's Lasix (a diuretic) medication was increased to 40 milligrams twice daily. A BNP (B-Natriuretic Pep) blood test was also ordered secondary to congestive heart failure.</p> <p>A laboratory report, dated 12/11/12, indicated the resident's BNP level was elevated at 801. Normal range 0-100.</p> <p>A physician's progress note, dated 12/12/12, indicated the resident was seen by a physician at the pacemaker clinic on 12/12/12 and a pacemaker was inserted. The resident's Lasix medication was increased to 40 mgs three times daily for 2 days. A BMP (basic metabolic profile) and BNP lab tests were to be obtained in 3 days. (12/15/12)</p> <p>The clinical record lacked any BMP and BNP lab tests for 12/15/12.</p> <p>During an interview with the DoN and RN consultant on 1/9/13 at 11:15 a.m., additional information was requested related to the lack of a lab report for the tests to have been completed on 12/15/12.</p> <p>During an interview on 1/9/13 at 1:45 p.m., the DoN indicated the BMP and</p>			

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	<p>BNP lab tests had not been completed on 12/15/12 as ordered by the physician on 12/12/12. The nursing staff had not made arrangements for the test to be completed on that date and it had not been done until 12/17/12. This resulted in a two day delay in obtaining the blood tests as ordered by the physician.</p> <p>The laboratory report, dated 12/17/12, indicated the resident's BNP level remained elevated at 974. Normal range 0-100. The BMP test was within normal limits except for a low calcium level of 8.1. Normal range 8.4-10.2.</p> <p>3.1-35(g)(2)</p>				

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F0329 SS=D	<p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure narcotic pain medication signed out for each resident was administered in accordance with the sign out records and monitored for efficacy of the medication for 3 of 10 residents (Resident #'s18, 57, and 41) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #18</p>	F0329	<p>1. The clinical records have been reviewed for Resident #'s 18, 57, and 41. Their narcotic pain medications are currently being signed out, administered to the resident as ordered, and monitored for efficacy.2. All residents with PRN (as needed) narcotic pain medication orders have the potential to be affected. Their clinical records have been reviewed and the narcotic pain medications are being signed out, administered to the resident as ordered, and monitored for efficacy.3. The facility's policy</p>	02/08/2013	

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	<p>was reviewed on 1/7/13 at 3:15 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic kidney disease with hemodialysis, peripheral neuropathy, charcot's foot disorder, arthritis, and diabetes mellitus.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 11/8/12, indicated the resident was moderately cognitively impaired, complained of the presence of pain almost constantly, and received medications as needed for the pain.</p> <p>A health care plan problem, dated 12/28/12, indicated Resident #18 was at risk for pain related to the multiple health problems noted above. One of the approaches for this problem was for staff to "administer/offer pain medication as ordered and monitor for efficacy."</p> <p>Current physician's orders, signed 12/24/12, indicated Resident #18 had an order for Vicodin (a narcotic pain medication) 5-500 milligrams (mg) tab 1 every 4 hours as needed (prn) for pain. The original date of this order was 11/5/12.</p> <p>The December 2012 and January 2013 "Controlled Drug Records" for</p>		<p>for Medication Administration (See Attachment G) has been reviewed and no changes are indicated at this time. The nurses have been re-educated on the policy (See Attachment H). A Pain and PRN Medication Monitoring form has been initiated (See Attachment I)4. The DON or designee will be responsible to complete the monitoring form daily on scheduled work days for 2 weeks, then weekly thereafter on an ongoing basis for a minimum of 6 months to ensure narcotic pain medications are signed out, administered and monitored for efficacy. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>the Vicodin medication for Resident #18 indicated the medication was signed out by the nursing staff on the following dates and times, but was not recorded as given on the resident's "PRN Medication Flow Sheet." This sheet is used by the facility to record the type of pain the medication is being given for, the date and time given, the severity of the pain, and the follow-up effectiveness of the medication.</p> <p>12/2/12 at 9 a.m., 1:30 p.m., 5:30 p.m., and 9:40 p.m.            12/3/12 at 1:40 a.m., 5:20 p.m., and 11:30 p.m.            12/4/12 at 4 p.m. and 8 p.m.            12/6/12 at 8 p.m.            12/8/12 at 7 p.m.            12/9/12 at 1:10 a.m. and 7:30 p.m.            12/11/12 at 8 p.m.            12/12/12 at 8:30 a.m. and 5:30 p.m.            12/13/12 at 4:30 p.m.            12/15/12 at 8 a.m., 1 p.m., 5:15 p.m., and 9:30 p.m.            12/16/12 at 9 a.m., 1 p.m., and 8 p.m.            12/17/12 at 8:15 p.m.            12/18/12 at 8 p.m.            12/20/12 at 8 p.m.            12/22/12 at 8:30 p.m.            12/23/12 at 9:10 p.m.            12/25/12 at 9 p.m.            12/26/12 at 3:30 p.m. and 9 p.m.            12/27/12 at 8 p.m.</p>			

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	<p>12/29/12 at 8 a.m. and 7:30 p.m. 12/30/12 at 8 a.m. and 8 p.m. 1/2/13 at 4:30 a.m. 1/6/13 at 12:35 a.m. and 8:30 a.m. 1/7/13 at 2:10 a.m.</p> <p>The administration of the pain medication for the dates and times noted above were not documented in the resident's nursing notes, the medication administration record, or the PRN Medication Flow Sheets.</p> <p>This indicated the Vicodin medication was signed out on the narcotic log on 40 occasions in December 2012 and January 2013 without documentation of the medication having been given and/or the effectiveness of the medication being monitored.</p> <p>During an interview with the DoN, AIT (Administrator in Training), and RN consultant on 1/9/13 at 11:15 a.m., additional information was requested in regards to the medications having been given on the dates and times noted above.</p> <p>During an interview on 1/9/13 at 2:00 p.m., the DoN indicated the facility had no information to provide in regards to the administration of the pain medication on the dates and times noted above.</p>						

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	<p>2. The clinical record for Resident #57 was reviewed on 1/7/13 at 9:20 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, osteoarthritis, osteoporosis, congestive heart failure, chronic obstructive pulmonary disease, and coronary artery disease.</p> <p>An admission MDS, dated 12/3/12, indicated the resident had no cognitive impairment and complained of the presence of pain frequently.</p> <p>A "Pain Assessment," dated 11/30/12, indicated the resident complained of generalized, back, and/or chest pain on an intermittent basis that could be "aching" and/or "shooting" in nature.</p> <p>A health care plan problem, dated 12/13/12, indicated Resident #57 was at risk for pain related to the multiple health problems noted above. One of the approaches for this problem was for staff to "administer/offer pain medication as ordered and monitor for efficacy."</p> <p>Current physician's orders, signed 12/26/12, indicated Resident #57 had an order for Tramadol (a narcotic pain medication) 50 mgs tabs 1 or 2 three</p>						

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	<p>times daily as needed for pain. The original date of this order was 11/27/12.</p> <p>The December 2012 and January 2013 "Controlled Drug Records" for the Tramadol medication for Resident #57 indicated the medication was signed out by the nursing staff on the following dates and times, but was not recorded as given on the resident's "PRN Medication Flow Sheet." This sheet is used by the facility to record the type of pain the medication is being given for, the date and time given, the severity of the pain, and the follow-up effectiveness of the medication.</p> <p>12/8/12 at 8:10 a.m.- one tablet 12/9/12 at 6:30 a.m.- one tablet 12/10/12 at 1:30 p.m. and 9 p.m. -one tablet each time 12/11/12 at 8:30 a.m.-one tablet and 7:30 p.m.-two tablets 12/12/12 at 5 a.m. and 9:30 p.m. -one tablet each time 12/13/12 at 4 p.m. and 8:30 p.m.-one table each time 12/19/12 at 8 p.m.-one tablet 12/20/12 at 3 p.m. and 8 p.m.-one tablet each time 12/21/12 at 6 a.m., 3 p.m., and 8 p.m. -one tablet each time 12/24/12 at 7:15 p.m.-one tablet</p>						

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	<p>12/26/12 at 8:15 a.m.-one tablet 12/29/12 at 8 p.m.-two tablets 12/30/12 at 3 p.m. and 8 p.m.-two tablets each time 12/31/12 at 9 p.m.-two tablets 1/1/13 at 9 p.m.--two tablets 1/2/13 at 2:30 p.m. and 9 p.m.-two tablets 1/3/13 at 9 p.m.-two tablets 1/4/13 at 5 p.m.-one tablet and 9 p.m.-two tablets</p> <p>The administration of the pain medication for the dates and times noted above was not documented in the resident's nursing notes, the medication administration record, or the PRN Medication Flow Sheets.</p> <p>This indicated the Tramadol medication was signed out on the narcotic log on 28 occasions in December 2012 and January 2013 without documentation of the medication having been given and/or the effectiveness of the medication being monitored.</p> <p>During an interview with the DoN, AIT (Administrator in Training), and RN consultant on 1/9/13 at 11:15 a.m., additional information was requested in regards to the medications having been given on the dates and times noted above.</p>			

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	<p>During an interview on 1/9/13 at 2:00 p.m., the DoN indicated the facility had no information to provide in regards to the administration of the pain medication on the dates and times noted above.</p> <p>3. The clinical record for Resident #41 was reviewed on 1/7/13 at 8:43 a.m.</p> <p>Diagnoses for Resident #41 included, but were not limited to, dementia, chronic pain, neck fracture, and osteoarthritis.</p> <p>Resident #41 had an order for Ultram (a narcotic pain medication) 50 mg (milligrams), dated 5/9/12, one tablet three times a day prn (as needed) for moderate pain.</p> <p>The "narcotic sign out sheets" for Resident #41 listed the dates and times the "as needed" Ultram pain medication was signed out for the resident. Included, but were not limited to, the following dates and times:</p> <p>11/2/12 at 3:30 a.m. 11/3/12 at 7:00 a.m. 11/4/12 at 7:00 a.m. 11/4/12 at 7:00 p.m. 11/7/12 at 11:30 p.m. 11/17/12 at 11:00 a.m.</p>						

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	<p>11/17/12 at 8:30 p.m. 11/18/12 at 7:00 a.m. 11/18/12 at 7:00 p.m. 11/21/12 at 1:00 p.m. 11/22/12 at 11:00 a.m. 11/23/12 at 8:00 p.m. 11/27/12 at 7:30 p.m. 11/28/12 at 2:30 a.m. 12/1/12 at 7:00 a.m. 12/1/12 at 7:00 p.m. 12/2/12 at 7:00 p.m. 12/12/12 at 7:00 a.m. 12/13/12 at 3:00 a.m. 12/25/12 at 7:00 p.m. 12/26/12 at 7:00 p.m. 12/29/12 at 7:00 a.m. 12/29/12 at 7:00 p.m.</p> <p>The Medication Administration Record (MAR), the PRN Medication Flow Sheet, and the nurses notes for November and December 2012 for Resident #41, lacked any information related to the Ultram medication having been given on the dates and times noted above.</p> <p>The "narcotic sign out sheets" for Resident #41 did not indicate what type of pain the medication was given for or if the medication relieved the resident's pain on the dates and times noted above.</p>						

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	<p>During an interview with the Director of Nursing (DoN), RN Consultant, and the Administer in Training on 1/9/13 at 11:15 a.m., additional information was requested related to the lack of documentation of administration of the narcotic pain medication on the dates and times noted above for Resident #41.</p> <p>During an interview on 1/9/13 at 2:00 p.m., the DoN indicated she had no additional information to provide related to the lack of documentation of administration of the narcotic pain medication signed out on the dates and times for Resident #41 noted above.</p> <p>4. Review of the current facility policy, dated 8/06, titled "Pain Management Procedure", provided by the RN Consultant on 1/9/13 at 12:00 p.m., included, but was not limited to, the following:</p> <p>"Purpose: It is the goal of this facility to assist residents in achieving their optimal level of comfort by providing an effective pain management program.</p> <p>Procedure:</p> <p>...4. Having determined that the</p>			

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	<p>resident is experiencing pain based upon assessment, follow physician orders and/or care plan.</p> <p>5. Documentation of administration of the ordered medication will be initialed in the front of the MAR [medication administration record] or on a Pain Management Flow Sheet.</p> <p>6. Evaluation of effectiveness will be determined by routine pain assessments completed with Nursing Summaries. The assessment will include type of pain scale used, pain level, pain location, routine pain medication effectiveness, # [number] of times PRN pain medication given...."</p> <p>3.1-48(a)(3)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food preparation equipment and counters were maintained in a clean and sanitary manner for 1 of 2 kitchen tours. This potentially affected all 81 of 81 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour, conducted with the Dietary Manager on 1/2/13 at 8:55 a.m., the following concerns were noted:</p> <p>The top of the oven was covered with a dark gritty substance.</p> <p>The sides of the two stoves had a large accumulation of some dried and/or greasy substances streaked down the sides where the stoves sat near to each other . The stoves were separated by a distance of approximately 10 inches.</p>	F0371	<p>1. No residents were harmed. The oven top was cleaned. The sides of the stove, grill, and oven were cleaned. The side of the serving counter was cleaned. 2. All residents have the potential to be affected. See below for corrective measures. 3. The facility's policies for cleaning the grill and oven (See Attachment J) was reviewed and no changes are indicated at this time. The Dietary staff has been re-educated on overall equipment sanitation (See Attachment K). A Dietary Monitoring form has been implemented (See Attachment L) 4. The Dietary Manager or designee will complete sanitation rounds daily (Monday through Friday) for 4 weeks then twice weekly for 4 weeks then weekly for two months then monthly there after for a minimum of 6 months to ensure continued compliance with equipment sanitation. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted</p>	02/08/2013			

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	<p>The side of the serving counter facing the interior of the kitchen had long dried drips and streaks.</p> <p>During an interview on 1/2/13 at 9:10 a.m., the Dietary Manager indicated she would have the staff clean the above noted areas right away.</p> <p>3.1-21(i)(3)</p>		accordingly, as warranted.		

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F0428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the pharmacist failed to note and report irregularities noted between the signing out of narcotic pain medications and documentation of the administration and monitoring of the medications for 2 of 10 residents (Resident #'s 18 and 41) reviewed for unnecessary medications and failed to ensure residents with multiple orders for acetaminophen would not be given the medication in excess of the recommended maximum dose for 1 of 10 residents (Resident # 87) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #18 was reviewed on 1/7/13 at 3:15 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic kidney disease with hemodialysis, peripheral</p>	F0428	<p>1. The consultant pharmacist has reviewed the clinical records for Resident #'s 18 and 41 and any irregularities have been communicated to the DON, Administrator, and attending physician. Their narcotic pain medications are currently being signed out, administered to the resident as ordered, and monitored for efficacy. The consulting pharmacist has also reviewed the clinical record for Resident # 87 and any irregularities have been communicated to the DON, Administrator, and attending physician. An order for the maximum amount of tylenol in a 24 hour period has been implemented by the attending physician. 2. All residents have the potential to be affected. The consultant pharmacist has reviewed their clinical records and any irregularities have been communicated to the DON, Administrator, and attending physician. Any orders received have been implemented by the facility. 3. The facility's policy for</p>	02/08/2013	

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	<p>neuropathy, Charcot's foot disorder, arthritis, and diabetes mellitus.</p> <p>Current physician's orders, signed 12/24/12, indicated Resident #18 had an order for Vicodin (a narcotic pain medication) 5-500 milligrams (mg) tab 1 every 4 hours as needed (prn) for pain. The original date of this order was 11/5/12.</p> <p>The December 2012 and January 2013 "Controlled Drug Records" for the Vicodin medication for Resident #18 indicated the medication was signed out by the nursing staff on the following dates and times, but was not recorded as given on the resident's "PRN Medication Flow Sheet." This sheet is used by the facility to record the type of pain the medication is being given for, the date and time given, the severity of the pain, and the follow-up effectiveness of the medication.</p> <p>12/2/12 at 9 a.m., 1:30 p.m., 5:30 p.m., and 9:40 p.m. 12/3/12 at 1:40 a.m., 5:20 p.m., and 11:30 p.m. 12/4/12 at 4 p.m. and 8 p.m. 12/6/12 at 8 p.m. 12/8/12 at 7 p.m. 12/9/12 at 1:10 a.m. and 7:30 p.m. 12/11/12 at 8 p.m.</p>		<p>the consultant pharmacist (See Attachment M) has been reviewed and no changes are indicated at this time. The consultant pharmacist has been re-educated to include reviewing narcotic sign out, administration, follow up documentation, and maximum amount of tylenol orders (See Attachment N). A Pharmacy Recommendation Review Form has been implemented (See attachment O)4. The DON or designee will review pharmacy recommendations and complete the Pharmacy Recommendation Form on a monthly basis for a minimum of 6 months to ensure the pharmacist has reviewed narcotic sign out, administration, follow up documentation and maximum amount of tylenol orders. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>12/12/12 at 8:30 a.m. and 5:30 p.m. 12/13/12 at 4:30 p.m. 12/15/12 at 8 a.m., 1 p.m., 5:15 p.m., and 9:30 p.m. 12/16/12 at 9 a.m., 1 p.m., and 8 p.m. 12/17/12 at 8:15 p.m. 12/18/12 at 8 p.m. 12/20/12 at 8 p.m. 12/22/12 at 8:30 p.m. 12/23/12 at 9:10 p.m. 12/25/12 at 9 p.m. 12/26/12 at 3:30 p.m. and 9 p.m. 12/27/12 at 8 p.m. 12/29/12 at 8 a.m. and 7:30 p.m. 12/30/12 at 8 a.m. and 8 p.m. 1/2/13 at 4:30 a.m. 1/6/13 at 12:35 a.m. and 8:30 a.m. 1/7/13 at 2:10 a.m.</p> <p>The administration of the pain medication for the dates and times noted above was not documented in the resident's nursing notes, the medication administration record, or the PRN Medication Flow Sheets.</p> <p>This indicated the Vicodin medication was signed out on the narcotic log on 40 occasions in December 2012 and January 2013 without documentation of the medication having been given and/or the effectiveness of the medication being monitored.</p> <p>During an interview with the DoN, AIT</p>						

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	<p>(Administrator in Training), and RN consultant on 1/9/13 at 11:15 a.m., additional information was requested in regards to the medications having been given on the dates and times noted above and any pharmacy reviews having been made during that time period.</p> <p>During an interview on 1/9/13 at 9:00 a.m., the DoN indicated the consulting pharmacist had reviewed the residents orders on 12/24/12. No recommendations were made in regards to the documentation and/or administration of the resident's narcotic pain medication.</p> <p>During an interview on 1/9/13 at 2:00 p.m., the DoN indicated the facility had no information to provide in regards to the administration of the pain medication on the dates and times noted above.</p> <p>2. The clinical record for Resident #41 was reviewed on 1/7/13 at 8:43 a.m.</p> <p>Diagnoses for Resident #41 included, but were not limited to, dementia, chronic pain, neck fracture, and osteoarthritis.</p> <p>Resident #41 had an order for Ultram (a narcotic pain medication) 50 mg</p>			

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	<p>(milligrams), dated 5/9/12, one tablet three times a day prn (as needed) for moderate pain.</p> <p>The "narcotic sign out sheets" for Resident #41 listed the dates and times the "as needed" Ultram pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>11/2/12 at 3:30 a.m. 11/3/12 at 7:00 a.m. 11/4/12 at 7:00 a.m. 11/4/12 at 7:00 p.m. 11/7/12 at 11:30 p.m. 11/17/12 at 11:00 a.m. 11/17/12 at 8:30 p.m. 11/18/12 at 7:00 a.m. 11/18/12 at 7:00 p.m. 11/21/12 at 1:00 p.m. 11/22/12 at 11:00 a.m. 11/23/12 at 8:00 p.m. 11/27/12 at 7:30 p.m. 11/28/12 at 2:30 a.m. 12/1/12 at 7:00 a.m. 12/1/12 at 7:00 p.m. 12/2/12 at 7:00 p.m. 12/12/12 at 7:00 a.m. 12/13/12 at 3:00 a.m. 12/25/12 at 7:00 p.m. 12/26/12 at 7:00 p.m. 12/29/12 at 7:00 a.m. 12/29/12 at 7:00 p.m.</p>			

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	<p>The Medication Administration Record (MAR), the PRN Medication Flow Sheet, and the nurses notes for November and December 2012 for Resident #41, lacked any information related to the Ultram medication having been given on the dates and times noted above.</p> <p>A pharmacist "Consultation Report" indicated the pharmacist reviewed Resident #41's clinical record on 11/26/12 and between 12/1/12 and 12/20/12. The report lacked any information related to the discrepancies between the MAR/PRN Medication Flow Sheet and the narcotic sign out sheets.</p> <p>During an interview with the Director of Nursing on 1/9/13 at 2:09 p.m., additional information was requested related to the lack of pharmacy recommendations regarding the irregularities between the MAR/PRN Medication Flow Sheet and the narcotic sign out sheet for Resident #41.</p> <p>The facility failed to provide any additional information as of exit on 1/9/13.</p> <p>3. The clinical record for Resident #87</p>			

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	<p>was reviewed on 1/7/13 at 1:20 p.m.</p> <p>Diagnoses for Resident #87 included, but were not limited to, chronic back pain, kyphosis, insomnia, and congestive heart failure.</p> <p>Current physician's orders for Resident #87 included, but were not limited to, the following orders for pain:</p> <p>a. Hydrocodone - APAP (a pain medication that contains Tylenol) 5-325 milligrams (mg) tablet give 1 tablet by mouth every 6 hours while awake (original order date 8/9/12.)</p> <p>b. Tylenol (a pain medication) 325 mg tablet give 2 tablets (650 mg) every 4 hours as needed for pain (original order date 8/24/11.)</p> <p>The resident had the potential to receive 5200 milligrams of Tylenol in a 24 hour period. The "2010 Nursing Spectrum Drug Handbook" indicated the maximum daily dose of Tylenol (acetaminophen) should not exceed 4000 milligrams per day.</p> <p>A pharmacist "Consultation Report" indicated the pharmacist reviewed Resident #87's clinical record between 12/1/12 and 12/20/12. The</p>				

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	<p>report lacked any recommendations made related to the potential of the resident exceeding the maximum daily recommended dose of Tylenol.</p> <p>During an interview with the Director of Nursing on 1/9/13 at 2:09 p.m., additional information was requested related to the lack of pharmacy recommendations regarding the potential of the resident exceeding the maximum daily recommended dose of Tylenol.</p> <p>The facility failed to provide any additional information as of exit on 1/9/13.</p> <p>4. Review of the current undated facility policy, titled "CONSULTANT PHARMACIST", provided by the RN Consultant on 1/9/13 at 12:00 p.m., included, but was not limited to, the following:</p> <p>"POLICY:</p> <p>A licensed pharmacist will be retained as a consultant to the facility to coordinate, supervise, and review pharmaceutical services on a regularly scheduled, on-premises basis. A written agreement will stipulate the financial arrangements and services to be provided.</p>			

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	<p><b>PROCEDURES</b></p> <p>The pharmacy consultant will:...</p> <p>...5. Report irregularities in drug acquisition, storage, handling, administration, and disposition in writing to the administrator and director of nursing...."</p> <p>3.1-25(i)</p>			
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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>A. Based on observation and interview, the facility failed to maintain resident rooms regarding gouged and/or rough doors and wood trim for 8 of 34 resident rooms [Room #'s 104, 112, 115, 117, 119, 215, 219, and 311] and 1 of 2 dining rooms [Main Dining Room] observed, regarding window blinds for 2 of 34 rooms observed, and failed to maintain the half walls around 2 of 3 nurse stations [Freedom Hall and Harmony Hall] observed. This had the potential to affect 81 of 81 residents residing in the facility.</p> <p>B. Based on observation and interview, the facility failed to ensure kitchen walls, floors, stationary counters, and vents were maintained in a clean and sanitary manner for 1 of 2 kitchen tours. This potentially affected 81 of 81 residents served food from the kitchen.</p> <p>Findings include:</p> <p>A 1. The environmental tour was conducted on 1/9/12 from 10:05 a.m. to 11:15 a.m., with the Administrator</p>	F0465	<p>A1. The Freedom Hall and Harmony nurse stations have had the veneer replaced around the outside edges of the counter tops. The doors in rooms 104, 112, 115, 117, 119, 215, 219 and 311 have been repaired. The window blinds in rooms 116 and 204 have been repaired. The wood chair rail trim on the window side of the wall in room 208 has been repaired. The wood chair rail trim in the Main Dining Room has been repaired. B1. The entire kitchen floor and floor of the dishwashing room has been replaced. The bottom, rear support bar of the serving counter has been cleaned. The two large vents on the walls which contain the kitchen air conditioning unit have cleaned. The door from the kitchen to the dining room has had scuff marks removed. The kitchen and dishwashing room walls have been repainted. A/B 2. All residents have the potential to be affected. Facility tour, including the kitchen, has been completed and any concerns noted have been repaired.A/B 3. The facility's preventative maintenance has been reviewed and no changes are indicated at this time (See Attachment P).</p>	02/08/2013			

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	<p>in Training [AIT,] the Maintenance Supervisor and the Housekeeping/Laundry Supervisor. During the tour the following observations were made:</p> <p>a. The Freedom Hall and Harmony nurse stations had veneer missing from around the outside edges of the counter tops. The missing veneer left exposed wood that could not be sanitized and was in areas where residents and visitors use.</p> <p>b. The doors in rooms 104, 112, 115, 117, 119, 215, 219 and 311 were gouged and had rough edges exposed. These rooms are all equipped for two residents to reside in them.</p> <p>c. The window blinds in rooms 116 and 204 were bent and broken. During the observation, the AIT indicated the facility was planning to replace all the window blinds and had not yet decided which type to purchase. These rooms were equipped for double occupancy.</p> <p>d. The wood chair rail trim on the window side of the wall in room 208 was gouged and rough. Resident #40's bed was against this wall.</p>		<p>The Maintenance Director has been re-educated on maintaining a safe, functional, sanitary, and comfortable environment for residents/staff, and the public (See Attachment Q). A Facility Rounds form has been initiated (See Attachment R). A Dietary Monitoring Tool as been implemented (See Attachment L).A/B 4. The Administrator or designee will be responsible for completing the Facility Rounds form on scheduled work days as follows: daily for 2 weeks then weekly for one month then monthly thereafter for a minimum of 6 months to ensure the facility is maintained in a safe, functional, sanitary, and comfortable environment. The Dietary Manager or designee will complete sanitation rounds daily (Monday through Friday) for 4 weeks then twice weekly for 4 weeks then weekly for two months then monthly there after for a minimum of 6 months to ensure continued compliance with equipment sanitation. Should concern(s) be observed, re-education will be provided. Results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>		

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	<p>e. The wood chair rail trim in the Main Dining Rood had gouged and rough areas. The table arrangements allowed for residents to be placed along the rough areas.</p> <p>B1. During the initial kitchen tour, conducted with the Dietary Manager on 1/2/13 at 8:55 a.m., the following concerns were noted:</p> <p>a. The entire kitchen floor and floor of the dishwashing room was very worn, discolored, and stained in multiple areas and lacked any luster or shine. The number of stained and dark areas made it difficult to determine if the floor was clean.</p> <p>b. The bottom, rear support bar of the serving counter (at least 6 feet long) had a heavy accumulation of dust and debris.</p> <p>B2. During a subsequent kitchen tour conducted with the Dietary Manager on 1/4/13 at 11:40 a.m., the following concerns were noted:</p> <p>a. Two large vents (approximately 12" x 18") on the walls which contain the kitchen air conditioning unit have an accumulation of dust and debris.</p> <p>b. The door from the kitchen to the dining room had multiple black</p>			

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	<p>scuffed areas.</p> <p>c. The paint on the kitchen walls was worn and thin. There are multiple areas of missing paint exposing the base of the wall behind the paint. There are intermittent dark scuffed areas on the kitchen wall that goes from the kitchen to the dishwashing room.</p> <p>d. During an interview on 1/4/13 at 11:45 a.m., the Dietary Manager indicated the floor was very old and the staining could not be removed. She thought plans might be in progress for the kitchen to be painted.</p> <p>e. During an interview with the Administrator in Training (AIT) and DoN on 1/9/13 at 11:30 a.m., the AIT indicated plans had been made to paint the kitchen, but they fell through with the first company contacted and they were looking for another company.</p> <p>3.1-19(f)</p>				