

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2011
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN46123
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F0000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00100416.</p> <p>Complaint IN00100416 - Substantiated. Federal/state deficiencies related to the allegations are cited at F206.</p> <p>Survey dates: November 28, 29, 30, December 1, & 2, 2011</p> <p>Facility number : 000231 Provider number: 155338 AIM number 100267900</p> <p>Survey team: Michelle Hosteter RN, TC Heather Lay RN Janet Stanton RN Rita Mullen RN</p> <p>Census bed type SNF/NF: 80 SNF: 31 Total: 111</p> <p>Census payor type: Medicare: 20 Medicaid: 63 Other: 28 Total: 111</p>	F0000	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies.	

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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F0206 SS=D	<p>Sample: 23 Supplemental sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/9/11 by Jennie Bartelt, RN.</p> <p>A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.</p> <p>Based on record review and interview, the facility failed to permit a resident to return to the facility after hospitalization. The deficient practice impacted 1 of 4 residents reviewed related to admission, discharge, and transfer in a sample of 23 and supplemental sample of 1. [Resident B]</p> <p>Findings include:</p> <p>On 12/1/11 at 1:30 P.M., Resident B's closed record was reviewed. Diagnoses included, but were not limited to, dysphagia, transient ischemic attack, and</p>	F0206	<p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident B no longer resides at the facility. <u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u> Residents with Medicaid as there primary payor source have the potential to be affected. Medicaid residents whose hospitalization or therapeutic leave exceeds the bed-hold period will be readmitted to the facility immediately upon the first availability of a bed in a</p>	01/01/2012	

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	<p>atrial fibrillation. Readmission date to the facility was 3/10/11 and discharge to hospital date was 11/11/11.</p> <p>A document titled "Bedhold Agreement" dated 11/11/11 included, but was not limited to, "Verbal request refused to privately hold, I decline to bedhold...."</p> <p>A "Social Service Department" progress note dated 11/20/11 at 5:55 P.M. included, but was not limited to, "Spoke with [Resident B's] daughter and she acknowledged receipt of bed hold policy and stated she understood we are not obligated to hold a medicaid bed for her mom... She did not want to pay for a bedhold at his time...."</p> <p>A "Social Service Department" progress note dated 12/2/11, no time, included, but was not limited to, "Late Entry: 11/28/11 at 1:00 P.M., [Resident #106's] daughter asked for another copy of the bedhold policy...."</p> <p>In an interview on 12/1/11 at 3:30 P.M., the Administrator indicated with any transfer or discharge, the "Notice of Transfer or Discharge" is given to the resident and/or family member.</p> <p>A document titled, "Open Medicaid Female Beds November 2011" was</p>		<p>semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. The state guidelines for permanent discharge from the facility will be followed. <u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> The Administrator or designee will conduct weekly audits of discharged residents where Medicaid was the primary payer source, to assure discharges were appropriate and in accordance with the state regulations. <u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u> Findings will be presented to QAA committee weekly for 4 weeks for trending. QAA committee will review findings and determine need for further monitoring. This will cease after three consecutive months of compliance.</p>				

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	<p>received from the Administrator on 12/2/11 at 11:45 A.M. The document indicated the facility had open female beds for each day in November 2011.</p> <p>On 12/2/11 at 2:30 P.M., Resident B's transferring hospital medical records were reviewed. Records included, but were not limited to, "Arrival: 11/11/11 at 1:33 A.M., Discharge: 11/25/11... Care Management Progress Notes, dated 11/22/11 at 3:53 P.M., I have spoken with [Administrator] and [Director of Admissions] from Manor Care at Prestwick....The facility is trying to meet and discuss whether they will accept the patient back.... Social Service Progress Notes, dated 11/23/11 at 4:17 P.M., Received call from CM [case manager]. Manor Care Prestwick is not willing to accept patient back, saying they feel they cannot manage patient's needs. [Resident B's] daughter is suspicious it is due to issues surrounding her sister...." Discharge diagnoses included, "status post CVA [cerebral vascular accident], aspiration pneumonia, Klebsiella UTI [urinary tract infection], acute cholecystitis, stage 4 decubitus ulcer, chronic Foley [urinary] catheter with leakage around catheter, chronic atrial fibrillation, protein/calorie malnutrition, chronic anemia and thrombocytopenia, s/p [status post] picc [peripherally inserted</p>				

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	<p>central catheter] line placement, and s/p PEG [percutaneous endoscopic gastrostomy] tube placement.</p> <p>This federal tag relates to Complaint IN00100416.</p> <p>3.1-12(a)(27)(B)</p>				

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F0278 SS=D	<p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 resident's cognitive status was correctly identified on the initial M.D.S. [Minimum Data Set] assessment in a sample of 23 residents reviewed related to accuracy of the M.D.S. [Resident #80]</p> <p>Findings include:</p> <p>In an interview during the initial</p>	F0278	<p>F278 D</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident # 80's cognitive status is correctly identified on the M.D.S.</p> <p>-</p> <p><u>How will other residents having the potential to be affected by</u></p>	01/01/2012	

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	<p>orientation tour on 11/28/11 at 10:40 A.M., R.N. #2 indicated Resident #80 required the use of wheelchair and bed alarms because he "was always trying to climb out of bed or self transfer from his wheelchair without staff assistance."</p> <p>The clinical record for Resident #80 was reviewed on 12/1/11 at 10:45 A.M. The resident was admitted on 8/10/11 with diagnoses which included, but were not limited to, depressive disorder, anxiety state, and senile dementia.</p> <p>An initial M.D.S. assessment was completed on 8/19/11.</p> <p>The section for "Hearing, Speech, and Vision" indicated the resident had "adequate hearing," "clear speech," "was understood [ability to express ideas and wants]," and "understands [ability to understand others]."</p> <p>The section evaluating "Cognitive Patterns" indicated a brief interview for mental status was not done because "resident is rarely/never understood." The "staff assessment for mental status" was completed, and indicated the resident had a short term memory problem and "severely impaired [never/rarely made decisions] cognitive skills for daily decision making.</p>		<p><u>the same deficient practice be identified and what actions will be taken?</u></p> <p>Residents with impaired cognition are at risk and have the potential to be affected.</p> <p>MDS Coordinator for each MDS submission will review cognitive status and interview coding to assure appropriate documentation is recorded in the clinical record as necessary in cases where the interview was not required.</p> <p><u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Prior to locking the MDS of a resident with impaired cognition, MDS coordinator will review again to ensure MDS accurately reflects the resident's cognitive status</p> <p>Interdisciplinary team members who are involved in MDS coding will be in-serviced on interview process accuracy and congruency.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>ADNS (Administrative Director of</p>		

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F0282 SS=E	<p>In addition, the section for "Pain Management" indicated a pain assessment interview should be conducted with the resident to determine any pain issues in the past 5 day period. The other option for this section was that no attempt would be made to do an interview because "the resident is rarely/never understood."</p> <p>In an interview on 12/2/11 at 11:45 A.M., the Director of Nurses indicated she had spoken with the M.D.S. Coordinators. They reported the resident was not interviewed until the next assessment.</p> <p>3.1-31(i)</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. Based on observation, record review and interview, the facility failed to ensure physician orders and Care Plan interventions were followed for 1 resident who fell and sustained a laceration to his forehead and was sent to the hospital for</p>	F0282	<p>Nursing Services) or designee will monitor weekly, for a period of 6 consecutive weeks of compliance, completed MDS assessments to assure the MDS accuracy in resident cognition was reviewed by the MDS coordinator.</p> <p>Findings will be presented to QAA committee weekly for 6 weeks for trending. QAA committee will review findings and determine need for further monitoring</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p>	01/01/2012	

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	<p>evaluation, for 2 residents who had specific parameters to "Hold" their blood pressure medications, for 1 resident who had a lab test ordered which was not done, and for 1 resident administered medication without a physician's order. This deficiency impacted 4 residents in a sample of 23 residents, and 1 resident in a supplemental sample of 1. [Residents #80, #60, #61, #39, and #106]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 11/28/11 at 10:40 A.M., R.N. #2 indicated Resident #80 had experienced a recent fall, sustaining a laceration to his forehead. She indicated he was had been in the facility for a few months, but had been moved recently to his current room and wing. The nurse indicated the resident had bed and wheelchair alarms, a low bed with floor mats, and bed bolsters because he continued to try to climb out of bed or transfer himself out of the wheelchair without assistance.</p> <p>The clinical record for Resident #80 was reviewed on 12/1/11 at 10:45 A.M. Diagnoses included, but were not limited to, senile dementia, depressive disorder, anxiety state, history of a left hip hemi-arthroplasty, history of chronic</p>		<p>Resident #80's MD orders reviewed and care plan was modified to reflect the appropriate fall interventions. RNs #4 will be reeducated on following proper parameters for administering blood pressure medications as well as tracking lab results.</p> <p>Resident #39 had her PT/INR drawn in the hospital on 11/19/11 and it was found to be within therapeutic limits.</p> <p>Resident #60 and #61 did have their B/P measured at the time of survey and found to be within normal limits.</p> <p>The medication error for Resident #106 was investigated and concluded by the DON. A Pain Re-Assessment was completed, resident was offered alternative pain medications but refused. Resident experienced no untoward reactions from medication error.</p> <p>- <u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u></p> <p>Residents with MD orders for Anti-Hypertensive medication have the potential to be affected. Residents requiring fall interventions and are frequent falls have the potential to be affected.</p>		

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	<p>kidney disease, hypertension, and atrial fibrillation.</p> <p>The quarterly M.D.S. [Minimum Data Set] assessment, dated 11/7/11, indicated the resident had clear speech, was able to express ideas and wants and understood verbal content, and had a "Brief Interview for Mental Status [BIMS]" score of "03" [severe impairment for cognitive patterns]. The assessment also indicated the resident required extensive physical assistance of 1 staff person for all daily care, including transfers.</p> <p>Electronic record information indicated the resident had falls on 8/25/11 at 4:15 P.M., 9/6/11 at 8:15 P.M., and 9/9/11 at 1:15 P.M. The assessment on 9/6/11 indicated "... Patient wanting to lay down soon after meals...."</p> <p>A Care Plan addressing falls was originally initiated on 8/10/11, and included an intervention of "bed in low position." On 8/25/11, the following interventions were added: "Ensure that tab alarm with shortened string is in place when in wheelchair/bed; Provide assist to transfer and ambulate as needed; reinforce need to call for assistance."</p> <p>On 9/6/11, the following Care Plan intervention was added: "Nursing to put</p>		<p>Residents with MD orders for Routine Pain medications have the potential to be affected. Residents with ordered labs have the potential to be affected. These residents will be identified, MD orders reviewed and care plans will be updated as necessary.</p> <p><u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed nurses will be in-serviced on the following:</p> <ul style="list-style-type: none"> ·Rights of Medication Administration ·Medication Administration Procedure ·Fall Guidelines and ·Lab Tracking. <p>ADNS or designee will conduct random medication administration observations a minimum of 10 times per week to assure medication parameters are followed as ordered. ADNS or designee will also conduct random observations at least five times per week x6 weeks to ensure fall prevention devices are utilized per plan of care.</p> <p>Director of Care Delivery (DCD) or designee will monitor daily lab tracking process x 6 weeks to assure labs that were drawn as</p>		

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	<p>resident to bed immediately following meals."</p> <p>An "Investigation Report," submitted to ISDH on 11/15/11 reporting a fall on that date, indicated the following:</p> <p>"6:45 P.M. [Resident's name] was wheeled from North dining room to the North nurse station. He was just adjacent to the station, close to the pass-through for staff to enter and exit the station. He was within arms reach of the station. The intention of this position was for the Nurse [name] to be close to the resident until the nurse's aid could finish moving people out of the dining room and assist [resident] to prepare to lay down in his room...."</p> <p>7:00 P.M. [Resident's name] began to lean forward, his chair alarm sounded. [Nurse's name] was seated behind the North Nurse station and responded to prevent the fall. She was approximately 3 steps away from [resident]. She placed her hands on his shoulder, instructed him to sit up and repositioned him with proper posture in his wheelchair... and returned to the nurse station.</p> <p>7:01 P.M. [Resident's name] leaned forward again. [Nurse] had her back turned while sending a fax, and did turn to</p>		<p>ordered.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>Findings will be presented to QAA Committee weekly x 6weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.</p>		

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	<p>respond to the alarm. At that same instant, [another nurse] was working about halfway down 800 hall and saw [resident] start to lean forward again. He responded, but could not reach the patient in time. [Resident's name] hit the floor head first from a sitting position...."</p> <p>7:02 P.M. ... found a laceration to forehead. Pressure was applied.... Ambulance was called...."</p> <p>In an interview on 12/2/11 at 10:30 A.M., the Administrator indicated he re-visited the investigation and determined the timeline need to be revised. He provided the new timeline which indicated the resident was brought to the Nurse's Station at 6:15 P.M., and first leaned forward, setting off his alarm, at 6:30 P.M.</p> <p>Although the timeline was revised, both reports indicated the nurse did not take the resident to his room and place him in bed immediately following his meal. The resident remained at the nurse's station for 15 minutes. After the resident set off his personal alarm by leaning forward, he still was not taken to his room and placed in bed.</p> <p>2. On 12/1/11 at 8:30 A.M., R.N. #4 was observed administering medications to</p>				

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	<p>Resident #60.</p> <p>The December 2011 M.A.R. [Medication Administration Record] indicated the resident's medications included, but were not limited to, the following: Norvasc 10 mg. [milligrams] 1 daily--"Hold if SBP [systolic blood pressure] is less than 100 or HR [heart rate] is less than 60;" and Metoprolol 50 mg. 1 daily--"Hold if SBP is less than 100 or HR is less than 60."</p> <p>The nurse was observed to administer all of the medications without checking the resident's blood pressure or heart rate.</p> <p>In an interview on 12/1/11 at 8:45 A.M., R.N. #4 indicated she was supposed to check the blood pressure and heart rate before giving the medications.</p> <p>The clinical record for Resident #60 was reviewed on 12/1/11 at 2:50 P.M. Diagnoses included, but were not limited to, coronary heart disease and hypertension.</p> <p>The December, 2011 Physician's Order recap [recapitulation] sheet listed orders for the following blood pressure medications: 11/4/10--Amlodipine Besylate [Norvasc] 10 mg. 1 daily--"Hold if SBP is less than 100 or HR is less than 60;" 11/4/11--Metoprolol 50 mg. 1 daily-</p>				

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	<p>-"Hold if SPB is less than 100 or HR is less than 60;" 11/4/11--Clonidine 0.1 mg. three times a day; and Ramipril 10 mg. 1 daily.</p> <p>The October 2011 M.A.R. had blood pressures recorded on 12 of 31 days, and heart rate recorded for 9 days.</p> <p>The November 2011 M.A.R. had blood pressures recorded on 14 of 30 days, and heart rate recorded for 11 days.</p> <p>3. In an interview during the initial orientation tour on 11/28/11 at 10:10 P.M., R.N. #2 indicated Resident #61 had experienced recent falls, and required the use of bed and wheelchair alarms.</p> <p>The clinical record for Resident #61 was reviewed on 11/28/11 at 12:07 P.M. Diagnoses included, but were not limited to, chronic kidney disease, syncope and collapse, atrial fibrillation, and hypertension.</p> <p>The November 2011 Physician's Order recap [recapitulation] sheet listed orders which included the following blood pressure medication: 6/24/11--Atenolol 25 mg. [milligrams] 1 daily--"Hold for HR [heart rate] less than 60; SBP [systolic blood pressure] less than 120."</p>				

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	<p>The August 2011 M.A.R. [Medication Administration Record] had blood pressures recorded on 10 of 31 days. On 7 of those 10 days, the systolic blood pressure was less than 120, but there was no evidence the medication had been held. A heart rate was recorded on 2 days.</p> <p>The September 2011 M.A.R. had blood pressures recorded on 10 of 30 days. On 7 of the 10 days, the systolic blood pressure was less than 120, but there was no evidence the medication was held. The heart rate was recorded on 10 days.</p> <p>The October 2011 M.A.R. had blood pressures recorded on 14 of 31 days. On 8 of the 14 days, the systolic blood pressure was less than 120, but there was no evidence the medication was held. The heart rate was recorded on 14 days.</p> <p>The November 2011 M.A.R. had blood pressures recorded on 16 of 30 days. On 10 of the 16 days, the systolic blood pressure was less than 120, but there was no evidence the medication was held. The heart rate was recorded on 12 days.</p> <p>In an interview on 12/1/11 at 8:45 A.M., R.N. #4 indicated the blood pressure and heart rate were to be checked prior to administering blood pressure medications which had "Hold" parameters.</p>				

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	<p>4. The clinical record of Resident #39 was reviewed on 11/28/11 at 12:15 P.M.</p> <p>Diagnoses for Resident #39 included, but were not limited to, dementia with delusions, depression and history of venous thrombosis (DVT).</p> <p>A physician's order, dated 11/1/11, indicated Resident #39 was to have a PT/INR (a blood test for clotting time) weekly on Mondays and Coumadin (a blood thinner) 4 mg (milligrams) everyday at 4:00 P.M.</p> <p>A Plan of Care for "Anticoagulant therapy to treat hx (history) of DVT...", dated 11/7/11, indicated one of the interventions was to "Review lab reports and report results to physician."</p> <p>A review of lab results indicated no PT/INR results for 11/14/11.</p> <p>During an interview with RN #8, on 12/2/11 at 12:15 P.M., she indicated the PT/INR due on 11/14/11 was not done.</p>	F0282	<p>F282 E</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #80's MD orders reviewed and care plan was modified to reflect the appropriate fall interventions. RNs #4 will be reeducated on following proper parameters for administering blood pressure medications as well as tracking lab results.</p> <p>Resident #39 had her PT/INR drawn in the hospital on 11/19/11 and it was found to be within therapeutic limits.</p> <p>Resident #60 and #61 did have their B/P measured at the time of survey and found to be within normal limits.</p> <p>The medication error for Resident #106 was investigated and concluded by the DON. A Pain Re-Assessment was completed, resident was offered alternative pain medications but refused. Resident experienced no untoward reactions from medication error.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will</u></p>	01/01/2012	

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			<p><u>be taken?</u></p> <p>Residents with MD orders for Anti-Hypertensive medication have the potential to be affected. Residents requiring fall interventions and are frequent falls have the potential to be affected. Residents with MD orders for Routine Pain medications have the potential to be affected. Residents with ordered labs have the potential to be affected. These residents will be identified, MD orders reviewed and care plans will be updated as necessary.</p> <p><u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed nurses will be in-serviced on the following: ·Rights of Medication Administration ·Medication Administration Procedure ·Fall Guidelines and ·Lab Tracking.</p> <p>ADNS or designee will conduct random medication administration observations a minimum of 10 times per week to assure medication parameters are followed as ordered. ADNS or designee will also conduct random observations at</p>		

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	<p>5. On 11/28/11 at 10:55 A.M., tour of the facility was initiated with Registered Nurse #2. Resident #106 was identified as a new admission with chronic pain who received Demerol injections at home prior to admission.</p> <p>On 11/30/11 at 1:30 P.M., Resident #106's record was reviewed. Diagnoses included, but were not limited to, cellulitis leg, weakness, hypertension, pain, anemia, and esophageal reflux.</p> <p>An "Admission Physician Orders" dated 11/18/11 included, but was not limited to, "Demerol HCL 100 milligrams by mouth</p>		<p>least five times per week x6 weeks to ensure fall prevention devices are utilized per plan of care.</p> <p>Director of Care Delivery (DCD) or designee will monitor daily lab tracking process x 6 weeks to assure labs that were drawn as ordered.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>Findings will be presented to QAA Committee weekly x 6weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.</p>		

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	<p>every 4 hours as needed for pain..."</p> <p>A "Controlled Substance Proof-Of-Use Record" included, but was not limited to, "Meperidine [Demerol] 50 milligrams, take 2 tablets equal 100 milligrams by mouth every 4 hours as needed... date 11/29/11 at 2:00 P.M., number of tablets or amount 2, amount remaining 28... date 11/29/11 at 4:00 P.M., number of tablets or amount 2, amount remaining 26..."</p> <p>In an interview on 12/1/11 at 11:45 A.M., the DoN indicated she would investigate the medication error.</p> <p>In an interview on 12/1/11 at 3:10 P.M., the DoN indicated there was a medication error and she would discuss with nursing.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to complete a comprehensive bowel assessment for a resident with bowel medications. The deficient practice impacted 1 of 23 residents reviewed related to bowel management. [Resident #61]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 11/28/11 at 10:10 A.M., R.N. #2 indicated Resident #61 had experienced falls and required the use of bed and wheelchair alarms, had a recent urinary tract infection, and received an antidepressant medication.</p> <p>The clinical record for Resident #61 was reviewed on 11/28/11 at 12:07 P.M. Diagnoses included, but were not limited to, history of syncope and collapse, debility, chronic kidney disease, morbid obesity, anxiety, depression, fibromyalgia, history of a C-2 spinal vertebra fracture, hemorrhoids, and constipation.</p> <p>The November 2011 Physician's order recap [recapitulation] sheet indicated the</p>	F0309	<p>F309 D</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Resident #61's medications and clinical record was reviewed; a comprehensive bowel assessment was also completed. Resident #61's care plan was updated to reflect the proper interventions and management of bowel function.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u></p> <p>All residents have the potential to be affected. <u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed Nurses will be in-serviced on guidelines for monitoring for acute change in condition including pertinent</p>	01/01/2012	

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	<p>resident had orders for a routinely scheduled pain medication of Oxycodone 5 mg. [milligrams] 1 by mouth every 6 hours; and P.R.N. [as needed] bowel medications of Senna Plus 2 tablets daily [ordered 6/29/11], Miralax 17 Gm. [grams] with 8 ounces of water daily [ordered 6/24/11], and Milk of Magnesia 10 ml. [milliliters] every 12 hours [ordered 6/29/11].</p> <p>The resident did not have any routine bowel medications ordered, and the P.R.N. medications had no parameters or specific directions on progression of use.</p> <p>On 11/21/11, the Nurse Practitioner ordered another P.R.N. bowel medication of Dulcolax Suppository per rectum 1 daily.</p> <p>The August 2011 M.A.R. [Medication Administration Record] indicated the resident had received 1 dose of M.O.M. on 8/1/11, and a dose of the Senna Plus on 8/1, 2, 4, and 5.</p> <p>The September 2011 M.A.R. indicated the resident received 1 dose of Senna Plus on 9/1 and 2.</p> <p>The October 2011 M.A.R. indicated no doses of any of the bowel medications had been given.</p>		<p>documentation, use of critical pathway guidelines, and physician notifications.</p> <p>Licensed Nurses will also be in-serviced on the guidelines for monitoring bowel movement status of residents, transcription of MD orders for bowel medication parameters including pertinent documentation and follow up.</p> <p>The Director of Care Delivery or designee will monitor weekly x 6 weeks nurses compliance with completion of bowel evaluations and administering bowel medications according to ordered parameters.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>Findings will be presented to QAA Committee weekly x 6weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.</p>	

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	<p>The November 2011 M.A.R. indicated the resident received a dose of M.O.M. on 11/7, 8, 11, 16, and 23; a dose of Miralax on 11/6; and a dose of Senna Plus on 11/6, 11, and 16.</p> <p>A comprehensive bowel history and bowel management assessment was not found in the record</p> <p>In an interview on 12/1/11 at 3:30 P.M., the Director of Nursing indicated the facility did not do bowel assessments, but used the toileting plan and B.M. [bowel movement] records to follow a resident on a daily basis.</p> <p>In a further interview on 12/2/11 at 11:45 A.M., the Director of Nursing indicated she had obtained additional information about Resident #61's bowel status--the resident had a past history of loose stools which were negative for C-Diff [Clostridium difficile], continued to have soft stools even though receiving narcotic pain medication which could cause constipation, and had a diagnosis of irritable bowel syndrome. She did not indicate where this diagnosis was located. The Director of Nursing also indicated that when the Nurse Practitioner examined the resident on 11/21/11, the Nurse Practitioner determined the resident</p>			

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F0322 SS=D	<p>had some abdominal distention and thought she needed the suppository. The resident ultimately chose to refuse the suppository.</p> <p>At the final exit on 12/2/11 at 5:00 P.M., a comprehensive bowel history and management assessment for this resident, collecting and summarizing all of the past and current information in order to determine an effective plan of care, was not found or provided for review.</p> <p>3.1-37(a)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on interview and record review, the facility failed to track actual gastrostomy tube feeding amounts for a resident who had a history of weight loss and a recent history of unplugging or turning off his tube feeding pump for 1 of 3 residents</p>	F0322	F322 D <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #69's MD orders were reviewed and care plan was updated to reflect current status. Dietitian	01/01/2012

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	<p>reviewed who received gastrostomy tube feedings in a sample of 23 residents. [Resident #69]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 11/28/11 at 10:27 A.M., R.N. #2 indicated Resident #69 received all of his fluids and nutrition by gastrostomy tube feedings due to gastroesophageal cancer, and had experienced weight issues because he would unhook, disconnect, or turn off the feeding pump.</p> <p>The clinical record for Resident #69 was reviewed on 12/2/11 at 9:30 A.M. Diagnoses included, but were not limited to, oral/pharynx cancer in situ, gastro-esophageal reflux disease, gastrostomy, status post Nissen fundoplication, and dysphagia.</p> <p>On 9/30/11, the physician ordered, "Tube feed: Two Cal HN 200 ml. [milliliters] bolus via pump every 4 hours. On at 12:00 A.M./Off at 6:00 A.M." A previous order on 8/31/11 indicated "Tube feed: Two Cal HN 250 ml. bolus via pump at 400 ml./hour at 1:00 P.M. and 6:00 P.M."</p> <p>In an interview on 12/2/11 at 3:00 P.M., R.N. #2 indicated the resident was</p>		<p>has re-assessed resident's nutritional needs and recommendations have been followed as ordered. Resident #69's weight is stable. Interventions are in place to assure nutritional needs are met.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u></p> <p>Residents receiving Enteral Feedings have the potential to be affected. Charts will be audited and care plans updated to assure nutrition needs are adequate and care needs are planned. <u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Nursing staff will be in-serviced on the guidelines for the care of a resident receiving Enteral Feedings. The ADNS or designee will monitor residents receiving Enteral Feedings 3x weekly to ensure MD orders are followed. <u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u> Findings will be presented to QAA Committee weekly x 6week, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.</p>		

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	<p>receiving a continuous tube feeding from 12:00 A.M. to 6:00 A.M., for a total amount of 1200 cc. [cubic centimeters] [200 cc. per hour for 6 hours]. The bolus feedings at 1:00 P.M. and 6:00 P.M. would add an additional amount of 500 cc. feeding, so that the resident should receive a total amount of 1700 cc. tube feeding every 24 hours.</p> <p>The "Nurse's Notes" from 9/25/11 through 12/2/11 indicated the resident had unhooked or clamped the feeding tube, or turned off the pump on 10/13/11 at 3:00 A.M.; 10/21/11 at 3:00 A.M.; 10/22/11 at 2:30 A.M.; 10/31/11 at 12:30 A.M.; 11/5/11 at 5:15 A.M.; 11/7/11 at 4:45 A.M.; 11/9/11 at 2:00 A.M., 3:00 A.M., and 2:00 P.M.; and 11/22/11 at 6:00 A.M.</p> <p>A "Nurse's Notes" on 11/8/11 at 10:30 P.M. indicated the resident had refused his 6:00 P.M. bolus feeding. The 11/9/11 note indicated the resident "did receive the full feeding but not [water] flush." The note on 11/22/11 indicated the pump feeding ran approximately 3 hours of the 6 hours scheduled.</p> <p>Although the October and November 2011 M.A.R.s [Medication Administration Records] indicated the order for the feedings, there were no actual amounts documented in each space,</p>				

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F0323 SS=G	<p>just the initials of the administering nurse.</p> <p>In an interview on 12/2/11 at 3:15 P.M., the Director of Nursing indicated the facility did not track the specific amounts of gastrostomy feedings received by a resident. She indicated, "Most residents on a G-tube get what's ordered."</p> <p>3.1-44(a)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure care was planned and/or implemented to prevent falls. The deficient practice affected 2 of 9 residents reviewed for falls in a sample of 23. [Resident #25, Resident #80] Resident #25 fell, the plan of care was not revised with interventions to prevent further falls, and Resident #25 subsequently fell and sustained a neck fracture.</p> <p>Findings include:</p>	F0323	<p>F323 G <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #25 no longer resides at the facility. Resident #80's care plan has been updated to include modified interventions for fall prevention. <u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u> Residents with fall activity have</p>	01/01/2012	

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	<p>1. Record review for Resident #25 was completed on 12/1/11 at 1:45 P.M. Diagnoses included, but were not limited to, dementia, diabetes, anemia, depression, and dysphagia.</p> <p>The care plan for Resident #25, dated 11/21/08 ,with revision date of 9/12/11 indicated, "...At risk for falls due to Disease process of dementia, antidepressant medication diabetes medication. Res (resident) puts self on floor and continues (sic) to be non compliant with call light for transfer assistance and attempts to self transfer...."</p> <p>Interventions were as follows:</p> <p>"...11/25/08: Notify physician and family/responsible party of any falls, provide adequate lighting, Have commonly used articles within easy reach, reinforce need to call for assistance. 5/10/11: Administer medication per physician 's order, encourage to transfer and change positions slowly. 6/6/11: Observe and report changes in gait/balance 9/12/11: Ensure that sensor alarm is in place when in w/c (wheelchair) and bed,. Ensure wheelchair is out in hallway when res. (resident) in bed. Implement use of preventative device sensor alarm to bed and wc, encourage to have wife call for</p>		<p>the potential to be affected. A chart audit was completed to identify other residents at risk for falls. Fall activity will be reviewed for each of these residents and the care plans audited and modified as necessary to ensure proper interventions for fall prevention are in place. <u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Licensed Nurses will be in-serviced on the Fall Guidelines with specific emphasis on following care plan interventions. Certified nursing staff will be in-serviced on Fall Prevention and following care plan interventions. The ADNS or designee will review the fall activity for all residents identified 5 x weekly x 6 weeks and ensure care plans for these residents are modified with proper interventions for fall prevention as necessary <u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u> Findings will be presented to QAA Committee weekly x 6week, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.</p>				

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	<p>assistance if res needs help with transfer. Encourage wife to get staff when re needs to be toileted or get out of bed ..."</p> <p>Nursing notes indicated the resident had a fall on 8/25/11 at 2:30 A.M. The nursing notes at this time indicated, " ...Res. Was found by writer sitting on floor in his room in upright position by his w/c...." There was no update of care plan done at this time regarding interventions for this fall.</p> <p>Nursing notes for Resident #25 on 9/6/11 at 11 P.M. indicated, "...While writer was receiving report from prior shift CNA 's (certified nursing aid) alerted that Res. Had fallen from his w/c onto floor face down, D/t (due to) possible head trauma Res was not removed from floor, v/s (vital signs) taken, Res. Was conscious et (and) alert et talking, 911 notified, family notified another nurse spoke with son ... stated he will meet Res. At hospital, MD office notified, attempted to call DCD [Direct Care Director] no reply. Notified DON ..., papers sent with ambulance , Hospital ER called with report will wait for reply from Hospital9/7/11 2:20 A.M. Received call from HOSp. ER spoke with ..., Res is being admitted with Fx (fractured) neck, stated Res. Remains alert Will pass on to management & next shift"</p>			

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	<p>Resident #25 fell, the plan of care was not revised with interventions to prevent further falls, and the resident fell again and sustained a neck fracture.</p> <p>A document titled HCR ManorCare Investigation Report indicated on 9/7/11 under summary of alleged incident: "...Resident on floor next to BR (bathroom) in room with hematoma to head ...Conclusion: Resident attempted to take self to BR s with line over it (without assist). Resident is one assist for transfers. Resident lost his balance and fell according to wife. Hematoma to head-Resident sent to ER for evaluation & tx (treatment). Since resident is not asking for help, sensor alarms or tab alarms will be used upon return to remind resident he needs assistance...."</p> <p>A MDS (Minimum Data Set) assessment (a tool used to assess different care areas for residents), dated 9/16/11, indicated the resident was unable to make decisions for himself.</p> <p>In an interview with the DON (Director of Nursing) on 12/2/11 at 3:35 P.M. regarding Resident #25, she indicated when the resident was found on floor on 8/25/11, this was considered a fall and should be on care plan. She indicated she</p>			

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	<p>did not know why there was no updated interventions at that time.</p> <p>The DON indicated at the exit confrence on 12/2/11 at 5:00 P.M., they did labs and a psychiatric referral on 8/26/11 and this was their intervention for the resident's fall on 8/25/11.</p> <p>2. In an interview during the initial orientation tour on 11/28/11 at 10:40 A.M., R.N. #2 indicated Resident #80 had experienced a recent fall, sustaining a laceration to his forehead. She indicated he had been in the facility for a few months, but had been moved recently to his current room and wing. The nurse indicated the resident had bed and wheelchair alarms, a low bed with floor mats, and bed bolsters because he continued to try to climb out of bed or transfer himself out of the wheelchair without assistance.</p> <p>The clinical record for Resident #80 was reviewed on 12/1/11 at 10:45 A.M. Diagnoses included, but were not limited to, senile dementia, depressive disorder, anxiety state, history of a left hip hemi-arthorplasty, history of chronic kidney disease, hypertension, and atrial fibrillation.</p> <p>The quarterly M.D.S. [Minimum Data Set] assessment, dated 11/7/11, indicated</p>			

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	<p>the resident had clear speech, was able to express ideas and wants and understood verbal content, and had a "Brief Interview for Mental Status [BIMS]" score of "03" [severe impairment for cognitive patterns]. The assessment also indicated the resident required extensive physical assistance of 1 staff person for all daily care, including transfers.</p> <p>Electronic record information indicated the resident had falls on 8/25/11 at 4:15 P.M., 9/6/11 at 8:15 P.M., and 9/9/11 at 1:15 P.M. The assessment on 9/6/11 indicated, "... Patient wanting to lay down soon after meals..."</p> <p>A Care Plan addressing falls was originally initiated on 8/10/11, and included an intervention of "bed in low position." On 8/25/11, the following interventions were added: "Ensure that tab alarm with shortened string is in place when in wheelchair/bed; Provide assist to transfer and ambulate as needed; reinforce need to call for assistance."</p> <p>On 9/6/11, the following Care Plan intervention was added: "Nursing to put resident to bed immediately following meals."</p> <p>An "Investigation Report," submitted to ISDH on 11/15/11 reporting a fall on that</p>				

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	<p>date, indicated the following:</p> <p>"6:45 P.M. [Resident's name] was wheeled from North dining room to the North nurse station. He was just adjacent to the station, close to the pass-through for staff to enter and exit the station. He was within arms reach of the station. The intention of this position was for the Nurse [name] to be close to the resident until the nurse's aid could finish moving people out of the dining room and assist [resident] to prepare to lay down in his room...."</p> <p>7:00 P.M. [Resident's name] began to lean forward, his chair alarm sounded. [Nurse's name] was seated behind the North Nurse station and responded to prevent the fall. She was approximately 3 steps away from [resident]. She placed her hands on his shoulder, instructed him to sit up and repositioned him with proper posture in his wheelchair... and returned to the nurse station.</p> <p>7:01 P.M. [Resident's name] leaned forward again. [Nurse] had her back turned while sending a fax, and did turn to respond to the alarm. At that same instant, [another nurse] was working about halfway down 800 hall and saw [resident] start to lean forward again. He responded, but could not reach the patient</p>				

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	<p>in time. [Resident's name] hit the floor head first from a sitting position...."</p> <p>7:02 P.M. ... found a laceration to forehead. Pressure was applied.... Ambulance was called...."</p> <p>In an interview on 12/2/11 at 10:30 A.M., the Administrator indicated he re-visited the investigation and determined the timeline needed to be revised. He provided the new timeline which indicated the resident was brought to the Nurse's Station at 6:15 P.M., and first leaned forward, setting off his alarm, at 6:30 P.M.</p> <p>Although the timeline was revised, both reports indicated the nurse did not take the resident to his room and place him in bed immediately following his meal. The resident remained at the nurse's station for 15 minutes. After the resident set off his personal alarm by leaning forward, he still was not taken to his room and placed in bed.</p> <p>3.1-45(a)(2)</p>				

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F0329 SS=D	<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 medication prescribed on an as-needed basis was administered based on specific indications for use in accordance with a plan of care for 1 of 2 residents reviewed related to as needed medication use in a sample of 23 residents. [Resident # 68]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 11/28/11 at 10:27 A.M., R.N. #2 indicated Resident #68 had chronic pain issues.</p>	F0329	<p>F329 D</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- The written parameters for Resident # 68's PRN medication administration were modified to clarify how to determine which PRN doses are to be given and when they are to be given around scheduled doses.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be</u></p>	01/01/2012			

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	<p>The clinical record for Resident #68 was reviewed on 11/29/11 at 10:37 A.M. Diagnoses included, but were not limited to, diabetes, incomplete quadriplegia, spinal cord injury, and idiopathic neuropathy.</p> <p>The November 2011 physician order recap [recapitulation] sheet indicated the resident received routine Baclofen and Dantrolene Sodium as skeletal muscle relaxant medications; and routine narcotic pain medications. In addition, the resident was receiving routine doses of Gabapentin [Neurontin], an anticonvulsant medication which has an unlabeled use as an adjunct treatment for pain.</p> <p>On 9/17/11, the Gabapentin was ordered to be given at 300 mg. [milligrams] three times a day. It was originally scheduled at 8:00 A.M., 2:00 P.M., and 8:00 P.M. On 11/28/11, the schedule was changed so that the Gabapentin was given at 7:00 A.M., 2:00 P.M., and 10:00 P.M.</p> <p>On 9/18/11, the physician also ordered: "Gabapentin 300 mg. 1 capsule three times a day P.R.N. [as needed];" "300 mg. 1 capsule at H.S. [bedtime] P.R.N.;" and "100 mg. 1 capsule twice a day P.R.N."</p> <p>There were no specific written parameters</p>		<p><u>identified and what actions will be taken?</u></p> <p>Residents who have orders for routine pain medications that are the same ordered medication for prn breakthrough have the potential to be affected.</p> <p>A chart audit will be completed to identify these residents and the written parameters for medication administration will be reviewed for clarity and compared to the Medication Administration Record for compliance with the parameters.</p> <p><u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed Nurses will be in-serviced on Order Transcription process.</p> <p>The DON or designee will audit identified residents 3 x weekly for appropriate written parameters for medication administration and compare them to the Medication Administration Record for compliance with the parameters.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p>		

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	<p>or indicators indicating how to determine which of the P.R.N. doses were to be given, or when they were to be given around the scheduled doses.</p> <p>In an interview on 12/1/11 at 2:45 P.M., R.N. #4 indicated she had not given any P.R.N. doses of the Gabapentin during the day. She believed they were mostly given during the night, when no scheduled doses were due. After reviewing the November, 2011 M.A.R. [Medication Administration Record], she indicated it was difficult to tell from the times entered on the form when the medication had been given.</p> <p>The October 2011 M.A.R. indicated the P.R.N. Gabapentin 300 mg. was given on: 10/14 at 2 A.M.; 10/16 at 1 A.M.; 10/17 at 4 A.M.; 10/23 at 11:30 P.M.; 10/28 at 2 A.M.; 10/30 at 11:45 [no A.M. or P.M. marked]; 10/30 at [unreadable]; 10/31 at "2"; and 10/31 at "2."</p> <p>The P.R.N. Gabapentin 300 mg. at H.S. was marked as given on 10/31/11, with no time listed.</p> <p>The P.R.N. Gabapentin 100 mg. was marked as given on 10/2 at 4:30 A.M.; 10/10/11 at 2 A.M.; 10/11/11 at 4:30 A.M.; 10/14 at 2 A.M.; and 10/27/11 at 2 A.M.</p>		Findings will be presented to QAA Committee weekly x 6week, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs.	

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	<p>There were no entries on the reverse side of the M.A.R. in the section for "Nurse's Medication Notes."</p> <p>The November 2011 M.A.R. indicated the resident received the P.R.N. Gabapentin 300 mg. on 11/4/11 at 4 P.M.; 11/6/11 at either 3:30 or 7:30 without A.M. or P.M. indicated, and with one number overwritten on another; 11/7/11 at 10 A.M.; 11/12/11 at 12:30 with no A.M. or P.M.; 11/16/11 at 2 A.M. and 7 P.M. [one hour before the scheduled dose at 8:00 P.M.]; 11/18/11 at "6" with no A.M. or P.M.; 11/19/11 at 12:30 [unreadable if A.M. or P.M.]; 11/20/11 at "10" [unreadable for A.M. or P.M.]; 11/25/11 at "11" with no A.M. or P.M.; 11/26/11 at 12 A.M. and 10 P.M.</p> <p>No doses of the P.R.N. Gabapentin 300 mg. at H.S. were marked as given.</p> <p>No doses of the P.R.N. Gabapentin 100 mg. twice a day were marked as given.</p> <p>There were no entries on the reverse side of the M.A.R. in the section for "Nurse Medication Notes."</p> <p>In an interview on 12/2/11 at 3:15 P.M., R.N. #2 indicated the resident just tells nursing staff when he wants a dose of the P.R.N. Gabapentin, and which one of</p>				

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F0371 SS=E	<p>P.R.N. Gabapentin capsules he wants. She indicated the staff just gives him that dose.</p> <p>3.1-48(a)(4)</p> <p>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</p> <p>Based on observation and interview, the facility failed to date open liquid in the refrigerator. The deficient practice impacted 1 of 1 facility kitchen and had the potential to affect 107 of 111 residents of the facility who consume food from the kitchen.</p> <p>Findings include:</p> <p>On 11/28/11 at 10:10 A.M., tour of the kitchen was initiated with the Dietary Manager.</p> <p>On 11/28/11 at 10:15 A.M., 4 trays with glasses of liquid were observed in the refrigerator. Each glass had a plastic lid. No date was observed on the individual</p>	F0371	<p>F371 E</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>The open liquid in the refrigerator was immediately dated with the appropriate date after it was identified.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u></p> <p>All residents have the potential to be affected. <u>What measure will be put into</u></p>	01/01/2012	

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	<p>glasses of liquid.</p> <p>At this time in an interview, the Dietary Manager identified the liquids as tomato juice, prune juice, and milk. She also indicated the expectation of the kitchen staff was to label each tray with the date and time the drink was prepared.</p> <p>3.1-21(i)(2)</p>		<p><u>place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The dietician or designee will make kitchen rounds 3 x weekly to ensure open liquids are dated appropriately.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>Findings will be presented to QAA Committee weekly x 3 weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs. QAA committee will review findings and determine need for further monitoring</p>		

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure the pharmacy provided timely the prescribed Demerol to a resident. The deficient practice impacted 1 of 23 residents reviewed related to provision of medications. [Resident #106]</p> <p>Findings include:</p> <p>On 11/28/11 at 10:55 A.M., tour of the facility was initiated with Registered Nurse #2. Resident #106 was identified as a new admission with chronic pain who received Demerol injections at home prior to admission.</p> <p>On 11/29/11 at 11:00 A.M., during an</p>	F0425	<p>F 425 D</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>The prescribed Demerol was ordered and refilled for resident #106.</p> <p><u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u></p> <p>- Residents with orders for C-2 PRN medications have the potential to be affected.</p>	01/01/2012			

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	<p>interview, Resident #106 indicated she needed pain medication and had been out since last night. At that time in an interview, the director of nursing [DoN] indicated the resident's pain medication was drop shipped and would arrive soon.</p> <p>On 11/30/11 at 1:30 P.M., Resident #106's record was reviewed. Diagnoses included, but were not limited to, cellulitis leg, weakness, hypertension, pain, anemia, and esophageal reflux. Resident #106's original admission date was 10/21/11 and current readmission date was 11/18/11.</p> <p>An "Admission Physician Orders" dated 10/21/11 included, but was not limited to, "Demerol HCL 100 milligrams by mouth every 4 hours as needed for pain..."</p> <p>An "Admission Physician Orders" dated 11/18/11 included, but was not limited to, "Demerol HCL 100 milligrams by mouth every 4 hours as needed for pain..."</p> <p>A "Controlled Substance Proof-Of-Use Record" included, but was not limited to, "Meperidine [Demerol] 50 milligrams, take 2 tablets equal 100 milligrams by mouth every 4 hours as needed... date 11/29/11 at 6:00 A.M., number of tablets or amount 2, amount remaining 0..."</p>		<p>Chart audit was done to identify all residents with C-2 PRN medications. And an audit conducted to ensure a sufficient supply was in stock and meds ordered as necessary.</p> <p><u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed Nurses will be in-serviced on the procedures for ordering C-2 meds from pharmacy.</p> <p>Identified residents will be audited three times weekly for 3 weeks by the DON or designee to ensure proper quantities of the medications exist and are being ordered appropriately.</p> <p><u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u></p> <p>Findings will be presented to QAA Committee weekly x 3 weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs. QAA committee will review findings and determine need for further monitoring</p>		

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	<p>A "Physician's Orders" dated 11/29/11 at 8:15 A.M., included, but was not limited to, "Discontinue previous Demerol order, Demerol 50 milligrams 2 by mouth every 4 hours while awake, and Demerol 50 milligrams 2 by mouth every 4 hours as needed at night..."</p> <p>A "Nurses Notes" dated 11/29/11 at 1:00 P.M., included, "N.O. [new order] to schedule pain meds [medications] during waking hours and PRN [as needed] during the NOC [night]."</p> <p>A "Controlled Substance Proof-Of-Use Record" included, but was not limited to, "Meperidine [Demerol] 50 milligrams, take 2 tablets equal 100 milligrams by mouth every 4 hours as needed... date 11/29/11 at 2:00 P.M., number of tablets or amount 2, amount remaining 28... date 11/29/11 at 4:00 P.M., number of tablets or amount 2, amount remaining 26..."</p> <p>In an interview on 12/1/11 at 11:45 A.M., the DoN indicated the resident was not given pain medication from 6:00 A.M. on 11/29/11 to 2:00 P.M. on 11/29/11 related to pharmacy not delivering on-time.</p> <p>On 12/1/11 at 12:10 p.m., a document, "Nurse's Notes," was received from the DON. At that time, the DON indicated the nurse's notes were updated with late</p>				

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	<p>entries regarding the incident with Resident #106's pain mediations. The document included, but was not limited to, "12/1/11 late entry for 11/29/11 6:30 A.M. was informed Demerol had been ordered and would be in next tote which comes before 7:00 A.M... 11/29/11 7:00 A.M. totes arrived and Demerol not in it... 10:00 A.M. assessed for s/s [signs and symptoms] of pain, none noted... Resident #106 asked when Demerol would be available... resident redirected to adm [Administrator]... .. 2:00 P.M. meds arrived and immediately gave resident 2 Demerol by mouth...."</p> <p>3.1-25(a)</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.</p> <p>Based on record review and interview, the facility failed to complete the second step of the Tuberculin (TB - tuberculosis) screening of a new resident and failed to have a chest x-ray done six months prior</p>	F0441	F 441 D <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #39 received 2 nd Step PPD and	01/01/2012

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	<p>to admission to the facility. This impacted 1 of 5 residents reviewed for TB screening in a sample of 23. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record of Resident #39 was reviewed on 11/28/11 at 12:15 P.M.</p> <p>Resident #39 was admitted to the facility on 11/1/11.</p> <p>Diagnoses for Resident #39 included, but were not limited to, dementia with delusions, depression and history of venous thrombosis (DVT).</p> <p>A Medication Administration Record, dated for the month of November 2011, indicated the second step TB skin test was administered 11/19/11. There was no indication the skin test was read.</p> <p>A facility document for the recording of TB skin testing indicated the second step was done on 11/19/11. There were no results for the second step.</p> <p>A review of chest x-rays for Resident #39 indicated the last chest x-ray, prior to admittance to the facility, was on April 3, 2011.</p>		<p>documentation is now in chart. MD was called with update, orders received and noted. <u>How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?</u> Newly admitted or readmitted residents have the potential to be affected. Clinical chart reviews have been completed for residents that were admitted within the past 2 weeks to assure compliance with administration of 2 step TB testing and having a valid Chest Xray. <u>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>Licensed Nurses and Admissions Director will be in-serviced on the State guidelines and requirements to have a valid Chest X ray (not greater than 6 months) at the time of admission to facility.</p> <p>Licensed Nurses will be in-serviced on the TB Testing Procedure. Admission Director is responsible to assure each new admission has a valid Chest X ray prior to being admitted to facility. Administration or designee will monitor 5 x weekly x 6 weeks admission paper work to assure compliance. ADNS or designee will monitor 5x weekly x 6 weeks documentation on MAR to assure TB testing is completed as</p>		

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	<p>During an interview with the Director of Nursing, on 11/30/11 at 10:30 A.M., she indicated the second step TB skin test was given but there was no record it was read.</p> <p>3.1-18(c) 3.1-18(e) 3.1-18(f)</p>		<p>ordered. . <u>How will the corrective action(s) be monitored to ensure the deficient practice does not recur?</u> Findings will be presented to QAA Committee weekly x 6 weeks, if non compliance is detected, the process will extend for 1 additional month during which 100% compliance occurs. QAA committee will review findings and determine need for further monitoring</p>		