

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2012
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NAME OF PROVIDER OR SUPPLIER  ALBANY HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 910 W WALNUT ST ALBANY, IN 47320
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 5, 6, 7, 8, 2012</p> <p>Facility number: 000309 Provider number: 155432 AIM number: 100288960</p> <p>Survey team: Betty Retherford, RN, TC Ginger McNamee, RN Karen Lewis, RN Delinda Easterly, RN</p> <p>Census bed type: SNF: 0 SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 8 Medicaid: 60 Other: 12 Total: 80</p> <p>Stage 2 Sample: 31</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March</p>	F0000	<p>This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Albany Health Care &amp; Rehabilitation Center agrees with the allegations and citations listed. Albany Health Care &amp; Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept the last date noted on this plan of correction as the facility's written credible allegation of compliance.</p>	
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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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	14, 2012 by Bev Faulkner, RN				

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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 ensure residents were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 2 of 3 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 22 and 64)</p> <p>Findings include:</p> <p>Review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 22 and 64 on 3/8/12 at 10:00 a.m., indicated the letters lacked information related to a list of items and services with charges for non-Medicare residents and what the resident's daily rate would be when</p>	F0156	<p>F156 Corrective action: Corrective action cannot be accomplished for residents #22 and 64 because the alleged deficient practice occurred in the past and the "Notice of Medicare Provider Non-Coverage" letters had already been mailed. The date the residents were to receive their non-coverage notification had passed prior to the facility receiving notice from the survey team that the letters lacked adequate information. Identification of other residents and corrective action: All residents who receive Medicare skilled services have the potential to be affected by the alleged deficient practice. Systemic changes: Future "Notice of Medicare Provider Non-Coverage" letters will contain required information. The IDT will be inserviced on the non-coverage letters. Monitoring:</p>	04/07/2012

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	<p>Medicare services were discontinued.</p> <p>During an interview on 3/8/12 at 10:50 a.m., the Administrator and Business Office Manager indicated they were not aware it was necessary to have this information listed on the non-coverage letters and would implement that procedure on future letters.</p> <p>3.1-4(f)(3)</p>		<p>The Administrator or Business Office Manager will review each notice prior to mailing. Results of monitoring will be reviewed monthly by the QA committee. Completion date: April 7, 2012</p>		

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F0223 SS=A	<p>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed regarding allegations of abuse. (Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 3/7/12 at 8:52 a.m.</p> <p>Resident #19's current diagnoses included, but were not limited to, colon cancer, cognitive impairment, depression, and anxiety.</p> <p>Review of a facility incident report provided by Director of Nursing (DoN), on 3/7/12 at 1:00 p.m., indicated the following:</p> <p>Incident date 2/29/12</p> <p>On 3/2/12 Certified Nursing Aide</p>	F0223	<p>F 223Corrective action: As soon as the DON was made aware of the allegation of abuse, CNA #2 was suspended pending the investigation. The reportable was sent to ISDH per regulation. CNA #2 was terminated upon completion of the investigation. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. Systemic changes: Employees have been inserviced on the abuse policy and their responsibility for reporting. New employees are in-serviced on the abuse policy during orientation. Monitoring: Interviews will be conducted with 5 randomly selected employees to determine their knowledge of the abuse policy. The Administrator or SSD will conduct the interviews each week for two months, then 5 randomly employee interviews will be conducted per month ongoing. Results of the interviews will be reviewed during the monthly QA meeting. Any recommendations made by the</p>	04/07/2012	

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	<p>(CNA) #1 reported to the DoN the allegation of abuse by CNA #2 to Resident #19 which occurred on 2/29/12. The CNAs were assisting Resident #19 from his chair to his bed. At that time, it became apparent that Resident #19 had a bowel movement in his brief. CNA #2 was alleged to have told Resident #19 "well this wouldn't have happened if you would let someone know, that's ridiculous." An investigation was started and CNA #2 was suspended immediately pending final investigation. CNA #2 was terminated on 3/5/12.</p> <p>During an interview with the Administrator and the DoN on 3/7/12 at 2:21 p.m., the DoN indicated the abuse allegation had not been reported to administration until 3/2/12. The DoN indicated CNA #1 was afraid of what CNA #2 might do if questioned by the nurse.</p> <p>Once aware of the abuse allegation, the facility followed their abuse policy and procedure in a timely and appropriate manner. This indicated there was a 2 day time period delay between the alleged abuse observation and report of the alleged abuse.</p> <p>On 3/7/12 at 2:32 p.m., the</p>		<p>committee will be followed. Completion date: April 7, 2012</p>		

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	<p>Administrator provided the revised 1/12, "Abuse, Neglect, and Misappropriation of Resident Property" policy. The policy indicated a resident has the right to be free from verbal abuse and must not be subjected to abuse by anyone, including facility staff.</p> <p>The purpose of the policy was to ensure resident rights are protected by providing a method for investigation and reporting of allegations of abuse.</p> <p>The policy indicated the definition of verbal abuse was the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability.</p> <p>The definition of mental abuse included, but was not limited to, humiliation, harassment, threats of punishment or deprivation.</p> <p>The policy interpretation and implementation indicated the staff would not commit verbal or mental abuse. The facility was to train employees through orientation and on-going sessions on abuse</p>				

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	<p>prohibition practices such as how staff should report their knowledge related to allegations without fear of reprisal. The facility was to ensure that all allegations of abuse were reported immediately to the Administrator of the facility.</p> <p>3.1-27(a)(1)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure</p>	F0225	F 225 Corrective action: As soon as the DON was made aware of the allegation of abuse, CNA #2	04/07/2012			

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	<p>the staff immediately reported an allegation of verbal abuse to the administrator as required for 1 of 3 residents reviewed regarding allegations of abuse. (Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 3/7/12 at 8:52 a.m.</p> <p>Resident #19's current diagnoses included, but were not limited to, colon cancer, cognitive impairment, depression, and anxiety.</p> <p>Review of a facility incident report provided by Director of Nursing (DoN), on 3/7/12 at 1:00 p.m., indicated the following:</p> <p>Incident date 2/29/12</p> <p>On 3/2/12 Certified Nursing Aide (CNA) #1 reported to the DoN the allegation of abuse by CNA #2 to Resident #19 which occurred on 2/29/12. The CNAs were assisting Resident #19 from his chair to his bed. At that time, it became apparent that Resident #19 had a bowel movement in his brief. CNA #2 was alleged to have told Resident #19 "well this wouldn't have happened if</p>		<p>was suspended pending the investigation. The reportable was sent to ISDH per regulation. CNA #2 was terminated upon completion of the investigation. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. Systemic changes: Employees have been inserviced on the abuse policy and their responsibility for reporting. New employees are in-serviced on the abuse policy during orientation. Monitoring: Interviews will be conducted with 5 randomly selected employees to determine their knowledge of the abuse policy. The Administrator or SSD will conduct the interviews each week for two months, then 5 randomly employee interviews will be conducted per month ongoing. Results of the interviews will be reviewed during the monthly QA meeting. Any recommendations made by the committee will be followed. Completion date: April 7, 2012</p>		

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	<p>you would let someone know, that's ridiculous." An investigation was started and CNA #2 was suspended immediately pending final investigation. CNA #2 was terminated on 3/5/12.</p> <p>During an interview with the Administrator and the DoN on 3/7/12 at 2:21 p.m., the DoN indicated the abuse allegation had not been reported to administration until 3/2/12. The DoN indicated CNA #1 was afraid of what CNA #2 might do if questioned by the nurse.</p> <p>Once aware of the abuse allegation, the facility followed their abuse policy and procedure in a timely and appropriate manner. This indicated there was a 2 day time period delay between the alleged abuse observation and report of the alleged abuse.</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the staff followed the facility policy and procedure for abuse for immediately reporting an allegation of abuse to the Administrator for 1 of 3 residents reviewed regarding allegations of abuse. (Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 3/7/12 at 8:52 a.m.</p> <p>Resident #19's current diagnoses included, but were not limited to, colon cancer, cognitive impairment, depression, and anxiety.</p> <p>Review of a facility incident report provided by Director of Nursing (DoN), on 3/7/12 at 1:00 p.m., indicated the following:</p> <p>Incident date 2/29/12</p> <p>On 3/2/12 Certified Nursing Aide</p>	F0226	<p>F 226 Corrective action: As soon as the DON was made aware of the allegation of abuse, CNA #2 was suspended pending the investigation. The reportable was sent to ISDH per regulation. CNA #2 was terminated upon completion of the investigation. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. Systemic changes: Employees have been inserviced on the abuse policy and their responsibility for reporting. New employees are in-serviced on the abuse policy during orientation. Monitoring: Interviews will be conducted with 5 randomly selected employees to determine their knowledge of the abuse policy. The Administrator or SSD will conduct the interviews each week for two months, then 5 randomly employee interviews will be conducted per month ongoing. Results of the interviews will be reviewed during the monthly QA meeting. Any recommendations made by the committee will be followed. Completion date: April 7, 2012</p>	04/07/2012			

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	<p>(CNA) #1 reported to the DoN the allegation of abuse by CNA #2 to Resident #19 which occurred on 2/29/12. The CNAs were assisting Resident #19 from his chair to his bed. At that time, it became apparent that Resident #19 had a bowel movement in his brief. CNA #2 was alleged to have told Resident #19 "well this wouldn't have happened if you would let someone know, that's ridiculous." An investigation was started and CNA #2 was suspended immediately pending final investigation. CNA #2 was terminated on 3/5/12.</p> <p>During an interview with the Administrator and the DoN on 3/7/12 at 2:21 p.m., the DoN indicated the abuse allegation had not been reported to administration until 3/2/12. The DoN indicated CNA #1 was afraid of what CNA #2 might do if questioned by the nurse.</p> <p>Once aware of the abuse allegation, the facility followed their abuse policy and procedure in a timely and appropriate manner. This indicated there was a 2 day time period delay between the alleged abuse observation and report of the alleged abuse.</p>				

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	<p>On 3/7/12 at 2:32 p.m., the Administrator provided the revised 1/12, "Abuse, Neglect, and Misappropriation of Resident Property" policy. The policy indicated a resident has the right to be free from verbal abuse and must not be subjected to abuse by anyone, including facility staff.</p> <p>The purpose of the policy was to ensure resident rights are protected by providing a method for investigation and reporting of allegations of abuse.</p> <p>The policy indicated the definition of verbal abuse was the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability.</p> <p>The definition of mental abuse included, but was not limited to, humiliation, harassment, threats of punishment or deprivation.</p> <p>The policy interpretation and implementation indicated the staff would not commit verbal or mental abuse. The facility was to train employees through orientation and</p>						

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	<p>on-going sessions on abuse prohibition practices such as how staff should report their knowledge related to allegations without fear of reprisal. The facility was to ensure that all allegations of abuse were reported immediately to the Administrator of the facility.</p> <p>3.1-28(a)</p>				

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident's dining needs were accommodated in a manner to maintain the resident's dignity for 1 of 1 randomly observed resident feeding self while in a Broda chair. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record for Resident #1 was reviewed on 3/6/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #1 included, but were not limited to, mental retardation with profound intellectual disabilities, convulsions, and congestive heart failure.</p> <p>A quarterly Minimum Data Set assessment, dated 1/23/12, indicated the resident required only limited assistance from one staff member for eating.</p> <p>A health care plan problem related to Resident #1's nutritional needs, dated</p>	F0241	<p>F241 Corrective action: Resident #1 has a tray for the broda chair during meals that maintains resident #1's dignity, accommodates resident #1's individual dining needs and enables resident #1 to self feed. Identification of other residents and corrective action: All residents who feed themselves have the potential to be affected by the alleged deficient practice. The restorative nurse has observed all residents during dining and individual accommodations have been implemented to maintain each resident's dignity. Systemic changes: Nursing staff will be inserviced on dignity and accommodation of individual resident dining needs. Monitoring: The Director of Nursing or licensed nursing designee will observe resident meal service randomly over all 3 meals 4 times per week for 4 weeks, then 2 times per week for 4 weeks, then 4 times per month ongoing. Results of meal service observations will be reviewed monthly by QA committee. Completion date: April 7, 2012</p>	04/07/2012

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	<p>4/4/11, included, but was not limited to, the approach of "Assist with meals as needed."</p> <p>During an observation on 3/5/12 at 11:45 p.m., Resident #1 was noted to be very small in stature and was sitting in a small Broda chair (a chair which aides positioning) which was in a low position to accommodate his feet touching the floor. The resident sat leaning forward in his chair. The resident was in front of a regular dining table. He was attempting to reach up onto the table to obtain a glass of lemonade that was sitting behind his divided plate. He was unable to reach up and get the lemonade. He was also trying to feed himself and had food all over his hands where he had attempted to feed himself and reach whatever he could without using the spoon. His clothing protector was on his lap and there was spillage and droppings of food on his shirt. The divided plate sat on the table and was level to the resident's eyes. The resident's mouth was below the level of the table when he put food into his mouth. A staff member who was also feeding another resident was observed to assist him at times and feed him with a spoon.</p>			

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	<p>During an interview with CNA #4 on 3/5/12 at 12 noon, she indicated the above observation was how the resident ate his meals "everyday." She indicated the resident had always leaned forward in the chair and tried to feed himself. The CNA made no comments related to the resident sitting too low from the table.</p> <p>During an interview with the Dietary Manager (who was observing the lunch meal in the dining room) on 3/5/12 at 12:10 p.m., she indicated Resident #1 always tried to feed himself at meals. She indicated the resident was sitting in his chair the same way he did for every meal service.</p> <p>During an observation on 3/7/12 at 12:00 p.m., Resident #1 was up in his low Broda chair sitting in front of a regular dining room table. The resident was holding a glass of liquid given to him by a CNA and was attempting to take a drink. He was able to tip the glass up and drink some of the liquid. His mouth and the top of the cup were below the level of the table. A CNA was assisting Resident #1 and another resident in the dining room. The divided plate was eye level with the resident and the resident was not observed to feed</p>						

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	<p>himself.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 3/7/12 at 4:05 p.m., additional information was requested related to Resident #1's chair being so low and his food items on the table being out of reach which made it difficult for him to feed himself and led to increased spillage and soiling of his clothing.</p> <p>During an interview on 3/8/12 at 8:25 a.m., the DoN indicated a special tray for the resident's Broda chair had been ordered yesterday after the meeting and was obtained within two hours. The DoN indicated the tray would be in use today.</p> <p>During an observation on 3/8/12 at 12:15 p.m., Resident #1 was up in his Broda chair in the dining room. A physician's order had been obtained for a tray to be applied to the Broda chair during meals. The tray was at the resident's waist level. His meal was on the tray in front of him. He had a spoon in his hand and was feeding himself broccoli from his divided plate with supervision and occasional assistance from a CNA.</p> <p>3.1-3(t)</p>				

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident's dining needs were accommodated for ease in self feeding for 1 of 1 randomly observed resident feeding self while in a Broda chair. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record for Resident #1 was reviewed on 3/6/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #1 included, but were not limited to, mental retardation with profound intellectual disabilities, convulsions, and congestive heart failure.</p> <p>A quarterly Minimum Data Set assessment, dated 1/23/12, indicated the resident required only limited assistance from one staff member for eating.</p> <p>A health care plan problem related to Resident #1's nutritional needs, dated</p>	F0246	<p>F246 Corrective action: Resident #1 has a tray for the broda chair during meals that accommodates individual dining needs and enables resident #1 to self feed. Identification of other residents and corrective action: All residents who feed themselves have the potential to be affected by the alleged deficient practice. The restorative nurse has observed all residents during dining and individual accommodations have been implemented as necessary. Systemic changes: Nursing staff will be inserviced on dignity and accommodation of individual resident dining needs. Monitoring: The Director of Nursing or licensed nursing designee will observe resident meal service randomly over all 3 meals 4 times per week for 4 weeks, then 2 times per week for 4 weeks, then 4 times per month ongoing. Results of meal service observations will be reviewed monthly by QA committee. Completion date: April 7, 2012</p>	04/07/2012

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	<p>4/4/11, included, but was not limited to, the approach of "Assist with meals as needed."</p> <p>During an observation on 3/5/12 at 11:45 p.m., Resident #1 was noted to be very small in stature and was sitting in a small Broda chair (a chair which aides positioning) which was in a low position to accommodate his feet touching the floor. The resident sat leaning forward in his chair. The resident was in front of a regular dining table. He was attempting to reach up onto the table to obtain a glass of lemonade that was sitting behind his divided plate. He was unable to reach up and get the lemonade. He was also trying to feed himself and had food all over his hands where he had attempted to feed himself and reach whatever he could without using the spoon. The divided plate sat on the table and was level to the resident's eyes. The resident's mouth was below the level of the table when he put food into his mouth. A staff member who was also feeding another resident was observed to assist him at times and feed him with a spoon.</p> <p>During an interview with CNA #4 on 3/5/12 at 12 noon, she indicated the above observation was how the</p>						

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	<p>resident ate his meals "everyday." She indicated the resident had always leaned forward in the chair and tried to feed himself. The CNA made no comments related to the resident sitting too low from the table.</p> <p>During an interview with the Dietary Manager (who was observing the lunch meal in the dining room) on 3/5/12 at 12:10 p.m., she indicated Resident #1 always tried to feed himself at meals. She indicated the resident was sitting in his chair the same way he did for every meal service.</p> <p>During an observation on 3/7/12 at 12:00 p.m., Resident #1 was up in his low Broda chair sitting in front of a regular dining room table. The resident was holding a glass of liquid given to him by a CNA and was attempting to take a drink. He was able to tip the glass up and drink some of the liquid. His mouth and the top of the cup were below the level of the table. A CNA was assisting Resident #1 and another resident in the dining room. The divided plate was eye level with the resident and the resident was not observed to feed himself.</p> <p>During an interview with the</p>			

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	<p>Administrator and Director of Nursing (DoN) on 3/7/12 at 4:05 p.m., additional information was requested related to Resident #1's chair being so low and his food items on the table being out of reach which made it difficult for him to feed himself.</p> <p>During an interview on 3/8/12 at 8:25 a.m., the DoN indicated a special tray for the resident's Broda chair had been ordered yesterday after the meeting and was obtained within two hours. The DoN indicated the tray would be in use today.</p> <p>During an observation on 3/8/12 at 12:15 p.m., Resident #1 was up in his Broda chair in the dining room. A physician's order had been obtained for a tray to be applied to the Broda chair during meals. The tray was at the resident's waist level. His meal was on the tray in front of him. He had a spoon in his hand and was feeding himself broccoli from his divided plate with supervision and occasional assistance from a CNA.</p> <p>3.1-3(v)(1)</p>				

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed related to resident diagnoses requiring medication administration and monitoring for 4 of 10 residents reviewed for unnecessary medications. (Resident #'s 18, 23, 100, and 105)</p> <p>Findings include:</p> <p>1). The clinical record for Resident #18 was reviewed on 3/7/12 at 1:00 a.m.</p>	F0279	F279 Corrective action: A care plan for constipation has been added to Resident #18's care plan. Resident #23's guaifenesin has been discontinued per physician order, therefore the care plan has no need for an update. Resident #105's care plan has been updated to include the use of aspirin and Lasix. Resident #100's care plan has been updated to include the use of Klor-con and Lasix. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. Each resident's care	04/07/2012	

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	<p>Diagnoses for Resident #18 included, but were not limited to, dementia, depressive disorder, and constipation.</p> <p>Current physician's orders for Resident #18 included, but were not limited to, the following orders for constipation:</p> <p>Docusate Sodium (a stool softener) 100 milligrams cap 1 routinely daily (original order date 12/8/11)</p> <p>Fleet enema (a chemical enema given to produce bowel evacuation) once daily as needed for constipation (original order date 10/11/11)</p> <p>Milk of Magnesia (a laxative) 30 milliliters once daily as needed for constipation (original order date 10/6/11)</p> <p>Polyethylene Glycol powder (a mild laxative) 17 grams in liquid once daily routinely for constipation (original order date 10/6/11)</p> <p>A review of the resident's comprehensive plans of care, last reviewed on 3/6/12, lacked any health care plan related to the resident's diagnosis of constipation requiring routine medication administration and</p>		<p>plan has been reviewed and updated as needed. Systemic changes: Nursing staff will be inserviced on care plan requirements. Monitoring: Care Plans are reviewed quarterly and updated as needed. Twenty four (24) hour reports and new physician orders will be reviewed 5 times a week during the morning IDT meeting. Care Plans will be updated as necessary. The Director of Nursing/Designee will audit 4 clinical records/care plans per week for 4 weeks, then audit 8 clinical records/care plans per month ongoing. Results of audits will be reviewed monthly by the QA committee. Completion date: April 7, 2012</p>	

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	<p>bowel monitoring.</p> <p>During an interview on 3/7/12 at 3:00 p.m., the Assistant Director of Nursing reviewed Resident #18's comprehensive plan of care and indicated she was unable to provide any health care planning related to the resident's diagnosis of constipation requiring medication administration and monitoring.</p> <p>2.) The clinical record for Resident #23 was reviewed on 3/7/12 at 11:45 a.m.</p> <p>Diagnoses for Resident #23 included, but were not limited to, debility, dementia with behavioral disturbance, and diabetes mellitus.</p> <p>Current physicians orders for Resident #23 indicated the resident had an order for guaifenesin (a medication given to thin secretions) 1200 milligrams once daily. The original date of this order was 1/23/12. The clinical record lacked any diagnosis for the use of the guaifenesin medication.</p> <p>His comprehensive health care plan, last reviewed on 1/27/12, lacked any health care planning related to the need for the guaifenesin medication.</p>				

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	<p>During an interview with the Director of Nursing on 3/7/12 at 4:05 p.m., additional information was requested related to the lack of health care planning for the guaifenesin medication.</p> <p>During an interview on 3/8/12 at 8:25 a.m., she had contacted the resident's physician and the guaifenesin medication had been discontinued.</p> <p>3.) The clinical record for Resident #105 was reviewed on 3/7/12 at 8:30 a.m.</p> <p>Resident #105's current diagnoses included, but were not limited to, mitral stenosis, edema, atrial fibrillation, and hypertension.</p> <p>The clinical record indicated the resident had current physician's orders for the following medications,</p> <p>a. Aspirin (a blood thinner medication) 325 milligrams 1 tablet daily for mitral stenosis. The original date of this order was 11/16/11.</p> <p>b. Lasix (a diuretic medication) 20 milligrams 1 daily at 12 noon. The original date of this order was</p>			

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	<p>1/17/2012.</p> <p>The clinical record lacked any healthcare plan related to the resident receiving the above medications.</p> <p>During an interview with the Assistant Director of Nursing on 3/7/12 at 1:45 p.m., additional information was requested related to the resident not having a healthcare plan related to the Lasix and Aspirin medications.</p> <p>During an interview with the Assistant Director of Nursing on 3/7/12 at 2:00 p.m. she indicated the resident did not have a healthcare plan for the Lasix and Aspirin medications. She further indicated the medications should have been care planned due to the risk of potential side effects related to the medications.</p> <p>4.) The clinical record for resident #100 was reviewed on 3/7/12 at 3:00 p.m..</p> <p>Resident #100's current diagnoses included, but were not limited to, edema, depressive disorder and senile dementia with delusions.</p> <p>The clinical record indicated the resident had current physician's</p>				

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	<p>orders for the following medications,</p> <p>a. Klor -Con M 20 (Potassium Chloride Microencapsulated Crystals , a mineral supplement) give 20 milliequivalents orally twice daily. (no diagnosis was listed) The original date of this order was 10/4/11.</p> <p>b. Lasix (a diuretic medication) 20 milligrams 1 daily at 8 a.m.. The original date of this order was 10/4/2011.</p> <p>The clinical record lacked any healthcare plan related to the resident receiving the above medications.</p> <p>During an interview with the Assistant Director of Nursing, on 3/7/12 at 1:45 p.m., additional information was requested related to the resident not having a healthcare plan related to the Lasix and Klor -Con medications.</p> <p>During an interview with the Assistant Director of Nursing, on 3/7/12 at 2:00 p.m., she indicated the resident did not have a healthcare plan for Lasix and Klor -Con medications. She further indicated the medications should have been care planned due to the risk of potential side effects related to the medications.</p>				

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	<p>5.) Review of the current facility policy, titled "Care Planning", dated June 2010, provided by the Director of Nursing on 3/8/12 at 12:20 p.m., indicated the following,</p> <p>The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.</p> <p>3.1-35(a)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 personal alarms were applied to alert staff of attempted rising or movement to decrease falling for 1 of 3 residents reviewed for falls of 10 who met the criteria for falls.</p> <p>Findings include:</p> <p>Resident #80's clinical record was reviewed on 3/7/12 at 10:33 a.m. The resident's diagnosis included, but were not limited to, Dementia with behavioral disturbances, senile dementia, muscle weakness, late effects of cerebrovascular disease, and osteoporosis.</p> <p>The resident had current 2/20/12, signed physician's order for a sensor alarm when in bed and recliner and a personal alarm on when up in the wheelchair. These orders were initiated on 10/5/11.</p> <p>A 2/3/12, Personal Alarm Assessment indicated the resident had a history of</p>	F0323	<p>F323 Corrective action: We are unable to correct the alleged deficient practice for Resident #80 as this occurred in the past. Identification of other residents and corrective action: All residents that have personal alarms have the potential to be affected by the alleged deficient practice. Systemic changes Nursing staff have been inserviced on personal alarm procedure and monitoring. Monitoring: The Director of Nursing or licensed designee will perform personal alarm checks randomly over all shifts 10 personal alarm checks per week for two months, then 10 personal alarm checks per month ongoing. Results of personal alarm checks will be reviewed in monthly QA committee meetings. Completion date: April 7, 2012</p>	04/07/2012

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	<p>previous falls and the resident tries to stand, transfer, and walk alone. The assessment indicated the resident had memory problems and/or disorientation or confusion and has poor safety awareness. The assessment indicated the resident required a sensor pad alarm and a personal alarm.</p> <p>A 2/2/12, Fall Risk Evaluation indicated the resident had no falls in the last three months, was ambulatory, incontinent, had an unsteady gait and used a cane or walker. The evaluation indicated the resident was on medications that could contribute to falls.</p> <p>A Nursing Progress Note for 7:15 a.m., on 3/2/12, indicated Resident #80 was found lying on her back on the floor. The resident denied having any pain and had no visible injuries.</p> <p>Review of a 3/3/12, 11:03 a.m., Nursing Progress Note indicated the resident slid out of her wheelchair in the North Dining Room and had no injuries.</p> <p>Review of the fall investigation for the 3/3/12, 11:03 a.m., indicated the resident's personal alarm was not attached and did not sound.</p>						

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	<p>The resident had a current care plan focus of potential for falls. The problem was initiated 2/15/11. Interventions included, but were not limited to providing the resident with a wheelchair and using a personal alarm on the resident when she was up in the wheelchair.</p> <p>During a 3/6/12, 2:53 p.m., interview with the Director of Nursing, she indicated the resident's personal alarm was not in use at the time of the fall. She indicated Resident #80 was being seen by occupational therapy for positioning and they thought the resident was trying to reposition herself in the wheelchair when she slid out.</p> <p>The revised 1/12, "Fall Evaluation Policy" was provided by the Director of Nursing on 3/8/12 at 8:28 a.m. The purpose of the policy was to detect the root cause of falls, identify supportive aides to prevent falls, to identify high-risk residents and institute interventions to reduce falls.</p> <p>3.1-45(a)(2)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 each resident had a diagnosis to support the use of medications for 2 of 10 residents reviewed for unnecessary medications. (Resident #'s 23 and 100)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #23 was reviewed on 3/7/12 at 11:45 a.m.</p>	F0329	F329 Corrective action: Resident #23's order for guaifenesin has been discontinued per physician order. Resident #100 now has a diagnosis for the Klor-con. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. Each resident's clinical record has been reviewed and updated to include diagnoses for each medication. Systemic changes: The MDS Coordinator and Electronic Medical Record Coordinator have been inserviced	04/07/2012

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	<p>Diagnoses for Resident #23 included, but were not limited to, debility, dementia with behavioral disturbance, and diabetes mellitus.</p> <p>Current physicians orders for Resident #23 indicated the resident had an order for guaifenesin (a medication given to thin secretions) 1200 milligrams once daily. The original date of this order was 1/23/12. The clinical record lacked any diagnosis for the use of the guaifenesin medication. The January and February Medication Administration Records indicated the medication had been given daily as ordered by the physician.</p> <p>During an interview with the Director of Nursing on 3/7/12 at 4:05 p.m., additional information was requested related to the diagnosis requiring the need for the guaifenesin medication.</p> <p>During an interview on 3/8/12 at 8:25 a.m., she had contacted the resident's physician and the guaifenesin medication had been discontinued.</p> <p>2.) The clinical record for resident #100 was reviewed on 3/7/12 at 3:00 p.m.</p>		<p>on required diagnosis for each medication. Monitoring: New admits' clinical record will be reviewed by the Electronic Medical Record Coordinator to ensure that each classification of medication has the appropriate diagnosis. 24 hour reports and new physician orders will be reviewed 5 times per week during morning IDT meetings to ensure all new medications ordered have an accompanying diagnosis. The Director of Nursing or Electronic Medical Record Coordinator will audit 4 clinical records per week for 4 weeks, then audit 8 clinical records per month ongoing. Results of audits will be reviewed monthly by the QA committee. Completion date: April 7, 2012</p>				

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	<p>Resident #100's current diagnoses included, but were not limited to, edema, depressive disorder and senile dementia with delusions.</p> <p>The clinical record indicated the resident had a current physician's order for the following medication,</p> <p>Klor -Con M 20 (Potassium Chloride Microencapsulated Crystals , a mineral supplement) give 20 milliequivalents orally twice daily. (no diagnosis was listed) The original date of this order was 10/4/11. The January and February 2012 Medication Administration Records indicated the medication had been given twice daily as ordered by the physician.</p> <p>The clinical record lacked any diagnosis related to the indication for use of the Klor-Con medication.</p> <p>During an interview with the Assistant Director of Nursing, on 3/7/12 at 1:45 p.m., additional information was requested related to the resident not having a diagnosis related to the Klor -Con medication.</p> <p>During an interview with the Assistant Director of Nursing, on 3/7/12 at 2:00 p.m., she indicated the resident did</p>			

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	not have a diagnosis for the Klor -Con medication. She further indicated the medication should have had a diagnosis related to the use of the medication.  3.1-48(a)(4)				

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <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.</p> <p>Based on record review and interview, the facility failed to follow established policies related to ensuring sliding scale insulin was administered and documented for 1 of 1 resident reviewed with orders for sliding scale insulin coverage. (Resident #66)</p> <p>Findings include:</p> <p>The clinical record for Resident #66 was reviewed on 3/7/12 at 2:11 p.m.</p> <p>Resident #66's current diagnoses included, but were not limited to,</p>	F0425	<p>F425 Corrective action: The sliding scale documentation for resident #66 was imputed incorrectly into the EMR. Identification of other residents and corrective action: All residents with sliding scale orders have the potential to be affected by the alleged deficient practice. An audit of all residents with sliding scale orders was completed to ensure all other orders are correctly imputed into the EMR system. No other residents were identified as having orders incorrectly entered into the EMR system. Systemic changes: Reviews of new sliding scale orders will continue to be</p>	04/07/2012			

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	<p>diabetes mellitus, hypertension and paranoid schizophrenia.</p> <p>The February 2012 recapitulation of physician's orders indicated Resident #66 had diabetic related orders which included, but were not limited to, the following:</p> <p>A. Novolin N (insulin) inject 22 units subcutaneous every morning. The original date of this order was 10/4/11.</p> <p>B. Monitor blood glucose levels at 6:00 a.m. and at 4:00 p.m. The original date of this order was 10/20/11.</p> <p>C. Administer Novolin R sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>0-59 call MD 60-200=0 201-250=2 units 251-300=4 units 301-350=6 units 351-400=10 units 401-16 units recheck in 2 hours if still above 400 call MD The original date of this order was 10/4/11.</p>		<p>reviewed during the morning IDT meetings to ensure the orders are correctly written and entered into the EMR system. Monitoring: The Director of Nursing or licensed nursing designee will audit 3 insulin orders per week for accuracy times 2 weeks, then 3 insulin orders every 2 weeks for accuracy, then 3 insulin orders monthly times two months, then on-going monthly. Evidence of an inaccurate EMR will be immediately corrected. Results of sliding scale audits will be reviewed in monthly QA meetings. Completion date: April 7, 2012</p>				

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	<p>A health care plan, dated 12/10/10, indicated Resident #66 had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia or hyperglycemia. Interventions for this problem included, administer medication as ordered and monitor/document medication side effects and effectiveness.</p> <p>Review of the December 2011 and February 2012 Medication Administration Record (MAR) lacked documentation of insulin sliding scale coverage on the following dates and times,</p> <p>December 11 at 4:00 p.m., the blood sugar result was 223, no insulin was documented as having been given. The resident should have received 2 units.</p> <p>December 18 at 4:00 p.m., the blood sugar result was 222, no insulin was documented as having been given. The resident should have received 2 units.</p> <p>February 15 at 4:00 p.m., the blood sugar result was 222, no insulin was documented as having been given. The resident should have received 2 units.</p>				

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	<p>February 22 at 6:00 a.m., the blood sugar result was 211, no insulin was documented as having been given. The resident should have received 2 units.</p> <p>During an interview with the Director of Nursing on 3/8/12 at 10:13 a.m., additional information was requested related to the lack of sliding scale coverage having been documented as given on the dates and time noted above.</p> <p>During an interview with the Corporate Electronic Medical Records (EMR) support staff on 3/8/12 at 10:33 a.m., she indicated she could not find any documentation to indicate the resident had received any insulin on the dates and times noted above.</p> <p>Review of the current facility policy, titled "Diabetes -Medication; Oral and Insulin", dated 3/2005, provided by the Director of Nursing on 3/8/12 at 3:00 p.m. indicated the following,</p> <p>Purpose:</p> <p>1.) To provide care to residents with diabetes mellitus in maintaining control of the disease, and to allow them to function safely in their</p>				

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	<p>environment.</p> <p>2.) To deter residents from going into hyperglycemia or hypoglycemia reactions.</p> <p>Performed by: Licensed Nursing</p> <p>Procedure:</p> <p>1. On admission, all residents with a diagnosis of diabetes mellitus, will have a physician's order on oral or insulin medications.</p> <p>2. The same dosage of insulin or oral medication will be given each a.m. and p.m. unless:</p> <p>a. The physician writes a new dosage order.</p> <p>b. The nurse receives a telephone order.</p> <p>c. The resident has a physician -ordered lab work that requires fasting.</p> <p>d. The resident is on a physician-ordered insulin on a sliding scale. The resident's dosage of insulin will be determined by blood glucose parameters ordered by the physician...</p>				

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	<p>5. Document medication given, site injection given, and any findings in appropriate place.</p> <p>3.1-25(a) 3.1-25(b)(3)</p>			

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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 facility failed to ensure the pharmacy consultant reviewed each resident's clinical record for the lack of diagnoses to support the use of medications and reported these irregularities to the attending physician for 2 of 10 residents reviewed for unnecessary medications. (Resident #'s 23 and 100)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #23 was reviewed on 3/7/12 at 11:45 a.m.</p> <p>Diagnoses for Resident #23 included, but were not limited to, debility, dementia with behavioral disturbance, and diabetes mellitus.</p> <p>Current physicians orders for Resident #23 indicated the resident had an order for guaifenesin (a</p>	F0428	F428 Corrective action: The Director of Nursing and Administrator provided this citing to the Consultant Pharmacist on 03-19-12 and discussed the lack of recommendation related to diagnosis for each medication. Identification of other residents and corrective action: All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and Administrator discussed lack of recommendation for diagnosis with the Consultant Pharmacist on 03-19-12. Systemic changes: The DON will meet monthly with the Consultant Pharmacist to review the pharmacy report to ensure a diagnosis exists for each medication. Monitoring: The DON will present the monthly report provided by the Consultant Pharmacist during the monthly QA meeting. Completion date: April 7, 2012	04/07/2012	

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	<p>medication given to thin secretions) 1200 milligrams once daily. The original date of this order was 1/23/12. The clinical record lacked any diagnosis for the use of the guaifenesin medication. The January and February 2012 Medication Administration Records for Resident #23 indicated the medication had been given daily as ordered by the physician.</p> <p>The clinical record indicated the pharmacist had reviewed the resident's medication orders on 1/25/12 and 2/28/12. No recommendations related to the need for a diagnosis to support the use of the guaifenesin medications were made.</p> <p>During an interview with the Director of Nursing on 3/7/12 at 4:05 p.m., additional information was requested related to the diagnosis requiring the need for the guaifenesin medication.</p> <p>During an interview on 3/8/12 at 8:25 a.m., she had contacted the resident's physician and the guaifenesin medication had been discontinued.</p> <p>2.) The clinical record for resident #100 was reviewed on 3/7/12 at 3:00 p.m.</p>				

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	<p>Resident #100's current diagnoses included, but were not limited to, edema, depressive disorder and senile dementia with delusions.</p> <p>The clinical record indicated the resident had a current physician's order for the following medication,</p> <p>Klor -Con M 20 (Potassium Chloride Microencapsulated Crystals , a mineral supplement) give 20 milliequivalents orally twice daily. (no diagnosis was listed) The original date of this order was 10/4/11.</p> <p>The clinical record lacked any diagnosis related to the indication for use of the Klor-Con medication.</p> <p>The clinical record indicated the Pharmacy Consultant had reviewed the clinical record for Resident #100 on the following dates, 12/20/11, 1/16/12, and 2/20/12.</p> <p>The Pharmacy Consultant failed to ensure a diagnosis was on the clinical record to support the use of the Klor-Con medication on the dates noted above.</p> <p>During an interview with the Assistant Director of Nursing on 3/7/12 at 1:45</p>			

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	<p>p.m., additional information was requested related to the resident not having a diagnosis related to the Klor -Con medication.</p> <p>During an interview with the Assistant Director of Nursing on 3/7/12 at 2:00 p.m., she indicated the resident did not have a diagnosis for the Klor -Con medication. She further indicated the medication should have had a diagnosis related to the use of the medication.</p> <p>3.1-25(i)</p>				