

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2013
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NAME OF PROVIDER OR SUPPLIER  AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F000000	<p>This visit was for the Investigation of Complaint IN00141215.</p> <p>Complaint IN00141215 - Substantiated. Federal/State deficiencies related to the allegations are cited at F166, F309, F314, F329, F333, and F520.</p> <p>December 16 &amp; 17, 2013</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 37 SNF/NF: 20 Residential: 62 Total: 119</p> <p>Census payor type: Medicare: 27 Medicaid: 12 Other: 80 Total: 119</p> <p>Sample: 7</p> <p>These deficiencies reflect state</p>	F000000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the complaint survey which was conducted on December 17, 2013. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective January 16, 2014.</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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	findings cited in accordance with 410 IAC 16.2.  Quality review completed on December 22, 2013, by Janelyn Kulik, RN.			

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure interventions put in place as a follow up to a grievance were acted upon related to not completing hourly checks for 1 of 3 grievances reviewed. (Resident #G)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 12/16/13 at 10:40 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, insomnia, aortic aneurysm, hyperlipidemia (elevated cholesterol levels), and glaucoma. The resident was discharged from the facility on 11/13/13.</p> <p>A Resident Concern form was initiated on 10/25/13 at 7:30 a.m. The form was initiated by the Director of Nursing. The form indicated Resident #G's family member voiced concerns related to the resident's oxygen not being on, dirty linens</p>	F000166	Resident #G is no longer in facility.No other residents with hourly checks as intervention to a grievance.IDT team will be inserviced by home office/clinical support on intervention follow up for grievances. Social Services/Designee to audit grievance interventions to ensure proper initiation and follow up with the interventions.Social Services/Designee to bring audits to QAA monthly for review and any recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14	01/16/2014			

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	<p>noted in the resident's room, and oxyyears (padding used over oxygen tubing where the tubing is place over the ears) were still not available. The "Resolution and Communication" section on the bottom of the Resident Concern form indicated the resident was to be placed on "hourly rounding." This resolution was communicated to the family member on 10/25/13 by the Director of Nursing.</p> <p>Daily "Hourly checks for (resident G's name)" forms were reviewed. The forms indicated the staff were to check the resident and document if the resident's call light was in reach, oxygen was in place, ears were protected, the resident was positioned for comfort and covered with blankets, and no used linens were in the room. The checks were not documented as completed on the following dates and times:                      10/26/16: 8:00 a.m. through 10:00 p.m.                      10/27/13: 7:00 a.m. through 10:00 p.m.                      10/28/13: 12:00 a.m. through 2:00 p.m. and 9:00 p.m. and 10:00 p.m.                      10/30/13: 7:00 a.m. through 5:00 p.m.                      10/31/13: 7:00 a.m. through 2:00 p.m. and 11:00 p.m.                      11/02/13: 7:00 a.m. through 2:00 p.m.</p>			

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	<p>and 11:00 p.m. 11/03/13: 7:00 a.m. through 11:00 p.m. 11/04/13 :7:00 a.m. through 11:00 p.m. 11/05/13: 7:00 a.m. through 2:00 p.m. 11/06/13: 7:00 a.m. through 1:00 p.m. 11/10/13: 7:00 a.m. through 11:00 p.m. 11/11/13: 7:00 a.m. through 2:00 p.m.</p> <p>When interviewed on 12/16/13 at 12:15 p.m., the Director of Nursing indicated the resident's family had voiced concerns to her and a grievance form was completed.</p> <p>When interviewed on 12/16/13 at 3:05 p.m., the Director of Nursing indicated staff should have been completing the hourly round observations as per the follow up resolution to the family members concern.</p> <p>The facility policy titled "Service Recovery" was reviewed on 12/16/13 at 3:00 p.m. The policy was dated December 2010. The facility Administrator provided the policy and indicated the policy was current. The policy indicated the Executive Director, Social Services , or other designees were responsible for the investigation and resolution of</p>				

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	<p>concerns. The policy also indicated the investigation was to include recommendations for actions related to the concern.</p> <p>This Federal tag relates to Complaint IN00141215.</p> <p>3.1-7(b)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure medically related social services were provided to maintain the resident's highest practicable psychosocial well-being related to monitoring the use of antidepressant medication increases for 1 of 3 residents review for antidepressant medication use in the sample of 7. (Resident #G)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 12/16/13 at 10:40 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, insomnia, aortic aneurysm, hyperlipidemia (elevated cholesterol levels), and glaucoma. The resident was admitted to the facility on 9/9/13. The resident was discharged from the facility on 11/13/13.</p> <p>The Physician orders were reviewed. An order was written on 9/10/13 for the resident to receive Zoloft ( an</p>	F000250	Resident #G is no longer in the facility. Residents taking antidepressants were reviewed for appropriate diagnosis and reason for medication. Executive Director/Designee will inservice Social Services on monitoring the use of residents on psychotropic medication including antidepressant medication as per regulations. DHS/Designee will inservice nursing staff on proper documentation of mood/behavior of residents in caretracker, daily skilled charting or change of condition as appropriate. IDT team to review antidepressant medication changes 5x weekly in CCM meetings. Social Services to audit residents with changes in antidepressant medication for appropriate diagnosis and documentation for the changes in social service progress notes 5x weekly for 4 weeks, then 2x weekly for 4 weeks then weekly thereafter until QAA states otherwise. DHS/designee will audit 5 resident charts weekly for proper nursing documentation of mood/behavior. Social Services/designee and DHS/designee will bring audits to QAA monthly for review and	01/16/2014			

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	<p>antidepressant medication) 50 milligrams once a day. An order was written on 9/20/13 for the resident to receive Zoloft 100 milligrams daily. An order was written on 11/6/13 for the resident to receive Zoloft 200 milligrams daily. Orders were written on 11/10/13 to discontinue Zoloft 200 milligrams and start Zoloft 100 milligrams daily.</p> <p>The 9/10/13 History and Physician report was reviewed. The report was completed by the Physician. The report indicated the resident's current diagnoses included generalized weakness, constipation, pneumonia, high blood pressure, glaucoma, aneurysm, hyperlipidemia, urinary retention, anxiety, GERD (gastric Esophageal Reflux Disease), and a history of deep vein thrombosis and prostate cancer. No diagnosis of depression was noted on the History and Physical report.</p> <p>The Physician Progress Notes were reviewed. A Progress Note completed on 9/20/13 indicated the resident's chief complaint was listed as 'still feels very weak, anxiety...feels very depressed, wants to go home.' The Progress Note also indicated the resident feels "I will never make it." The Progress Note also indicated</p>		<p>recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14</p>	

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	<p>depression was noted and the plan was for Zoloft 100 milligrams.</p> <p>The 10/2/13 Physician Progress Note indicated the resident had generalized weakness and fatigue and his anxiety was improving.</p> <p>The 11/6/13 Physician Progress Note indicated the resident was "depressed" and was not sure what he wanted out of life and feels sad and hopeless and had a flat affect and slow speech and his anxiety was improved. The plan on the Progress Note was to increase the Zoloft to 200 milligrams.</p> <p>A "Change in Condition" form was initiated on 9/20/13 (no time listed). The form indicated the Physician was in the facility to see the resident and a new order was given for the resident to receive Zoloft 100 milligrams daily. There were no signs and symptoms of the condition change listed on the form.</p> <p>A "Change In Condition" form was initiated on 11/10/13 on the 7:00 a.m. -3:00 p.m. shift. The form indicated the resident was lethargic, slow to respond, and difficult to arouse at times. The Physician was notified and orders were obtained to decrease</p>				

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	<p>the Zoloft medication to 100 milligrams daily. The form also indicated the resident's responsible party was notified. The bottom of the form was signed by the Social Service Director and the Director of Nursing.</p> <p>The Social Service Progress Notes were reviewed. The first entry was made on 9/10/13. This entry indicated the resident arrived to the facility on 9/9/13 from the hospital. The entry indicated the resident had diagnoses of generalized anxiety disorder, sever anxiety, aneurysm, constipation, increase weakness and glaucoma. No diagnose of depression was listed. The note indicated the resident was receiving Dsyrel, Xanax (a medication for anxiety), Klonopin (a medication for seizures and acute episodes of bipolar disorder). The progress note did not indicated the resident was receiving Zoloft.</p> <p>The 9/12/13 Social Service Progress Note indicated the resident's medical record was reviewed for behaviors and psychoactive medications. The note indicated the resident had diagnoses of insomnia, generalized anxiety disorder and severe anxiety. The note listed the resident's medication and now included Zoloft as a medication the resident was</p>			

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	<p>receiving. The note indicated staff reported the resident was anxious, irritable, and had unrealistic fears. Interventions that worked for the resident included reassurance and changing the subject.</p> <p>The 9/20/13 Social Service Progress Note indicated the resident's behaviors and medications were reviewed at a meeting on 9/19/13 and no behaviors, mood concerns, or medication changes were noted.</p> <p>A Geriatric Depression Scale form was completed on 9/10/13. The Social Service Director completed the form. The resident's total score was (0). The form indicated a score greater than (5) was suggestive of depression and a scores greater than (10) were almost always depression. A Brief Interview for Mental Status (BIMS) interview was completed on 9/10/13. The resident's score was (6) which indicated his cognitive patterns were severely impaired.</p> <p>An Initial Psychosocial Assessment/MDS Supportive Documentation Tool &amp; Progress Notes dated 9/23/13 was reviewed. The note was completed by the Social Service Director. The note indicated the resident was interviewed</p>						

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	<p>by the Social Service Director and included a section titled "Mood." The resident answered "not at all" to (10) questions he was asked regarding being bothered about feeling down, depressed, or hopeless, having trouble falling or staying asleep or sleeping too much, feeling bad about himself or short tempered, or having thoughts that would be better off dead or hurting self in some way, amongst others.</p> <p>The 9/16/13 Minimum Data Set (MDS) admission assessment indicated the resident did not display any inattention, disorganized thinking or altered level of consciousness. The assessment also indicated the resident answered "no" to (9) mood questions asked regarding being bothered my symptoms such as feeling down, depressed, or hopeless, feeling bad about self, or thought of being better off dead, amongst others.</p> <p>The Behavior Detail records from 9/2013 thru 11/2013 were reviewed. For the month of September, daily entries were made 9/1/13 through 9/27/13. These entries all indicated no behaviors were noted</p> <p>For the month of October, daily</p>			

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	<p>entries were made 10/1/13 through 10/31/13. No behaviors were recorded 10/1/13 through 10/12/13. The only documented entries of behaviors in October were as follows:</p> <ul style="list-style-type: none"> <li>-On 10/14/13 at 4:26 p.m., the resident was noted to be yelling when he was being turned due to pain and the Nurse was notified.</li> <li>-On 10/20/13 at 3;17 p.m., the resident was noted to call out at random times during the shift and letting the resident know staff was there if he needed anything was effective.</li> <li>-On 10/22/13 at 9:49 p.m., resident yells out when doing ADL's (Activities of Daily Living)</li> </ul> <p>For the month of November, daily entries were made 11/2/13 through 11/13/13. All the entries indicated no behaviors were noted.</p> <p>The 9/2013, 10/2013, and the 11/2013 Skilled Nursing Assessment and Data Collection forms were reviewed. Each form had a section titled "Mood and Behavior." In this sections staff were to check if the resident exhibited little interest in doing things, appears depressed, trouble falling or staying asleep, appears to have little energy, poor appetite, overeats, difficulty</p>						

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	<p>concentrating, fidgety/restless, suicidal expressions, lethargy, delusions, behaviors, rejection of care. The forms indicated staff were to check all of the above that applied.</p> <p>The 9/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas checked in the Mood and Behaviors section: 9/10/13- 9/14/13 9/16/13-9/20/13</p> <p>On the 9/11/13 form there was a narrative note written at 10:30 (no a.m. or p.m. listed) which indicated the resident complained of anxiety and not wanting to participate in therapy. The resident's son expressed to the staff he did not want his father to do anything he did not want to do and staff was required to give the resident preferential treatment. Xanax was given for anxiety.</p> <p>The 10/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas in the Mood and Behaviors section: 10/01/13-10/10/13 10/12/13-10/16/13 10/18/13-10/26/13</p>				

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	<p>On the 10/17/13 form there was a line with the word "none" above it marked on the Mood and Behavior section.</p> <p>The 11/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas in the Mood and Behaviors section: 11/01/13- 11/12/13</p> <p>The resident's care plans were reviewed. A care plan initiated on 9/12/13 indicated the use of Psychotropic drugs placed the resident at risk for other drug related effects. The care plan indicated the resident was receiving anxiolytics (anti anxiety medications) and anti-depressant medications. An Individual Plan Report completed on 9/16/13 for "Mood and Behaviors" indicated the Resident had severe anxiety at times, gets irritable, and had unrealistic fears. The Individual Plan also indicated the resident usually will calm down when offered reassurance or a change of the conversation. The Social Service Director provided this care plan and identified this as the resident's individual care plan for behaviors and mood.</p> <p>The 2010 Nursing Spectrum Drug</p>						

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	<p>Handbook indicated Zoloft was an antidepressant medication and for adults the initial dose was recommended to be 50 milligrams a day with increases to a maximum of 200 milligrams a day. When receiving Zoloft the patient's mental status was to be monitored carefully.</p> <p>When interviewed on 12/16/13 at 11:40 a.m., the Social Service Director indicated she monitors the residents chart upon admission for psychotropic medications, diagnoses, and the possible need for psych services. The Social Service Director indicated the resident had a lot of pain and it appeared his behavior of yelling out occurred when he was receiving care and would stop after that. The Director indicated those were the only behaviors documented.</p> <p>When interviewed on 12/17/13 at 12:45 p.m., the Social Service Director indicated she was aware the resident's Zoloft medication dosage had been increased as the facility had daily meeting where all the new Physician orders are reviewed. The Social Service Director indicated she did not look at the Physician Progress Notes related to the dates the Zoloft was increased and she was not aware of the statements the resident</p>				

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	<p>made to the Physician on the above dates to follow up on the statements. The Social Service Director indicated she did not necessarily note any signs or symptoms to increase the dosage.</p> <p>This Federal tag relates to Complaint IN00141215.</p> <p>3.1-34(a)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 follow their policy related to completing follow up assessments after a change in the resident's physical condition for 1 of 3 resident's reviewed for change of condition in the sample of 7. (Resident #G)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 12/16/13 at 10:40 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, insomnia, aortic aneurysm, hyperlipidemia (elevated cholesterol levels), and glaucoma. The resident was admitted to the facility on 9/9/13. The resident was discharged from the facility on 11/13/13.</p> <p>A Change in Condition Form was completed on 11/11/13 on the 3:00 p.m.-11:00 p.m. shift. The form was completed by an LPN and indicated</p>	F000309	Resident #G is no longer in the facility Residents currently being assessed for change in condition were reviewed for proper follow up assessments. DHS/designee will inservice Licensed Nursing staff on proper documentation and assessment for those residents with change in conditions as per policy. DHS/Designee will audit change in condition documentation for timely follow up assessments as per policy 5x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x weekly thereafter until QAA states otherwise. DHS/designee will bring audits to QAA monthly for review and recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14	01/16/2014			

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	<p>the resident's lung sounds were clear and diminished at the bases. Gurgling was noted in the resident's throat. The Physician order was for the resident to receive Mucinex 600 milligrams twice day. The back page of the form had sections for Nursing to complete every shift for 72 hours with relates to the change in condition. The first follow up assessment of the resident's respiratory status was not completed on the form until the 3:00 p.m. - 11:00 p.m. shift on 11/12/13 at 10:10 p.m. This entry indicated the resident's lungs sound were clear but diminished at the bases.</p> <p>The 11/2013 Nurses' Notes were reviewed. There were no entries completed 11/10/13 through 11/12/13.</p> <p>When interviewed on 12/16/13 at 2:00 p.m., the Director of Nursing indicated Nursing staff were to document an assessment related to the identified change in condition on the back of the Change in Condition Form every shift for the following 72 hours.</p> <p>This Federal tag relates to Complaint IN00141215.</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure the an unavoidable pressure ulcer developed related to a resident, identified as having staff assist with his bedpan use, developed a suspected deep tissue injury in the shape of a bedpan for 1 of 3 residents reviewed for wounds in the sample of 7. (Resident #G)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 12/16/13 at 10:40 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, insomnia, aortic aneurysm, hyperlipidemia (elevated cholesterol levels), and glaucoma. The resident was admitted to the facility on 9/9/13. The resident</p>	F000314	Resident #G is no longer in the facility. No other residents with deep tissue injury at this time. Residents utilizing a bed pan were assessed for any skin impairments related to bed pan usage. No issues were found at this time. DHS/designee will inservice licensed nursing staff on policy and procedures for residents with new skin impairments. DHS/designee will inservice nursing staff on proper bed pan usage with residents. DHS/designee will audit residents with new skin impairments for proper documentation 2x weekly x 2 months, then weekly thereafter until QAA states otherwise. DHS/designee will observe 2 nursing staff providing bed pan assistance weekly x 2 months, then every other week x 2 months, then monthly x 2 months until QAA states otherwise. This observation will be completed to include all shifts. DHS/designee will bring	01/16/2014

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	<p>was discharged from the facility on 11/13/13.</p> <p>The 9/16/13 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (5). This score indicated the resident's cognitive patterns were impaired. The assessment also indicated the resident required extensive assistance ( resident involved in activity with staff providing weight bearing support) of two plus persons for bed mobility and dressing. The assessment indicated the resident required extensive assistance of one person assist for toilet use and personal hygiene. The assessment also indicated the resident had one Stage I (intact skin with non blanchable redness) pressure ulcer and no other ulcers, wounds or skin problems.</p> <p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" report was initiated on 10/23/13. The report indicated the resident had a "Suspected Deep Tissue Injury" noted on his buttock. The section on the report labeled "Anatomical Location" had two body diagrams on it to indicate where the skin areas were located. On the diagram of the</p>		<p>audits to QAA monthly for review and recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14</p>				

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	<p>posterior side of the resident's body the facility had marked a "U" shaped line which started at the waist on the left side and continued down the resident's left buttock, across to the right buttock and up the buttock to the right waist area. The area was measured as 52 cm (centimeters) in length and 1.4 cm in width and the color was noted to be "purple." The following measurement of the above area were documented on the report.</p> <p>10/30/13: 15.1 cm x 1 cm 11/06/13: 8.4 cm x 0.3 cm 11/13/13: 6.4 cm x 0.3 cm</p> <p>There was no Skin Impairment Circumstance, Assessment, and Intervention form completed related to the development of the suspected deep tissue injury area.</p> <p>When interviewed on 12/17/13 at 11:35 a.m. the Director of Nursing indicated a Skin Impairment Circumstance form should have been initiated when the suspected deep tissue injury was first observed to the resident's buttock areas. The Director of Nursing indicated Nursing assessment of the area were to be completed once a shift for 72 following the observation of the new wound.</p>			

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	<p>When interviewed on 12/16/13 at 12:15 p.m., the Director of Nursing indicated the resident developed a suspected deep tissue area to the buttock on 10/23/13. The Director of Nursing indicated the night shift informed her of the area at approximately 6:00 a.m. on 10/23/13 and she was in the facility at this time. The Director of Nursing indicated she interviewed the CNA at this time and the CNA indicated the resident was not on the bed pan. When asked if the area was caused by a bed pan the Director of Nursing replied "it could have been." The Director of Nursing indicated the Wound Nurse/Unit Manager at the time interviewed the staff caring for the resident for the past 72 hours and no staff reported putting the resident on the bed pan.</p> <p>When interviewed on 12/16/13 at 3:00 p.m., the facility Administrator indicated she was aware the resident had pressure ulcers but had not been informed the area discovered on 10/23/13 had an irregular shaped as noted on the wound sheet. The Administrator indicated she should have been informed of the area.</p> <p>When interviewed on 12/17/13 at</p>			

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	<p>1:15 p.m., the facility Administrator indicated she would have looked at the investigation of the area if she had been informed. The Administrator indicated she was not aware of any inservices or education/training done related to the development of the area. The Administrator indicated there were bedpans in the facility for residents to use.</p> <p>When interviewed on 12/17/13 at 1:25 p.m., LPN #1 was in the supply room and he indicated he was familiar with items in the supply store room. The LPN indicated there were two types of bed pans usually available and one is a small fracture pan and the other is plastic larger one which is about 2-3 inches high all around.</p> <p>When interviewed on 12/17/13 at 1:30 p.m., the Director of Nursing indicated one of the staff interviewed did indicate the resident used the bed pan at times but she did not recall which employee that was.</p> <p>When interviewed on 12/17/13 at 1:35 p.m., LPN #2 indicated he worked on the hall Resident #G had resided on. The LPN indicated he worked the 3:00 p.m. to 11:00 p.m. shifts at the time and the resident</p>			

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	<p>rarely got out of bed on this shift. The LPN indicated he had heard in change of shift report that the resident apparently may have been left on the bed pan. LPN #2 indicated he never had placed the resident on the bed pan but did recall seeing a bed pan in a plastic bag in the resident's room. The LPN indicated it was the big one. The LPN indicated he talked with the CNA's on his hall and one CNA did indicate the resident used the bedpan at times. The LPN indicated in the past the resident would ask for the urinal and was able to use to the urinal. LPN #2 indicated he did not feel the resident would be able to put himself on or off the bed pan.</p> <p>When interviewed on 12/17/13 at 1:40 p.m., CNA #3 indicated she usually worked the day shift on the hall Resident #G resided on and she had taken care of the resident. The CNA indicated she had put the resident on the bedpan at times and he would have a bowel movement. The CNA indicated she used the smaller pan. CNA #3 indicated the resident required assistance to turn to his side. The CNA indicated the resident's bedpan was kept in a bag in the bathroom and it was the midnight shift CNA's responsibility to change them out on Mondays. The</p>			

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	<p>CNA indicated the night shift Nurse told her about the area at the change of shift when she came on the day it happened. The CNA indicated she did not put the resident on the bedpan after that. The CNA indicated the resident's condition had declined and she would ask him if he wanted to use the bedpan but he would decline. CNA #3 indicated she saw the area on the day it was observed and it looked like a "bruise" and was "right where a bedpan would go."</p> <p>When interviewed on 12/17/13 at 1:55 p.m., CNA #4 she worked on the 100 hall and had taken care of Resident #G. The CNA indicated the resident was incontinent of bowel and bladder. The CNA indicated she had never placed the resident on the bedpan. The CNA indicated there was a bedpan in the resident's room but she was not aware of any Nurses or CNA's using the bedpan.</p> <p>When interviewed on 12/17/13 at 2:00 p.m. the Director of Nursing indicated there were other residents in the facility who used bedpans and no other resident's ever had any skin issues from the bedpan. The Director of Nursing indicated they did not interview any other residents who used bedpans and did not complete</p>			

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	<p>any monitoring or audits of bed pan use at the time to determine if there we other identified concerns.</p> <p>The facility policy titled "Guidelines for Circumstance and Reassessment Forms" was reviewed on 12/17/13 at 11:35 a.m. There was no date on the policy. The Administrator provided the policy and indicated the policy was current. The policy indicated the purpose of the form was "to provide a mechanism for investigation, assessment, care plan update, interdisciplinary team review and follow up for specific episodes." The policy indicated the appropriate Circumstance and Reassessment Form" was to be used as applicable to each episode. The policy indicated the top portion of the form was to be completed to determine the circumstance and investigation of the occurrence. New interventions or approaches were to be evaluated and added to the care plan.</p> <p>The policy also indicated the interdisciplinary team was to review the completed form in the daily stand up meetings. The review was to include the thoroughness of the investigation, circumstance and the approach/interventions response.</p>			

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	<p>A blank "Skin Impairment Circumstance Investigation" form was reviewed. Sections on the form include listing the type of impairment, Environmental and Equipment Inspections, and Prevention Updates. There was also a section on the form for IDT (Interdisciplinary team) review and recommendations. The form was to be signed by the IDT members who reviewed it.</p> <p>The facility policy titled "Accident and Incident Reporting Guidelines" was reviewed on 12/17/13 at 3:00 p.m. The policy was dated 11/2010. the Nurse Consultant provided the policy and indicated the policy was current. The Policy indicated all accidents and incidents including injuries of unknown sources were to be reported to the department supervisor. Investigative action was to be initiated by the attending Nurse or Nursing Supervisor by completing a "Circumstance and Reassessment" form and the completed form was to be brought to the daily stand up meetings for review. Administrative staff were to complete the investigation by completing the "Interdisciplinary Team" section.</p> <p>This Federal tag relates to Complaint IN00141215.</p>			

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	3.1-40(a)(1) 3.1-40(a)(2)			

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F000329 SS=D	<p>483.25(I) 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's drug regime remained free of unnecessary medications related to increases in the dosage of an antidepressant medication without indications for the dosage increase for 1 of 3 residents reviewed for use of antidepressant medications in the sample of 7. (Resident #G)</p> <p>Findings include:</p>	F000329	Resident #G is no longer in the facility. Residents taking antidepressants were reviewed for appropriate diagnosis and reason for medication. Executive Director/Designee will inservice Social Services on monitoring the use of residents on psychotropic medication including antidepressant medication as per regulations. DHS/Designee will inservice nursing staff on proper documentation of mood/behavior of residents in caretracker, daily skilled charting or change of condition as	01/16/2014			

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	<p>The closed record for Resident #G was reviewed on 12/16/13 at 10:40 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, insomnia, aortic aneurysm, hyperlipidemia (elevated cholesterol levels), and glaucoma. The resident was admitted to the facility on 9/9/13. The resident was discharged from the facility on 11/13/13.</p> <p>The Physician orders were reviewed. An order was written on 9/10/13 for the resident to receive Zoloft ( an antidepressant medication) 50 milligrams once a day. An order was written on 9/20/13 for the resident to receive Zoloft 100 milligrams daily. An order was written on 11/6/13 for the resident to receive Zoloft 200 milligrams daily. Orders were written on 11/10/13 to discontinue Zoloft 200 milligrams and start Zoloft 100 milligrams daily.</p> <p>The 9/10/13 History and Physician report was reviewed. The report was completed by the Physician. The report indicated the resident's current diagnoses included generalized weakness, constipation, pneumonia, high blood pressure, glaucoma, aneurysm, hyperlipidemia, urinary</p>		<p>appropriate.IDT team to review antidepressant medication changes 5x weekly in CCM meetings. Social Services to audit residents with changes in antidepressant medication for appropriate diagnosis and documentation for the changes in social service progress notes 5x weekly for 4 weeks, then 2x weekly for 4 weeks then weekly thereafter until QAA states otherwise. DHS/designee will audit 5 resident charts weekly for proper nursing documentation of mood/behavior.Social Services/designee and DHS/designee will bring audits to QAA monthly for review and recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14</p>				

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	<p>retention, anxiety, GERD (gastric Esophageal Reflux Disease), and a history of deep vein thrombosis and prostate cancer. No diagnosis of depression was noted on the History and Physical report.</p> <p>The Physician Progress Notes were reviewed. A Progress Note completed on 9/20/13 indicated the resident's chief complaint was listed as 'still feels very weak, anxiety...feels very depressed, wants to go home.' The Progress Note also indicated the resident feels "I will never make it." The Progress Note also indicated depression was noted and the plan was for Zoloft 100 milligrams.</p> <p>The 10/2/13 Physician Progress Note indicated the resident had generalized weakness and fatigue and his anxiety was improving.</p> <p>The 11/6/13 Physician Progress Note indicated the resident was "depressed" and was not sure what he wanted out of life and feels sad and hopeless and had a flat affect and slow speech and his anxiety was improved. The plan on the Progress Note was to increase the Zoloft to 200 milligrams.</p> <p>A "Change in Condition" form was</p>						

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	<p>initiated on 9/20/13 (no time listed). The form indicated the Physician was in the facility to see the resident and a new order was given for the resident to receive Zoloft 100 milligrams daily. There were no signs and symptoms of the condition change listed on the form.</p> <p>A "Change In Condition" form was initiated on 11/10/13 on the 7:00 a.m.-3:00 p.m. shift. The form indicated the resident was lethargic, slow to respond, and difficult to arouse at times. The Physician was notified and orders were obtained to decrease the Zoloft medication to 100 milligrams daily. The form also indicated the resident's responsible party was notified. The bottom of the form was signed by the Social Service Director and the Director of Nursing.</p> <p>The Social Service Progress Notes were reviewed. The first entry was made on 9/10/13. This entry indicated the resident arrived to the facility on 9/9/13 from the hospital. The entry indicated the resident had diagnoses of generalized anxiety disorder, severe anxiety, aneurysm, constipation, increase weakness and glaucoma. No diagnosis of depression was listed. The note indicated the resident was receiving</p>						

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	<p>Dsyrel, Xanax (a medication for anxiety), Klonopin (a medication for seizures and acute episodes of bipolar disorder). The progress note did not indicated the resident was receiving Zoloft.</p> <p>The 9/12/13 Social Service Progress Note indicated the resident's medical record was reviewed for behaviors and psychoactive medications. The note indicated the resident had diagnoses of insomnia, generalized anxiety disorder and severe anxiety. The note listed the resident's medication and now included Zoloft as a medication the resident was receiving. The note indicated staff reported the resident was anxious, irritable, and had unrealistic fears. Interventions that worked for the resident included reassurance and changing the subject.</p> <p>The 9/20/13 Social Service Progress Note indicated the resident's behaviors and medications were reviewed at a meeting on 9/19/13 and no behaviors, mood concerns, or medication changes were noted.</p> <p>A Geriatric Depression Scale form was completed on 9/10/13. The Social Service Director completed the form. The resident's total score was</p>			

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	<p>(0). The form indicated a score greater than (5) was suggestive of depression and a scores greater than (10) were almost always depression. A Brief Interview for Mental Status (BIMS) interview was completed on 9/10/13. The resident's score was (6) which indicated his cognitive patterns were severely impaired.</p> <p>An Initial Psychosocial Assessment/MDS Supportive Documentation Tool &amp; Progress Notes dated 9/23/13 was reviewed. The note was completed by the Social Service Director. The note indicated the resident was interviewed by the Social Service Director and included a section titled "Mood." The resident answered "not at all" to (10) questions he was asked regarding being bothered about feeling down, depressed, or hopeless, having trouble falling or staying asleep or sleeping too much, feeling bad about himself or short tempered, or having thoughts that would be better off dead or hurting self in some way, amongst others.</p> <p>The 9/16/13 Minimum Data Set (MDS) admission assessment indicated the resident did not display any inattention, disorganized thinking or altered level of consciousness.</p>						

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	<p>The assessment also indicated the resident answered "no" to (9) mood questions asked regarding being bothered my symptoms such as feeling down, depressed, or hopeless, feeling bad about self, or thought of being better off dead, amongst others.</p> <p>The Behavior Detail records from 9/2013 thru 11/2013 were reviewed. For the month of September, daily entries were made 9/1/13 through 9/27/13. These entries all indicated no behaviors were noted</p> <p>For the month of October, daily entries were made 10/1/13 through 10/31/13. No behaviors were recorded 10/1/13 through 10/12/13. The only documented entries of behaviors in October were as follows:</p> <ul style="list-style-type: none"> <li>-On 10/14/13 at 4:26 p.m., the resident was noted to be yelling when he was being turned due to pain and the Nurse was notified.</li> <li>-On 10/20/13 at 3;17 p.m., the resident was noted to call out at random times during the shift and letting the resident know staff was there if he needed anything was effective.</li> <li>-On 10/22/13 at 9:49 p.m., resident yells out when doing ADL's (Activities of Daily Living)</li> </ul>						

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	<p>For the month of November, daily entries were made 11/2/13 through 11/13/13. All the entries indicated no behaviors were noted.</p> <p>The 9/2013, 10/2013, and the 11/2013 Skilled Nursing Assessment and Data Collection forms were reviewed. Each form had a section titled "Mood and Behavior." In this sections staff were to check if the resident exhibited little interest in doing things, appears depressed, trouble falling or staying asleep, appears to have little energy, poor appetite, overeats, difficulty concentrating, fidgety/restless, suicidal expressions, lethargy, delusions, behaviors, rejection of care. The forms indicated staff were to check all of the above that applied.</p> <p>The 9/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas checked in the Mood and Behaviors section: 9/10/13- 9/14/13 9/16/13-9/20/13 On the 9/11/13 form there was a narrative note written at 10:30 (no am or p.m. listed) which indicated the resident complained of anxiety and</p>						

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	<p>not wanting to participate in therapy. The resident's son expressed to the staff he did not want his father to do anything he did not want to do and staff was required to give the resident preferential treatment. Xanax was given for anxiety.</p> <p>The 10/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas in the Mood and Behaviors section: 10/01/13-10/10/13 10/12/13-10/16/13 10/18/13-10/26/13 On the 10/17/13 form there was a line with the word "none" above it marked on the Mood and Behavior section.</p> <p>The 11/2013 Skilled Nursing Assessment and Data Collection forms dated for the following dates did not have any of the above areas in the Mood and Behaviors section: 11/01/13- 11/12/13</p> <p>The resident's care plans were reviewed. A care plan initiated on 9/12/13 indicated the use of Psychotropic drugs placed the resident at risk for other drug related effects. The care plan indicated the resident was receiving anxiolytics (anti anxiety medications) and</p>						

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	<p>anti-depressant medications. An Individual Plan Report completed on 9/16/13 for "Mood and Behaviors" indicated the Resident had severe anxiety at times, gets irritable, and had unrealistic fears. The Individual Plan also indicated the resident usually will calm down when offered reassurance or a change of the conversation. The Social Service Director provided this care plan and identified this as the resident's individual care plan for behaviors and mood.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated Zoloft was an antidepressant medication and for adults the initial dose was recommended to be 50 milligrams a day with increases to a maximum of 200 milligrams a day. When receiving Zoloft the patient's mental status was to be monitored carefully.</p> <p>When interviewed on 12/16/13 at 11:40 a.m., the Social Service Director indicated she monitors the residents chart upon admission for psychotropic medications, diagnoses, and the possible need for psych services. The Social Service Director indicated the resident had a lot of pain and it appeared his behavior of yelling out occurred when he was</p>			

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	<p>receiving care and would stop after that. The Director indicated those were the only behaviors</p> <p>When interviewed on 12/17/13 at 12:40 p.m., the facility Administrator indicated the IDT (Interdisciplinary Team) meets daily and they go over every new medication order. The facility Administrator indicated Social Service is responsible for reviewing and monitoring the resident related to the psychotropic medication orders or changes.</p> <p>When interviewed on 12/17/13 at 12:45 p.m., the Social Service Director indicated she was aware the resident's Zolofit medication dosage had been increased as the facility had daily meeting where all the new Physician orders are reviewed. The Social Service Director indicated she did not look at the Physician Progress Notes related to the dates the Zolofit was increased and she was not aware of the statements the resident made to the Physician on the above dates to follow up on the statements. The Social Service Director indicated she did not necessarily note any signs or symptoms to increase the dosage.</p> <p>The policy titled "Psychoactive Drug</p>						

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	<p>Monitoring" was reviewed on 12/16/13 at 3:00 p.m. The policy had a last revised date of 09/17/2012. The facility Administrator provided the policy and identified the policy as current. The policy indicated resident's who receive antidepressant, hypnotic, antianxiety, or antipsychotic medications were to be monitored to evaluate the effectiveness of the medication. The policy indicated therapy with psychoactive drugs was to be initiated at a low dose and gradually increased as necessary. The policy also indicated the following conditions are to be satisfied prior to the initiation and/or continuation of therapy:</p> <ol style="list-style-type: none"> <li>1. Possible reversible causes for the resident's distress have been ruled out.</li> <li>2. Use results in maintenance or improvement in the resident's functional status.</li> <li>3. Long-term daily use had been accompanied by unsuccessful gradual dosage reductions unless reduction is clinically contraindicated.</li> <li>4. The need for and response to therapy are monitored and documented in the resident's medical record.</li> </ol> <p>The above policy also indicated continued need for psychoactive</p>			

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	<p>medication it to be re-assessed regularly by the care plan team and the prescriber. The need for continued use was to be documented in the medical record. Non pharmacological interventions including behavior modification or social services and their effects are to be documented as a part of care planning for the resident and are to utilized by the prescriber.</p> <p>This Federal tag relates to Complaint IN00141215.</p> <p>3.1-48(a)(1) 3.1-48(a)(4)</p>			

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F000333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure resident's remained free of significant medication error related to a diuretic medication given daily instead for every other day as ordered by the Physician which resulted in the resident requiring the administration of IV (intravenous) fluids for 1 of 3 residents reviewed for dehydration in the sample of 7. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 12/16/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, high blood pressure, chronic kidney disease, and edema.</p> <p>Review of the 9/28/13 Minimum Data Set (MDS) quarterly assessment indicated resident had received a diuretic medication on (7) days during the last (7) days. A care plan initiated on 4/4/13 indicated the resident was at risk for alterations in nutrition and hydration. The care plan was last</p>	F000333	<p>Resident #D received IV fluids and has had no negative outcome related to the medication error. Nurses 4, 5, 6, 7 were counseled on medication administration. No other residents with significant medication errors were noted. DHS/designee will inservice Licensed nursing/QMA staff on proper medication administration as per policy. Home office/Clinical support will inservice IDT on proper completion of Prevention Update on the Medication Error Circumstance, Assessment and Intervention report. DHS/designee will observe medication administration passes to cover all shifts, with 2 nurses weekly x 2 months, then 1 nurse weekly x 2 months, then 1 nurse monthly thereafter until QAA states otherwise. ED/DHS to audit Medication Error Circumstance forms weekly for completion of Prevention Update section and appropriate follow up. DHS/ED/Designee will bring audits to QAA monthly for review and recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14</p>	01/16/2014			

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	<p>updated on 9/27/13. Care plan interventions included for staff to administer medications as ordered by the Physician.</p> <p>Review of the 10/2013 Medication Administration Record indicate there was a Physician's order for the resident to receive one tablet Furosemide (a diuretic medication) 20 milligrams orally every other day. The order was originally written on 5/3/2012. The Furosemide medication was signed out as administered to the resident daily from 10/1/13 through 10/13/13 and 10/15/13 through 10/19/13. The Furosemide was not resumed until 10/28/13.</p> <p>A "Medication Error Circumstance, Assessment, and Intervention" report was completed on 10/20/13. The report indicated the medication error was found on 10/20/13 at 7:00 a.m. on the MAR (Medication Administration Record). The nature of the error indicated a medication was given every day instead of every other day as transcribed. The medication was identified as Lasix ( Furosemide) 20 milligrams. The resident's Physician and his Responsible Party were notified.</p>			

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	<p>On the 10/20/13 Medication Error Circumstance, Assessment, and Intervention report there was a section titled "Prevention Update." In this section there were spaces to check if any Nursing Education, Nursing Counseling, ongoing chart review for medication accuracy, or monitoring of side effects had been completed. These areas in the "Prevention Update" section were all blank. The section was signed by an LPN.</p> <p>There was another section on the 10/20/13 Medication Error Circumstance, Assessment, and Intervention report titled "IDT (Interdisciplinary Team) Review." This section contained areas to mark if the IDT reviewed the above Prevention Update and agreed with the plan to maximize safety. This section was not completed. Five IDT team members signed the above sheet with the noted blanks.</p> <p>A "Change in Condition" form was initiated on 10/24/13 (no time listed). The form indicated the resident was noted to have "abnormal labs-dehydration." The Physician response was for the resident to receive IV fluids of 0.9% normal saline at 150 ml's (millimeters) an</p>						

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	<p>hour x 3 liters and to obtain a BMP (laboratory test) after the fluids were administered.</p> <p>The October 2013 Physician orders were reviewed. The following orders were written:            10/20/13- Patient to have BMP on 10/21/13.            10/22/13 - Hold Lasix x 2 days (10/23/13 and 10/24/13), push oral hydration every shift, repeat BMP on 10/24/13, and obtain a renal ultrasound.            10/24/13- Resident to receive 0.9 % Normal Saline via IV at 150 milliliters per hour for a total of (3) liters            10/26/13- Continue to hold Lasix and push fluids.</p> <p>The 9/2013 and the 10/2013 laboratory test results were reviewed and the following results were recorded;            09/03/2013            BUN (Blood Urea Nitrogen): 37 (normal level 7-22)            Creatinine: 1.8 (normal level .4-1.5)</p> <p>10/01/2013            BUN: 43 (normal level 7-22)            Creatinine: 1.8 (normal level .4- 1.5)            Sodium : 146 (normal level 135-147)            Potassium: 4.0 (normal level 3.5-5.0)</p>						

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	<p>10/03/2013 BUN: 51 (normal level 7-22) Creatatine: 1.9 (normal level .4- 1.5)</p> <p>10/21/2013 BUN: 74 (normal level 7-22) Creatanine 2.3 (normal level .4-1.5)</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated adverse reactions to Furosemide included, dehydration and anemia. The Handbook also indicated BUN laboratory levels were to be monitored.</p> <p>When interviewed on 12/16/13 at 3:05 p.m., the Director of Nursing indicated the medication error was found by a Nurse during medication pass. The diuretic medication was being administered once a day instead of every other day. The Director of Nursing indicated no Nursing staff inservicing or staff education was completed related to the above medication error. The Director of Nursing indicated other charts on the unit were audited at this time. The DON indicated the facility had Nurses reviewing the monthly orders and as a result of the above error they assigned a Manager to review the monthly orders. The DON indicated there were no Nursing</p>				

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	<p>inservices or education completed related to the medication errors the Nurses were making when they gave the medication daily instead of every other day as the order was written on the Medication Administration Record.</p> <p>The facility policy title "Med Pass Procedures &amp; Error Prevention" was reviewed on 12/17/13 at 11:40 a.m. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated during medication administration pass the staff were to triple check the medications for accuracy by comparing the ancillary label, the resident label, and the Medication Administration Record three times. The three times were to be as the medication was pulled from the cart, as the medication was prepared for administration, and as the medication container was placed back into the medication cart.</p> <p>This Federal tag relates to Complaint IN00141215.</p> <p>3.1-48(c)(2)</p>				

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F000520 SS=G	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview the facility failed to ensure a Medication Error was accurately identified and addressed in the Quality Assessment and Assurance committee meeting related to numerous Nurses failing to follow the policy for checking medication orders prior to administering medications for 1 resident in the sample of 7. (Resident #D) (Nurse #4, #5, #6, and #7)</p>	F000520	Resident #D received IV fluids and has had no negative outcome related to the medication error. Nurses 4, 5, 6, 7 were counseled on medication administration. No other residents with significant medication errors were noted. DHS/designee will inservice Licensed nursing/QMA staff on proper medication administration as per policy. Home office/Clinical support will inservice IDT on proper completion of Prevention Update on the Medication Error	01/16/2014			

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	<p>Findings include:</p> <p>The record for Resident #D was reviewed on 12/16/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, high blood pressure, chronic kidney disease, and edema.</p> <p>Review of the 10/2013 Medication Administration Record indicate there was a Physician's order for the resident to receive one tablet Furosemide (a diuretic medication) 20 milligrams orally every other day. The order was originally written on 5/3/2012. The Furosemide medication was signed out as administered to the resident daily from 10/1/13 through 10/13/13 and 10/15/13 through 10/19/13. The Furosemide was not resumed until 10/28/13. The above medication was initialed as given by approximately (4) different staff members. Those staff members were Nurse #4, #5, #6, and #7.</p> <p>A "Medication Error Circumstance, Assessment, and Intervention" report was completed on 10/20/13. The report indicated the medication error was found on 10/20/13 at 7:00 a.m.</p>		<p>Circumstance, Assessment and Intervention report. DHS/designee will observe medication administration passes to cover all shifts, with 2 nurses weekly x 2 months, then 1 nurse weekly x 2 months, then 1 nurse monthly thereafter until QAA states otherwise. ED/DHS to audit Medication Error Circumstance forms weekly for completion of Prevention Update section and appropriate follow up. DHS/ED/Designee will bring audits to QAA monthly for review and recommendations for 6 months and then Quarterly thereafter until 100% compliance is achieved.1/16/14</p>		

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	<p>on the MAR (Medication Administration Record). The nature of the error indicated a medication was given every day instead of every other day as transcribed. The medication was identified as Lasix ( Furosemide) 20 milligrams. The resident's Physician and his Responsible Party were notified.</p> <p>On the 10/20/13 Medication Error Circumstance, Assessment, and Intervention report there was a section titled "Prevention Update." In this section there were spaces to check if any Nursing Education, Nursing Counseling, ongoing chart review for medication accuracy , or monitoring of side effects had been completed. These areas in the "Prevention Update" section were all blank. The section was signed by an LPN.</p> <p>There was another section on the 10/20/13 Medication Error Circumstance, Assessment, and Intervention report titled "IDT (Interdisciplinary Team) Review." This section contained areas to mark if the IDT reviewed the above Prevention Update and agreed with the plan to maximize safety. This section was not completed. Five IDT team members signed the above</p>			

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	<p>sheet with the noted blanks.</p> <p>A "Change in Condition" form was initiated on 10/24/13 (no time listed). The form indicated the resident was noted to have "abnormal labs-dehydration." The Physician response was for the resident to receive IV fluids of 0.9% normal saline at 150 ml's (millimeters) an hour x 3 liters and to obtain a BMP (laboratory test) after the fluids were administered.</p> <p>The October 2013 Physician orders were reviewed. The following orders were written: 10/20/13- Patient to have BMP on 10/21/13. 10/22/13 - Hold Lasix x 2 days (10/23/13 and 10/24/13), push oral hydration every shift, repeat BMP on 10/24/13, and obtain a renal ultrasound. 10/24/13- Resident to receive 0.9 % Normal Saline via IV at 150 milliliters per hour for a total of (3) liters 10/26/13- Continue to hold Lasix and push fluids.</p> <p>The 9/2013 and the 10/2013 laboratory test results were reviewed ad the following results were recorded; 09/03/2013</p>						

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	<p>education was completed related to the above medication error. The Director of Nursing indicated other charts on the unit were audited at this time. The DON indicated the facility had Nurses reviewing the monthly orders and as a result of the above error they assigned a Manager to review the monthly orders. The DON indicated there were no Nursing inservices or education completed related to the medication errors the Nurses were making when they gave the medication daily instead of every other day as the order was written on the Medication Administration Record.</p> <p>The facility policy title "Med Pass Procedures &amp; Error Prevention" was reviewed don 12/17/13 at 11:40 a.m. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated during medication administration pass the staff were to triple check the medications for accuracy three times. The times three times were to be as the medication was identified, as the medication was prepared, and as the medication container was put back.</p> <p>When interviewed on 12/17/13 at 11:38 a.m., the facility Administrator indicated the Quality Assessment and</p>						

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	<p>Assurance team consists of the Administrator, DON, ADON, MDS Nurse, Unit Manager, and the Medical Director. The Administrator indicated there are standard quality measures covered at each meeting. These measures included Medication Errors. The Administrator indicated at the 11/20/13 Quality Assessment and Assurance meeting it was determined there were transcription errors. The plan that was put into place was to have a Department manager review and sign the monthly Physician orders instead of a staff Nurse. The Administrator indicated the plan did not address the issue of the 10/2013 Medication Errors for Resident #D in which the errors occurred by Nurses not following the policy to verify the order written on the MAR (Medication Administration Record) prior to administering medications to the resident rather than a transcription error.</p> <p>This Federal tag relates to Complaint IN00141215.</p> <p>3.1-52(b)</p>				

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