

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155763	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2013
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NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 TRAIL RIDGE RD ALBION, IN 46701
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: February 5, 6, 7, 8, 11, and, 12, 2013.</p> <p>Facility number: 011296 Provider number: 155763 AIM number: 200827620</p> <p>Survey Team: Carol Miller, RN, TC Diane Nilson RN (February 5, 6, 7,8,and,11, 2013) Tim Long RN Rick Blain RN (February 5, 7,and, 8, 2013)</p> <p>Census Bed Type: SNF/NF: 63 Residential: 11 Total: 74</p> <p>Census Payor Type: Medicaid: 39 Medicare: 11 Other: 24 Total: 74</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410</p>	F0000	<p>This plan of correction is to serve as North Ridge Village Nursing and Rehab Center's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing and Rehab Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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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	IAC 16.2. Quality Review completed on February 14, 2013 by Randy Fry RN.			

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F0247 SS=A	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review the facility failed to notify a resident (#75) of a roommate change in a timely manner for 1 of 22 residents interviewed.</p> <p>Findings include:</p> <p>An interview with resident #75 on 2/6/13 at 9:30 A.M. indicated she had gotten a new roommate several weeks earlier after her husband passed away. Resident #75 indicated the first time she heard about the new roommate was when they put the roommates name on the door.</p> <p>Review of the resident's clinical record did not indicate any notification for resident #75 of getting a new roommate recently.</p> <p>An interview with the Assistant Director of Nursing (ADN) on 2/8/13 at 2:05 PM indicated she could not locate any information of resident #75 receiving notification of a new roommate after her husband passed away. The ADN indicated the resident should have been notified of a new</p>	F0247	<p>F247 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE It is the practice of North Ridge Village Nursing and Rehab Center to provide notification before the resident's room or roommate in the facility is changed.</p> <p>I. Resident #75 currently has a roommate. She is agreeable and the pairing is compatible at this time.</p> <p>II. Residents who may experience a room or roommate change have the potential to be affected.</p> <p>III. The facility utilizes the Residents' Rights as part of its policies and procedures. Social Service personnel have been re educated regarding Residents' Rights. Social Services will notify residents if they are going to have a roommate or a room change and the notification will be documented.</p> <p>IV. The SSD or her designee is conducting quality improvement audits to ensure that residents who experience a room or roommate change are notified. Residents experiencing a room or roommate change will be monitored for 6 months to ensure they have been notified. Results of these</p>	03/08/2013			

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	roommate before the roommate was to move in. 3.1-3(v)(2)		audits will be reported to the QA committee monthly.		

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise a written plan of care after a change in condition, for 1 of 1 residents reviewed for a decline in urinary incontinence (Resident #66), in a sample of 40.</p> <p>Findings include:</p> <p>The record for Resident #66 was reviewed on 2/8/2013 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/4/12 with diagnoses including, but not limited to dementia with behavioral disturbances and hypertonicity of the</p>	F0280	<p>F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>It is the practice of North Ridge Village Nursing and Rehab Center to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by</p>	03/08/2013			

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	<p>bladder.</p> <p>The Minimum Data Set (MDS) admission assessment, dated 10/8/2012, indicated the resident was continent of bowel and occasionally incontinent of urine. The Quarterly MDS assessment, completed on 1/7/2013, indicated the resident was continent of bowel, but frequently incontinent of urine.</p> <p>Review of a 3 day bowel and bladder monitoring record, dated 10/5/12 through 10/7/12, indicated on 10/5/12 the resident was toileted at 12 midnight, 3:00 a.m., 4:00 a.m., 7:00 a.m., 1:00 p.m., 4:00 p.m., and 8:00 p.m., and urinated in the toilet. The record indicated the resident had a small urine incontinence at 1:00 p.m., and 7:00 p.m.</p> <p>On 10/6/12, the bowel and bladder record indicated the resident was toileted at 1:00 a.m., 3:00 a.m., 4:00 a.m., and 5:00 a.m., and urinated in the toilet. The rest of the monitoring record was not completed with blanks for the rest of the day.</p> <p>On 10/7/12, the bowel and bladder record indicated the resident was toileted at 12 midnight, 3:00 a.m., 5:00 a.m., 7:00 a.m., 10 a.m., 1:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m., and had urinated in the toilet.</p>		<p>a team of qualified persons after each assessment.</p> <p>I. Resident #66 has been re assessed for urinary incontinence and the care plan has been updated to reflect the outcome of the assessment.</p> <p>II. All residents that have a change in bladder continence have the potential to be affected.</p> <p>III. The facility has a policy regarding care planning. The care plan team has been re educated on this policy. Residents who have a change in urinary incontinence will have their care plan reviewed and revised as necessary.</p> <p>IV. The MDS coordinator or her designee will conduct a quality improvement audit of care plans for accuracy. The care plans are being reviewed with completion of the MDS comprehensive assessment weekly for 6 months. Results of these audits will be reported to the QA committee monthly.</p>				

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	<p>The bowel and bladder record indicated, "If incontinent of bladder, attempt to identify the type or urinary incontinence below" and below this statement Functional incontinence was circled to identify the type of incontinence.</p> <p>The summary of the bowel and bladder record indicated to continue with the current program to decrease incontinent episodes and decrease the risk of skin breakdown.</p> <p>Review of a quarterly nursing assessment, dated 12/27/12, indicated the resident was continent of bowel and bladder.</p> <p>Review of an interdisciplinary team progress note, dated 1/28/13, indicated the resident had a fall on 1/27/13 with no injuries. The progress note indicated the toileting program was reviewed and to continue, and the resident's care plan was reviewed and to continue with the current care plan interventions.</p> <p>Review of a care plan initiated 10/24/12, and revised on 1/14/13, indicated the resident was at risk for falls, with risk factors including history of falls, high risk medications,</p>						

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	<p>unsteady gait, non-compliance with staff assist, dementia, and overactive bladder.</p> <p>The only other care plan which mentioned a toileting program was initiated 1/14/13 and indicated the resident had impaired mobility related to dementia</p> <p>The only intervention listed which related to bladder status indicated to continue with the current toileting schedule. This intervention was dated 1/28/13.</p> <p>There were no revisions to the care plan after the resident was assessed on the quarterly MDS to have an increase in urinary incontinence, and no documentation regarding a new bowel and bladder assessment to indicate the resident was frequently incontinent of urine.</p> <p>CNA #1 was interviewed, at 11:23 a.m., on 2/8/13 and indicated Resident #66 required a one person assist for toileting, was usually incontinent of urine when the CNA got the resident up in the morning, was incontinent at times, but was usually continent during the day. CNA #1 indicated she was not sure what toileting schedule the resident was on, but she toileted the resident</p>			

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	<p>before breakfast, and before and after lunch. She indicated the resident wore an incontinent brief, was confused, and did not use her call light.</p> <p>The MDS/LPN coordinator was interviewed at 9:48 a.m., on 2/11/13, and indicated Resident #66 did not have a toileting schedule. She indicated the resident had a diagnosis of overactive bladder, and when she completed the quarterly MDS, on 1/7/13, the documentation from the CNA input on the assessments showed an increase in urinary incontinence for the resident. She indicated she used the information from the 3 day Bowel and Bladder monitoring record to update the care plan and incontinent program for the residents , but she had not gotten back the bowel and bladder monitoring record, so had not updated the care plan to show the resident was now incontinent. She indicated she did not see the bowel and bladder record until 2/11/13. The MDS nurse indicated the care plan intervention, dated 1/28/13, which indicated to continue with the current toileting schedule was documented on the care plan due to a fall, but the resident was not on any toileting</p>			

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	<p>program because she did not have the new bowel and bladder record, dated 1/15-17, 2013, back from the CNAs who filled out the bowel and bladder record.</p> <p>The Assistant Director of Nursing(DNS) was interviewed, at 10:07 a.m., on 2/11/13, and indicated the MDS nurse was responsible to provide QMA #2 who was the Unit Manager, the bowel and bladder monitoring record for the CNAs to complete. The Assistant DNS indicated QMA #2 got the bowel and bladder record for Resident #66 in December, 2012, and placed the bowel and bladder record in the Activity of Daily Living (ADL) book for the CNAs to complete. She indicated the dates for the bowel and bladder record were predated by the MDS nurse before placing in the ADL books. The Assistant DNS indicated when the CNAs completed the record they were to leave it in the ADL books and the MDS nurse was responsible to collect the completed bowel and bladder assessments, and then proceed to write a toileting program and update the care plans.</p> <p>Review of the "Urinary Incontinence" policy (undated), at 3:10 p.m., on 2/11/13, and provided by the MDS</p>				

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	<p>nurse, at 3:08 p.m., on 2/11/13, indicated the goals for the residents who experienced urinary incontinence was to restore as much bladder function as possible and to prevent urinary tract infections.</p> <p>The procedures for this goal included, but were not limited to the following:</p> <p>Residents newly admitted or with a change in cognition, physical ability or change in urinary tract function would be evaluated by the nursing staff;</p> <p>The evaluation would include a comprehensive assessment which would include voiding patterns (3 day voiding worksheet), medication review, patterns of fluid intake, functional and cognitive abilities, type and frequency of physical assistance necessary, pertinent diagnoses, identification of potential skin breakdown, and contributing environmental factors and assistive devices.</p> <p>The procedure indicated the type of incontinence would be identified, and an individual care plan with interventions to facilitate the highest practicable level of functioning and minimize further decline would be developed, and a bladder retraining program developed, if applicable.</p> <p>3.1-35(d)(2)(B)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to assess a resident who had an increase in urinary incontinence, for an individualized toileting program and per facility policy. This affected 1 of 1 residents reviewed for a decline in urinary incontinence, Resident #66, in a sample of 40 residents.</p> <p>Findings include:</p> <p>The record for Resident #66 was reviewed on 2/8/2013 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/4/12 with diagnoses including, but not limited to dementia with behavioral disturbances and hypertonicity of the bladder.</p>	F0315	<p>F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>It is the practice of North Ridge Village Nursing and Rehab Center to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>I. Resident #66 has been re assessed for bladder incontinence.</p> <p>II. All incontinent residents have the potential to be affected.</p> <p>III. The facility has a policy for assessing urinary incontinence. Licensed nurses have been re educated on this policy. This re education stressed the importance</p>	03/08/2013

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	<p>The Minimum Data Set (MDS) admission assessment, dated 10/8/2012, indicated the resident was continent of bowel and occasionally incontinent of urine.</p> <p>The Quarterly MDS assessment, completed on 1/7/2013, indicated the resident was continent of bowel, but frequently incontinent of urine.</p> <p>Review of a 3 day bowel and bladder monitoring record, dated 10/5/12 through 10/7/12, indicated on 10/5/12 the resident was toileted at 12 midnight, 3:00 a.m., 4:00 a.m., 7:00 a.m., 1:00 p.m., 4:00 p.m., and 8:00 p.m., and urinated in the toilet. The record indicated the resident had a small urine incontinence at 1:00 p.m., and 7:00 p.m.</p> <p>On 10/6/12, the bowel and bladder record indicated the resident was toileted at 1:00 a.m., 3:00 a.m., 4:00 a.m., and 5:00 a.m., and urinated in the toilet. The rest of the monitoring record was not completed with blanks for the rest of the day.</p> <p>On 10/7/12, the bowel and bladder record indicated the resident was toileted at 12 midnight, 3:00 a.m., 5:00 a.m., 7:00 a.m., 10 a.m., 1:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m., and had urinated in the toilet.</p>		<p>of the development of individualized toileting programs based on the completion of the three-day bowel and bladder monitoring record. In addition, the three-day bowel and bladder tracking records will be reviewed during morning IDT clinical meeting to further ensure completion, assessment, and development of individualized toileting programs. Residents will be re assessed for urinary incontinence during the MDS Assessment period. Residents who have a change in urinary incontinence will have their care plan reviewed and revised as necessary.</p> <p>IV. The MDS coordinator or her designee is conducting quality improvement audits to ensure that residents are assessed for bladder incontinence. Resident assessments will be reviewed with the completion of the MDS comprehensive assessment weekly for 6 months. Results of these audits will be reported at the QA committee monthly.</p>	

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	<p>The bowel and bladder record indicated, "If incontinent of bladder, attempt to identify the type or urinary incontinence below" and below this statement Functional incontinence was circled to identify the type of incontinence.</p> <p>The summary of the bowel and bladder record indicated to continue with the current program to decrease incontinent episodes and decrease the risk of skin breakdown.</p> <p>Review of a quarterly nursing assessment, dated 12/27/12, indicated the resident was continent of bowel and bladder.</p> <p>Review of an interdisciplinary team progress note, dated 1/28/13, indicated the resident had a fall on 1/27/13 with no injuries. The progress note indicated the toileting program was reviewed and to continue, and the resident's care plan was reviewed and to continue with the current care plan interventions.</p> <p>Review of a care plan initiated 10/24/12, and revised on 1/14/13, indicated the resident was at risk for falls, with risk factors including history of falls, high risk medications, unsteady gait, non-compliance with</p>			

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	<p>staff assist, dementia, and overactive bladder.</p> <p>The only other care plan which mentioned a toileting program was initiated 1/14/13 and indicated the resident had impaired mobility related to dementia</p> <p>The only intervention listed which related to bladder status indicated to continue with the current toileting schedule. This intervention was dated 1/28/13.</p> <p>There were no revisions to the care plan after the resident was assessed on the quarterly MDS to have an increase in urinary incontinence, and no documentation regarding a new bowel and bladder assessment to indicate the resident was frequently incontinent of urine.</p> <p>CNA #1 was interviewed, at 11:23 a.m., on 2/8/13 and indicated Resident #66 required a one person assist for toileting, was usually incontinent of urine when the CNA got the resident up in the morning, was incontinent at times, but was usually continent during the day. CNA #1 indicated she was not sure what toileting schedule the resident was on, but she toileted the resident before breakfast, and before and after lunch. She indicated the</p>			

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	<p>resident wore an incontinent brief, was confused, and did not use her call light.</p> <p>At 9:43 a.m., on 2/11/13, the Assistant Director of Nursing provided a Bowel and Bladder Monitoring Record, which was dated 1/15/13 through 1/17/13. The record was completed and indicated on 1/15/13, the resident had 3 episodes of large urinary incontinence, on 1/16/13, the resident had 1 large episode of urinary incontinence and 2 small episodes of urinary incontinence, and on 1/17/13, the record indicated the resident had 8 episodes of large urinary incontinence.</p> <p>There was no summary to indicate the type of urinary incontinence, or what toileting plan would be put in place to address the increase in incontinent episodes. The Assistant Director of Nursing indicated the Minimum Data Set (MDS) Nurse was responsible for the Bowel and Bladder assessments and toileting schedules.</p> <p>The MDS/LPN coordinator was interviewed at 9:48 a.m., on 2/11/13, and indicated Resident #66 did not have a toileting schedule. She indicated the resident had a diagnosis</p>						

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	<p>of overactive bladder, and when she completed the quarterly MDS, on 1/7/13, the documentation from the CNA input on the assessments showed an increase in urinary incontinence for the resident. She indicated she used the information from the 3 day Bowel and Bladder monitoring record to update the care plan and incontinent program for the residents , but she had not gotten back the bowel and bladder monitoring record, so had not updated the care plan to show the resident was now incontinent. She indicated she did not see the bowel and bladder record until 2/11/13. The MDS nurse indicated the care plan intervention, dated 1/28/13, which indicated to continue with the current toileting schedule was documented on the care plan due to a fall, but the resident was not on any toileting program because she did not have the new bowel and bladder record, dated 1/15-17, 2013, back from the CNAs who filled out the bowel and bladder record.</p> <p>The Assistant Director of Nursing(DNS) was interviewed, at 10:07 a.m., on 2/11/13, and indicated the MDS nurse was responsible to provide QMA #2 who was the Unit Manager, the bowel and bladder</p>						

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	<p>monitoring record for the CNAs to complete. The Assistant DNS indicated QMA #2 got the bowel and bladder record for Resident #66 in December, 2012, and placed the bowel and bladder record in the Activity of Daily Living (ADL) book for the CNAs to complete. She indicated the dates for the bowel and bladder record were predated by the MDS nurse before placing in the ADL books. The Assistant DNS indicated when the CNAs completed the record they were to leave it in the ADL books and the MDS nurse was responsible to collect the completed bowel and bladder assessments, and then proceed to write a toileting program and update the care plans.</p> <p>QMA #2 was interviewed, at 11:09 a.m., on 2/11/13, and indicated she made out the CNA assignment sheets. She indicated a 72 hour Bowel and Bladder assessment was completed on any new admission or re-admission from the hospital. She indicated the assessments were placed in the ADL binders located at the CNA stations on each hall. The CNAs were responsible to check daily in the ADL binders on each hall, and were responsible to complete the bowel and bladder assessments placed in the binders, then to leave</p>				

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	<p>the assessments in the binders. The QMA indicated when the MDS nurse retrieved the assessments from the binders, she would use the assessments to write toileting programs and care plans for the residents. The QMA indicated when the MDS nurse finished writing the toileting programs, staff would discuss this information in the daily morning meetings then QMA #2 would make out the CNA assignment sheets reflecting this new information. She indicated she used to document "scheduled toileting program" on the CNA assignment sheets for any resident who was on scheduled toileting, but started putting specific toileting times on the assignment sheets about 6 weeks to 2 months ago.</p> <p>She indicated Resident #66 currently had "scheduled toileting program" documented on the CNA assignment sheet, but after the bowel and bladder monitoring record, dated 1/15-17,2013 was completed, she would indicate a specific time schedule for toileting the resident.</p> <p>The Minimum Data Set (MDS) nurse, was interviewed at 2:22 p.m., on 2/11/13, and indicated bowel and bladder assessments were completed</p>				

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	<p>quarterly and/or more often if a change in status.</p> <p>She indicated either herself or QMA #2 would retrieve the completed bowel and bladder assessment from the Activities of Daily Living (ADL) book. She indicated neither one of them pulled the completed form(dated 1/15-1/17,2013)from the ADL book, and indicated they "missed" it. She indicated she just saw the completed Bowel and Bladder assessment on 2/11/13. She indicated once the form was completed, she used it to make an individual bowel and bladder schedule for the resident and then updated the care plan.</p> <p>Review of the "Urinary Incontinence" policy (undated), at 3:10 p.m., on 2/11/13, and provided by the MDS nurse, at 3:08 p.m., on 2/11/13, indicated the goals for the residents who experienced urinary incontinence was to restore as much bladder function as possible and to prevent urinary tract infections.</p> <p>The procederes for this goal included, but were not limited to the following: Residents newly admitted or with a change in cognition, physical ability or change in urinary tract function would be evaluated by the nursing staff; The evaluation would include a</p>						

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	<p>comprehensive assessment which would include voiding patterns (3 day voiding worksheet), medication review, patterns of fluid intake, functional and cognitive abilities, type and frequency of physical assistance necessary, pertinent diagnoses, identification of potential skin breakdown, and contributing environmental factors and assistive devices.</p> <p>The procedure indicated the type of incontinence would be identified, and an individual care plan with interventions to facilitate the highest practicable level of functioning and minimize further decline would be developed, and a bladder retraining program developed, if applicable.</p> <p>3.1-41(a)(2)</p>			

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F0329 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 2 residents (75, 93) of 10 residents reviewed for unnecessary medications were free from unnecessary psychotropic medications by attempting non-pharmacological interventions before administration of the medications.</p> <p>Findings include:</p> <p>1. Resident #75's clinical record was</p>	F0329	<p>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>It is the practice of North Ridge Village Nursing and Rehab Center to ensure each residents drug regimen is 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 indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>	03/08/2013

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	<p>reviewed on 2/7/13 at 1:00 P.M.. The record indicated the resident was started on Xanax (an antianxiety medication) 0.25 milligrams (mg), 1 tablet by mouth every 8 hours as needed (PRN) for increased anxiety. Review of the resident's Medication Administration Record (MAR) for January 2013 indicated the resident was administered Xanax 0.25mg on 5 occasions in January 2013. On one occasion on 1/13/13 at 8:00 P.M. it was documented non-pharmacological interventions were attempted before administration of Xanax. On the other 4 occasions (1/6/13, 1/7/13, and twice on 1/8/13) Xanax 0.25mg was administered without non-pharmacological interventions attempted first.</p> <p>Review of Resident #75's nurse's notes for January 2013 indicated no non-pharmacological interventions were attempted before the administration of PRN Xanax 0.25mg on the 4 occasions indicated.</p> <p>An interview with LPN #5 on 2/7/13 at 2:20 P.M. indicated she gave resident #75 Xanax several times in January 2013 and she had tried non-pharmacological interventions before administering the medications but she did not document the</p>		<p>combinations of the reasons above.</p> <p>I. Resident #75 was assessed by her attending physician for the continued use of her psychotropic medications. Resident # 93 no longer resides in the facility.</p> <p>II. Residents that utilize psychotropic medications have the potential to be affected.</p> <p>III. The facility has a policy regarding the use of psychotropic medication as well as a behavior management program. Licensed nurses and social service personnel have been re educated on this policy. This re education stressed the importance of the provision of non-pharmacological interventions prior to administration of psychotropic medications; and the use of the behavior management program. The facility has also implemented a daily IDT meeting that will include the review of any behaviors and the interventions utilized to manage those behaviors.</p> <p>IV. The SSD or her designee is conducting a quality improvement audit to ensure that residents are monitored for non-pharmacological interventions prior to the use of anti-anxiety medications and that these interventions have been documented. A random sample of 5 residents receiving psychotropic medications will be monitored 3 times per week for 30 days; then monthly for 6 months. The</p>				

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	<p>interventions.</p> <p>An interview with LPN # 3 on 2/7/13 at 2:30 P.M. indicated she gave resident # 75 Xanax PRN once in January and she tried non-pharmacological interventions before administering but she did not document the interventions.</p> <p>Review of resident #93's clinical record was on 2/8/13 at 9:30 A.M. The record indicated the resident was started on Lorazepam (an antianxiety medication) 0.5 mg PRN every 4 hours for agitation. Review of the resident's MAR indicated she received Lorazepam 0.5mg PRN on 15 occasions in November 2012, 13 occasions in December and 2 occasions in January 2013. The MAR did not indicate any non-pharmacological interventions were attempted before administration of the medications. Review of resident #93's Nurse's Notes for November and December 2012 and January 2013 indicated no interventions were attempted before administration of Lorazepam 0.5 mg PRN.</p> <p>An interview with the Assistant Director of Nursing (ADN) on 2/8/13 indicated nurse's should be</p>		<p>pharmacy consultant will assist in monitoring during monthly visits. Results of these audits will be reported to the QA committee monthly.</p>				

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	<p>documenting non-pharmacological interventions attempted before administration of PRN psychotropic medications. The ADN indicated the behavior book lists the interventions to be attempted for particular behaviors to be attempted for residents.</p> <p>Review of the undated facility Psychotropic Medication Policy indicated under Policy, #5: "Prior to the initiation of psychotropic medications the IDT should assess the resident to rule out possible causes (environmental stressors, psychosocial stressors, treatable medical conditions). Non-pharmacological interventions should be attempted and response to these interventions documented in the clinical record."</p> <p>3.1-48(a)(4)</p>				

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview the facility failed to ensure medication were used within proper time period after opening for 3 medications</p>	F0431	<p>F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>It is the practice of North Ridge Village Nursing and Rehab Center to</p>	03/08/2013			

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	<p>observed in 3 medication storage units in the facility.</p> <p>Findings include:</p> <p>An observation on 2/11/13 at 1:45 P.M., of the 300 hall medication cart indicated resident #20's Travatan 0.004% eye drops were opened 11/4/12. An interview with LPN #5 indicated the eye drops are to be discarded within 90 days of opening.</p> <p>An observation on 2/11/13 at 1:50 P.M., of the split hall medication cart (300 and 400 hall residents) indicated resident # 6s Artificial Tears eye drops were opened 10/20/12. An interview with LPN #6 indicated the resident had not used the Artificial Tears eye drops since they were opened but they should have been discarded after 90 days.</p> <p>An observation on 2/11/13 at 2:10 P.M., of the 400 hall medication cart indicated resident #120's Levemir insulin bottle was opened 1/10/13. An interview with LPN # 3 indicated the Levemir should have been discarded after 30 days of opening which would have been 2/9/13.</p> <p>An interview with the Assistant Director of Nursing (ADN) on 2/11/13</p>		<p>employ or obtain the services of a licensed pharmacist who establishes a system of records and receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Drugs and biological are stored in locked compartments under proper temperature controls, and only authorized personnel have access to the keys. The facility provides separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can readily be detected.</p> <p>I. Resident #20, #6, and #120 had their expired medication removed from the medication cart.</p> <p>II. All residents that have medication have the potential to be affected.</p> <p>III. The facility has a policy</p>		

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R0000	<p>at 2:15 P.M. indicated the medications should have been discarded appropriately, the eye drops after 90 days and the insulin after 30 days. The ADN indicated there was not a policy for discarding opened medication bottles.</p> <p>3.1-25(m)</p>	R0000	<p>addressing expired medication. Licensed nurses have been re educated regarding this policy. Additional systemic changes are being implemented through our quality improvement program identified below.</p> <p>IV. The DON or her designee is conducting quality improvement audits to ensure expired medication is removed immediately. Medication carts will be audited 3 times per week for 30 days, then 2 times per week for 30 days, then weekly for 4 months. The pharmacy consultant will assist with medication cart audits during monthly visits. Results of these audits will be reported to the QA committee monthly.</p> <p>This plan of correction is to serve as North Ridge Village Nursing and Rehab Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing and Rehab Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	