

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2012
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NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit also included investigation of Complaint IN00116533</p> <p>Complaint IN00116533: Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 17, 18, 19, 20, 21, 2012</p> <p>Facility number: 000141 Provider number: 155236 AIM number: 100283860</p> <p>Survey team: Melanie Strycker, R.N. - Team Coordinator Janet Stanton, R.N. Heather Lay, R.N.</p> <p>Census bed type: SNF/NF--136 Total--136</p> <p>Census payor type: Medicare--21 Medicaid--88 Other--27 Total--136</p> <p>Sample: 24</p>	F0000	<p>This plan of correction is prepared and executed because it is required by the Provisions of State and Federal Regulations. Avon Health and Rehabilitation maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such a nature as to limit our capability to provide adequate care.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 1, 2012 by Bev Faulkner, RN</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation, and interview, the facility failed to develop an individualized dialysis care plan regarding a resident's actual access site [catheter] but referred to an access site [graft or fistula] that did not exist for the resident. The facility also failed to develop an individualized care plan for residents who was receiving Hospice services. These deficient practices affected 3 residents reviewed in a sample of 24 residents reviewed. [Residents #32, # 11 and #105]</p>	F0279	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Care plans for the residents #32, #11 and #105 updated to the resident's current conditions and Hospice Services where applicable. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents receiving dialysis and hospice services have the potential to be affected. Care Plans of residents receiving</p>	10/21/2012

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	<p>Findings include:</p> <p>1. On 9/17/12 at 8:40 A.M., tour was initiated with Licensed Practical Nurse [LPN] #11.</p> <p>At that time, Resident #32 was described as receiving dialysis services with an access site [catheter] in his left neck. He was described as being interviewable at times.</p> <p>On 9/18/12 at 11:30 A.M., Resident #32's record was reviewed. Diagnoses included, but were not limited to, anemia, insulin dependent diabetes mellitus, end stage renal disease, and depression.</p> <p>Resident #32 was admitted to the facility on 1/19/12.</p> <p>A dialysis careplan, included, but was not limited to, "Focus: Dialysis related to renal failure... date initiated 1/30/12... Goals: Will have no signs or symptoms of complications from dialysis... Interventions [date initiated 1/30/12]: Do not draw blood or take blood pressure in arm with graft, encourage resident to go for the scheduled dialysis appointments, observe for and report to MD as needed any signs or symptoms of</p>		<p>dialysis and hospice services were reviewed and updated.</p> <p>What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>DON/Designee to consult with facility Social Services and Hospice service provider upon admission and monthly thereafter to coordinate care plans to reflect services /care provided by Hospice. How the corrective actions will be monitored to ensure the deficient practice will not recur: DON/Designee will monitor scheduled care plan updates acknowledging for its accuracy and coordination of care Weekly X 3 months and report to QA committee during monthly QA until substantial compliance is met and until compliance is met and determined by QA committee.</p>				

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	<p>infection to access site... [date initiated 7/12/12]: Administer medications as ordered by MD, observe for renal insufficiency, observe labs and report to doctor as needed...."</p> <p>There was no documentation in Resident #32's dialysis careplan regarding his current access site [catheter].</p> <p>A "Minimum Data Set" assessment, dated 7/9/12, included, but was not limited to a "Brief Interview for Mental Status" score of 9 indicating a moderate cognitive impairment.</p> <p>On 9/18/12 at 3:30 P.M., documentation regarding Resident #32's access sites was requested from the Director of Nursing [DoN] and Assistant Director of Nursing [ADoN]. At that time, in an interview, the DoN indicated Resident #32 had a catheter [in neck] as an access site, but would clarify if he had a graft or fistula.</p> <p>On 9/19/12 at 9:40 A.M., in an interview, Resident #32 indicated he only had the site in his neck for dialysis and had not had a different site [graft or fistula].</p>						

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	<p>At that time, Resident #32 was observed with geriatric sleeves [protective coverings] on both arms. There was no observation of a graft or fistula.</p> <p>On 9/19/12 at 3:30 P.M., in an interview, the ADoN indicated Resident #32 was admitted with a catheter not a graft or fistula and did not have a graft of fistula as an access site.</p> <p>On 9/20/12 at 2:30 P.M., the DoN provided the facility's policy and procedure on "Monitoring of Dialysis Fistula/Catheter" dated 4/12.</p> <p>The policy and procedure included, but was not limited to, "Purpose: To observe condition and patency of dialysis fistula/catheter... Procedure: If the resident has a catheter for dialysis the nurse will assess the catheter site for any signs of drainage and condition of the dressing to the site..."</p> <p>Resident #32's dialysis careplan did not include information regarding his access site.</p> <p>2. On 9/17/12 at 8:40 A.M., tour was initiated with Licensed Practical Nurse [LPN] #11.</p>				

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	<p>At that time, Resident #11 was identified as being interviewable and receiving hospice services.</p> <p>On 9/18/12 at 12:25 P.M., Resident #11's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type 2, anemia, end stage renal disease, and depression.</p> <p>A facility "Hospice" careplan, included, but was not limited to, "Focus: Admitted to [name of hospice agency] services for comfort care... Date initiated: 1/26/12... Goals: Resident will remain comfortable and will have her emotional and spiritual needs met... Interventions: Date initiated 1/26/12: Continue to encourage resident to make daily decisions for self, provide 1 to 1 visits for support and comfort as needed, provide comfort care and pain free management, provide visits to support her emotional and spiritual needs..."</p> <p>Resident #11's hospice agency careplans, dated 1/26/12, included, but were not limited to, "Admission Plan of Care, Affirmation of Present Spiritual Comfort, Acceptance of Death, and Utilization of Spiritual</p>						

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	<p>Resources, At Risk for Injury related to Falls, Bowel Elimination, Cardiac/Circulatory Function and Fluid Volume Alteration, Cognitive Alteration, Infection, Normal Grief Process, Nutrition/Hydration, Patient Activity Mobility, Physical Comfort Alteration, Skin/Membrane Integrity, and Urinary Elimination..."</p> <p>The interventions for each careplan did not include services proved by the facility only services provided by hospice staff.</p> <p>On 9/20/12 at 5:30 P.M., in an interview, the Assistant Director of Nursing indicated that anything the hospice agency provided was above and beyond what the facility provided to the resident. She indicated the facility does everything the hospice agency does.</p> <p>On 9/21/12 at 1:00 P.M., the Director of Nursing and the Assistant Director of Nursing were unable to provide a coordinated hospice careplan for Residents #105 and #11.</p> <p>3. In an interview during the initial orientation tour, on 9/17/12 at 8:40 A.M., the Assistant Director of Nursing indicated Resident #105 was receiving Hospice services.</p>						

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	<p>The clinical record for Resident #105 was reviewed on 9/18/12 at 1:40 P.M. Diagnoses included, but were not limited to, senile dementia-Alzheimer's type with behavior disturbance, depressive disorder, dysphagia, communication deficit, hypertension, and joint disorder.</p> <p>The resident was admitted to a Hospice agency service on 8/9/12.</p> <p>A significant change M.D.S. [Minimum Data Set] assessment, completed on 8/30/12, indicated the resident had adequate hearing but unclear speech, was not able to be interviewed for a BIMS [Brief Interview for Mental Status] score and was evaluated by staff to be moderately impaired in cognitive skills for daily decision-making, required physical assistance of 1-2 staff for all daily care, was usually incontinent of both bowel and bladder, and was receiving routinely scheduled pain medication.</p> <p>The facility Care Plan, dated 8/28/12, had problem areas with accompanying interventions for the disciplines of Activities, Dietary, Nursing, and Social Services.</p> <p>There were no problem areas or</p>				

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	<p>interventions, related to Hospice responsibilities and services to be provided by that agency, listed in the facility Care Plan for Activities, Dietary, or Nursing.</p> <p>The facility Social Service discipline had one entry that indicated the following: "Resident accepted to [name of Hospice agency] for Hospice care due to end stage dementia." The Interventions were listed as: "Help coordinate care with Hospice staff, nurse liaison, and facility; Increase care and support as condition deteriorates; Provide emotional care and spiritual support for resident and family."</p> <p>A coordinated list of specific responsibilities, duties, and services to be provided to the resident by facility and Hospice staff was not listed.</p> <p>The Hospice agency Care Plan, which was located in a separate binder at the Nurse's Station, listed the services to be provided by the Hospice nurse, social worker, chaplain, aide, and volunteer.</p> <p>A coordinated list of specific responsibilities, duties, and services to be provided to the resident by each</p>			

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	<p>of the facility and Hospice disciplines was not listed.</p> <p>In an interview on 9/21/12 at 9:25 A.M., the Director of Nursing indicated the Hospice nurse did attend the facility's care plan conference, and that the facility maintained communication with the agency through telephone conferences when needed.</p> <p>On 9/20/12 at 5:30 P.M., in an interview, the Assistant Director of Nursing indicated that anything the hospice agency provided was above and beyond what the facility provided to the resident. She indicated the facility does everything the hospice agency does.</p> <p>On 9/21/12 at 1:00 P.M., the Director of Nursing and the Assistant Director of Nursing were unable to provide a coordinated hospice care plan for Residents #105 and #11.</p> <p>3.1-35(b)(1) 3.1-35(c)(2)(C)</p>						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow careplan interventions related to fall prevention for 1 of 11 residents reviewed with a history of falls [Resident #11]. In addition the facility failed to follow physician's orders regarding starting a medication for 2 days [Resident #11] in 1 of 24 residents reviewed for medication errors and failed to remove a medication patch per physician's orders in 1 of 17 residents [Resident #135] observed during medication pass.</p> <p>Findings include:</p> <p>1. On 9/17/12 at 8:40 A.M., tour was initiated with Licensed Practical Nurse [LPN] #11.</p> <p>At that time, Resident #11 was identified as interviewable and as receiving hospice services.</p> <p>On 9/18/12 at 12:25 P.M., Resident #11's record was reviewed. Diagnoses included, but were not</p>	F0282	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Concerns related to the residents #11 and #135 corrected at the time of Survey. (Call-light placed in reach, clarification of medication order, and removal of medication patch).</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>DON/Designee will conduct in-service by 10/21/12 stressing the importance of resident interventions and their location, review of the physician progress notes for possible orders, call light location, and removal of medication patches in a timely manner.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>DON/Designee to utilize monitoring tool for compliance of</p>	10/21/2012			

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	<p>limited to, diabetes mellitus type 2, anemia, end stage renal disease, and depression.</p> <p>A "Fall" careplan, included, but was not limited to, "Focus: [Resident #11] is at risk for falls related to weakness and impaired mobility. Resident will try and take self to bathroom... also turns off chair alarm... Goal: Will be free from injury related to falls through next review... Interventions: Keep call light within reach at all times and encourage resident to use it to call for assist with all transfer/ambulation attempts... Date initiated: 1/28/11..."</p> <p>The nurse progress notes included, but were not limited to the following days Resident #11 experienced a fall: 8/31/12 at 12:31 P.M. [found in front of wheelchair]; 8/30/12 at 12:45 P.M. [found in front of recliner]; 8/30/12 at 7:57 A.M. [found in front of recliner]; 8/18/12 at 2:06 A.M. [found in front of recliner]; 4/3/12 at 1:15 P.M., [found in front of wheelchair]..."</p> <p>There was no documentation of injury with the falls.</p> <p>On 9/19/12 at 9:30 A.M., Resident #11 was observed in her room sitting in her recliner. At that time, her call light was observed under her bed [out</p>		<p>call light location, checking progress notes for missed orders and removal of medication patch 5 days a week by selecting 5 residents randomly for 4 weeks, then thereafter 2 x a week for 4 weeks. Report to the QA committee monthly until substantial compliance is met and then remain on on-going observation for QA review.</p>		

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	<p>of reach].</p> <p>On 9/19/12 at 9:35 A.M., in an interview, Resident #11 indicated she needed a blanket and could not reach her call light. She indicated she was unable to get a blanket by herself.</p> <p>On 9/19/12 at 9:45 A.M., in an interview, Qualified Medication Aide #4 indicated Resident #11's call light should have been placed by the resident. She indicated her Certified Nursing Assistant [CNA] #3 assisted her to the chair.</p> <p>On 9/19/12 at 9:50 A.M., in an interview, CNA #3 indicated she forgot to put the call light in reach of the resident and left the call light by the bed.</p> <p>The facility "CNA Flow Sheet," dated 9/4/12, included, but was not limited to, "Keep all call lights in reach..."</p> <p>A "Psychiatric Progress Notes," dated 9/17/12, for Resident #11 included, but was not limited to, "will begin Depakote 125 milligrams two times per day for aggression related to dementia... order entered into the computer..."</p> <p>A "Physician's Order Listing," dated</p>						

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	<p>9/19/12, included, but was not limited to the following medications: Acetaminophen 500 milligrams, Bisacodyl 10 milligrams, Polyethylene Glycol 17 grams, Flonase 50 micrograms, Artificial Tears, Albuterol, Ativan 0.5 milligrams, Morphine Sulfate 5 milligrams, Refresh, Lantus, Fentanyl 50 micrograms per hour, Scopolamine..."</p> <p>There was no active order or documentation of Depakote 125 milligrams as ordered on 9/17/12.</p> <p>On 9/19/12 at 3:30 P.M., in an interview, the Director of Nursing [DoN] indicated the nurse practitioner did not successfully enter the order into the computer system on 9/17/12 and the order was missed by nursing staff. She indicated it was nursing staff responsibility to check the paper record to make certain new orders are entered into the computer system.</p> <p>On 9/21/12 at 11:55 A.M., the DoN provided the facility's policy and procedure on "Administrative Physician's Orders," dated 1/2012.</p> <p>The policy and procedure included, but was not limited to, "Purpose: To provide general guidelines when receiving, transcribing, notification,</p>						

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	<p>and care planning physician's orders... Following a physician's visit, a licensed nurse will: Check the paper chart for any new written physician orders and transcribe them into the electronic medical record."</p> <p>2. During an observation of the medication pass on 9/18/12, at 8:25 A.M., RN #1 was observed to perform hand hygiene and prepare medications for Resident #135. Medications included, but were not limited to, 2 Lidoderm lidocaine (a pain medication) patches. RN #1 entered the resident's room and informed the resident he had her morning medications.</p> <p>RN #1 was observed to don a pair of clean gloves. When RN #1 lifted the resident's shirt to place the 2 lidocaine patches on her back, he indicated the resident still had her patches on from the previous night. Two medication patches were observed on the resident's back. RN #1 removed the two patches from the resident's back, removed his gloves while enclosing the used patches inside his gloves, and then discarded them into the resident's trash can. RN #1 then went into the resident's bathroom and performed</p>			

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	<p>handwashing before returning and donning new gloves. RN #1 then applied the two new lidocaine patches to the resident's back.</p> <p>On 9/18/12, at 11:30 A.M., the clinical record of Resident #135 was reviewed. Physician's medication orders for this resident indicated "Lidoderm 5% 2 patches topical on back Q 0900 [every 9:00 A.M.] and remove Q 2100 [every 9 P.M.]"</p> <p>3.1-35(g)(2)</p>			

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F0309 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 interview and record review, the facility failed to develop a system to comprehensively assess, monitor, or implement appropriate and timely interventions, for 1 of 8 residents reviewed for inadequate pain management in a sample of 24 residents reviewed. [Resident #65]</p> <p>Findings include:</p> <p>On 9/19/12 at 1:00 P.M., Resident #65's record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, pain, muscle weakness, and anemia.</p> <p>A "Pain" careplan included, but was not limited to, "Focus [date initiated 6/27/11]: [Resident #65] experiences pain with complaints of chronic pain in her shoulder area. Resident also has a history of fracture... Goals: will voice a level of comfort through review date... Interventions [date initiated 6/27/11]: Administer routine pain medications as ordered by MD,</p>	F0309	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Residents #65 pain assessment and medication reviewed and updated as warranted during the survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents receiving PRN pain medications have potential to be affected. An audit of residents utilizing PRN pain medications performed to evaluate possible scheduled pain medication for residents utilizing frequent (5 or more) PRN doses as directed by the physician. What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur: DON/Designee will conduct in-service with all nurses by 10/21/12 related to on-going review of PRN pain medications and assessments. How the</p>	10/21/2012	

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	<p>Evaluate the effectiveness of pain interventions, Observe and report changes..."</p> <p>A "Medication Administration Record," dated 9/12, included, but was not limited to, "Hydrocodone-Acetaminophen... Dose: 5-325 milligrams orally every 4 hours as needed for pain [date initiated 10/7/11]..."</p> <p>There was no other documentation of scheduled or as needed pain medications.</p> <p>The "Medication Administration Record [MAR]" dated July, August, and September, 2012 indicated the as needed "Hydrocodone-Acetaminophen" was given at least once per day 27 of 31 days in July, at least once per day 28 of 31 days in August, and from September 1 through September 19, was given 17 of 19 days. Several of the days the medication was given 3 to 4 times per day.</p> <p>Review of the September MAR indicated Resident #65 received 3 or more doses of pain medication on the following dates: 9/3, 9/4, 9/7, 9/10, and 9/12.</p>		<p>corrective actions will be monitored to ensure the deficient practice will not recur: DON/Designee will monitor compliance utilizing tool for completion of PRN pain medication reviews. This will continue weekly x 2 months and thereafter monthly x 2 months and report to monthly QA committee until substantial compliance is met and then remain on on-going observation for QA review.</p>				

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	<p>There was no documentation in progress notes or on the Medication Administration Record of a pain assessment for the days Resident #65 complained of pain.</p> <p>On 9/20/12 at 5:30 P.M., all pain documentation was requested from the Director of Nursing and Assistant Director of Nursing for July, August, and September, 2012.</p> <p>The following pain evaluation was provided.</p> <p>A "Pain Evaluation" assessment, dated 7/7/12 at 11:39 A.M., included, but was not limited to, "[marked as yes] Does the resident have any diagnosis which would give reason to believe he/she would be in pain... Right leg and lower back pain... [marked as yes] Does the resident verbalize pain... What does the pain feel like [marked]: aching... Nonverbal signs of pain [marked]: grimacing/distorted face, frowning/scowling, moaning...."</p> <p>On 9/20/12 at 1:25 P.M., in an interview, Resident #65 indicated she has to always ask for pain medication. She indicated when she gets the medication it helps [the pain]. She indicated her pain was caused by</p>			

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	<p>headaches [related to hitting her head as a child a lot] and back pain.</p> <p>On 9/21/12 at 11:00 A.M., in an interview, the Director of Nursing [DoN] indicated Resident #65 had routine pain medication prior to being hospitalized in June, 2012 and that the discharging physician [from the hospital] did not re-order the scheduled pain medication.</p> <p>At that time, in an interview, the DoN indicated the facility did not have any further documentation for Resident #65.</p> <p>3.1-37(a)</p>				

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F0329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 interview and record review, the facility failed to ensure non-pharmacological interventions were attempted before a PRN [Pro Re Nata--"as needed"] psychoactive medication was administered; and failed to ensure a GDR [Gradual Dose Reduction] for a psychoactive medication was either attempted or was determined to be clinically contraindicated; for 4 of 17 residents reviewed who were receiving psychoactive medications in a sample</p>	F0329	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Residents #42, #63, #108 and #112 were reviewed 9/26/12 for appropriate GDR recommendations. Facility will review these residents during Psychotropic medication management team meeting each month for 90 days for potential for GDR and thereafter as indicated. How other residents having the potential to be affected by the same</p>	10/21/2012			

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	<p>of 24 residents. [Residents #42, #63, #108, and #112]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 9/17/12 at 8:45 A.M., the Assistant Director of Nursing indicated Resident #112 experienced falls, required the use of wheelchair and bed alarms, and had her bed placed in a low position.</p> <p>The clinical record for Resident #112 was reviewed on 9/17/12 at 9:35 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbance, explosive personality, muscle weakness with difficulty walking, symbolic dysfunction, hypertension, and insomnia.</p> <p>A quarterly M.D.S. [Minimum Data Set] assessment, dated 7/18/12, indicated the resident had moderate difficulty hearing, had unclear speech, only sometimes understood others, was unable to complete a "Brief Interview for Mental Status" and was evaluated by staff to be moderately impaired in cognitive decision-making skills, required the physical assistance of 1-2 staff for all daily care, and was not steady requiring staff assistance to stabilize balance.</p>		<p>deficient practice will be identified and what corrective actions will be taken: All residents with psychoactive medications have the potential to be affected. Nursing staff educated on 9/25/12 related to providing and documenting non-pharmalogical interventions prior to administering PRN psychoactive mediations. What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur: DON/Designee will complete additional in-service by 10/21/12 to stress the importance of behavior tracking, documentation and attempt of intervention prior to administering PRN psychoactive medications. DON/Designee will review EMAR for PRN psychoactive medication and supporting documentation for non-pharmological intervention prior to administration 5 x a week. How the corrective actions will be monitored to ensure the deficient practice will not recur: Social Service Director/Designee to monitor compliance weekly and report the results to QA committee monthly until 3 months of substantial compliance has been noted and thereafter continue on-going observation for QA review.</p>				

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	<p>The electronic health record listing medications ordered by the physician included, but was not limited to, an order dated 4/25/12 for "Lorazepam [an anti-anxiety medication] 0.5 mg. [milligrams] every three hours PRN for agitation."</p> <p>The electronic health record documentation [the eMAR] for medication administration indicated a PRN dose of the Lorazepam was given as follows:</p> <p>May, 2012--one PRN dose of Lorazepam was given on 5/1, 2, 3, 4, 5, 6, 7, 10, 11, 14, 15, 17, 18, 21, 22, 23, 24, 25, 26, 28, and 31. A second dose was also given on 5/1, 2, 3, 10, 18, 21, 25, and 26.</p> <p>There were Nurse's Progress notes on 5/3, 5/4, and 5/21/12 addressing other issues. There was no documentation related to the behavior displayed or interventions attempted prior to administering the Lorazepam.</p> <p>June, 2012--one PRN dose of Lorazepam was given on 6/1, 2, 3, 4, 5, 8, 14, 15, 16, 17, 19, 24, 25, 26, and 28.</p> <p>Nurse's Progress notes indicated the</p>				

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	<p>following: 6/17/12 at 3:55 A.M.- -"Resident went to sleep at 1:20 A.M. after receiving Ativan [Lorazepam]." 6/20/12 at 2:29 A.M.--"Resident went to bed after 1:30 A.M. this night. Ativan was given to assist her due to agitation." 6/26/12 at 5:26 A.M.- -"Resident has been awake and agitated all night. She did receive a PRN Ativan and this did not help."</p> <p>There was no other documentation related to the behavior displayed or interventions attempted prior to administering the Lorazepam.</p> <p>July, 2012--one PRN dose of Lorazepam was given on 7/4 and 7/9/12. There were no Nurse's Notes for those dates, and no information elsewhere in the clinical record related to the behavior displayed or the interventions tried prior to administration of the Lorazepam.</p> <p>August, 2012--one PRN dose of Lorazepam was given on 8/4, 5, 20, 24, 26 [at 5:58 P.M.], and 31 [at 1:26 A.M.].</p> <p>A Nurse's Progress note, dated 8/26/12 at 6:06 P.M., indicated "Resident agitated times three staff to ambulate 200 feet toileted agitation continued ambulated another 100</p>				

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	<p>feet ineffective had to ambulate another 200 feet continue to be ineffective trying to hit and bite staff during care and after ambulation." [sic] There was no indication other interventions, besides the ambulation, were attempted.</p> <p>An electronic health record "Behavior Sheet," dated 8/31/12 at 5:39 A.M., indicated "Behavior Symptoms" of "Repetitive verbalizations, resistant to care, hitting others, yelling/screaming;" with "Interventions" of "Approached in calm manner; established eye contact; don't argue or confront; toileted; offered a snack; talk with resident; resident was walked a couple of times and did not cooperate with this activity; medication."</p> <p>September, 2012--one PRN dose of Lorazepam was given on 9/9, 12, and 13, 2012. A Nurse's Progress note on 9/12 indicated some interventions were attempted prior to administering the Lorazepam.</p> <p>In an interview on 9/19/12 at 9:35 A.M., the Director of Nursing indicated there was an intervention to ambulate the resident on the Care Plan, and she had seen staff doing that "a lot."</p>						

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	<p>One Care Plan entry, dated 2/14/12, addressed a problem of "Behavior- -Resident has had episodes of becoming verbally aggressive with staff during care." The interventions were listed as: "Assess for any unmet needs such as hunger or thirst, etc.; Call resident by name in a calm tone of voice; If agitated or resistive to care, reapproach later; Offer resident her 'Winnie the Pooh' teddy bear which she enjoys and is comforted by it; Place resident on Behavior management program if/when needed."</p> <p>Another Care Plan entry, dated 2/17/12, addressed a problem of "Resident has had episodes of hitting and grabbing staff while care provided." Interventions were listed as: "Approach calmly and talk to resident clearly and slowly by writing out on paper or on dry erase boards step by step what you are trying to do; Assess for thirst, hunger, pain, etc.; Let her know she is safe and you are here to help her. Reapproach later and with another staff member as needed."</p> <p>2. The clinical record for Resident #108 was reviewed on 9/20/12 at 3:10 P.M. Diagnoses included, but</p>			

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	<p>were not limited to, dementia, depression, anxiety, and diabetes with neuropathy.</p> <p>An annual M.D.S. [Minimum Data Set] assessment, dated 8/20/12, indicated the resident had adequate hearing, clear speech, and understood others; had a BIMS [Brief Interview for Mental Status] score of "05" [0-7=severe impairment for cognitive decision-making skills]; had no psychosis or behaviors; required the physical assistance of 1-2 staff for all daily care; and was receiving anti-anxiety and anti-depressant medications.</p> <p>The electronic health record listing medications ordered by the physician included, but was not limited to, an order dated 4/2/12 for Xanax [an anti-anxiety medication] 0.5 mg. [milligrams] one in the morning and one after lunch routinely each day; and an order dated 3/9/12 for Xanax 0.5 mg. every 4 hours PRN.</p> <p>The electronic health record documentation [the eMAR] for medication administration indicated a PRN dose of the Lorazepam was given as follows:</p> <p>June, 2012--a PRN dose of Xanax</p>			

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	<p>was given on 6/9 at 8:34 P.M., 6/10 at 9:43 P.M., 6/11 at 8:36 P.M., 6/15 at 4:49 P.M., 6/22 at 6:41 P.M., 6/26 at 3:52 P.M., and 6/30 at 8:03 P.M.</p> <p>A "Behavior Sheet" report, dated 6/22/12 at 8:49 P.M., had nothing checked for "Behavior Symptoms," and listed only one "Intervention" of "Medication."</p> <p>A "Behavior Sheet" report, dated 6/26/12 at 10:43 P.M., listed behavior symptoms of "Repetitive questions," and "Hallucinations." The "Interventions" were listed as "Approached in calm manner; Identified self; Established eye contact; Called resident by name; Used distraction (describe in comments); Television." There was no additional description of "distraction" in the comment section.</p> <p>July, 2012--a PRN dose of Xanax was given on 7/1 at 9:32 P.M., 7/2 at 9:31 P.M., 7/3 at 9:01 P.M., 7/5 at 9:37 P.M., 7/6 at 9:11 P.M., and 7/20 at 5:03 P.M.</p> <p>A "Behavior Sheet" report, dated 7/1/12 at 9:41 P.M., listed behaviors of "Repetitive verbalizations," and "Repetitive questions." Interventions were listed as "Talk with resident,"</p>			

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	<p>and "Medication." The "Comments" section indicated "Resident anxious tonight repeats herself and wants something to sleep."</p> <p>A "Behavior Sheet" report, dated 7/2/12 at 10:06 P.M., had no behavior symptoms checked. The only intervention listed was "Medication."</p> <p>A "Behavior Sheet" report, dated 7/3/12 at 9:24 P.M., had no behavior symptoms listed. The only intervention listed was "Medication."</p> <p>A "Behavior Sheet" report, dated 7/5/12 at 10:30 P.M., had no behavior symptoms listed. The only intervention listed was "Medication."</p> <p>A "Behavior Sheet" report, dated 7/6/12 at 9:52 P.M., had no behavior symptoms listed. The only intervention listed was "Medication."</p> <p>August, 2012--a PRN dose of the Xanax was given on 8/10 at 7:08 P.M., 8/15 at 11:52 P.M., 8/20 at 8:59 P.M., 8/21 at 8:43 P.M., 8/23 at 1:40 A.M., 8/26 at 6:43 P.M., and 8/29 at 8:40 P.M.</p> <p>A "Behavior Sheet" report, dated 8/20/12 at 9:59 P.M., listed behaviors of "Repetitive verbalizations," and</p>						

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	<p>"Hallucinations." Interventions were listed as "Approached in calm manner, Called resident by name, Medication."</p> <p>A "Behavior Sheet" report, dated 8/21/12 at 9:21 P.M., listed one behavior as "Hallucinations." The only intervention listed was "Medication."</p> <p>September, 2012--one PRN dose of Xanax was given on 9/7 at 8:40 P.M., 9/8 at 7:33 P.M., 9/9 at 7:51 P.M., 9/10 at 6:49 P.M., 9/12 at 12:56 A.M., and 9/13 at 8:02 P.M.</p> <p>A "Behavior Sheet" report, dated 9/12/12 at 9:29 P.M., listed behaviors of "Hallucinations," and "Delusions." Interventions were listed at "Approached in calm manner, Established eye contact, Called resident by name, Explained what they were going to do, Used simple sentences, Don't argue or confront, Left alone and reapproached later, Changed a position, Talk with resident."</p> <p>A Nurse's Note, dated 12/20/11 at 4:34 A.M., indicated "Resident complained of feeling nervous and restless and requested nerve pill. Upset because did not receive at</p>				

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	<p>bedtime. Explained it was as needed and she need to ask for it. She thought it was routine and she said she always gets it every night. Medication given...."</p> <p>During the daily conference on 9/20/12 at 4:45 P.M., the Director of Nursing was given the opportunity to submit any documentation related to interventions attempted prior to the administration of the PRN Xanax. She was also given the opportunity to provide any Care Plan and/or interventions relating to the resident's anxiety.</p> <p>On 9/21/12 at 9:25 A.M., the Director of Nursing provided a copy of a Care Plan entry, dated 10/5/11, addressing "Resident takes antianxiety medication for feelings of anxiousness and nervousness and is at risk for adverse side effects." The interventions listed were: "Administer medication per M.D. orders; Observe for any changes in mood, motivation, or behavior and report; Observe for side effects [symptoms listed]; Report any pertinent lab results to M.D."</p> <p>In an interview at that time, the Director of Nursing indicated she had provided all of the documentation available [the Behavior Sheet reports</p>				

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	<p>and Nurse' Notes] related to the resident's behaviors and intervention attempted prior to the administration of the PRN Xanax.</p> <p>3. On 9/21/12 at 10:00 A.M., Resident #63's record was reviewed. Diagnoses included, but were not limited to, unspecified psychosis, dementia, muscle weakness, and dysphagia.</p> <p>A "Minimum Data Set" assessment, dated 7/14/12. included, but was not limited to, "Brief Interview Mental Status" score of 7 [severe impairment].</p> <p>A "Behavior" careplan included, but was not limited to, "Resident has episodes of cursing/yelling at staff... Goals: Resident will come to the nurse's station dining area for all three meals... Interventions [date initiated: 4/13/11]: Cue resident to daily schedules such as meals, activities, etc, Cue resident to look at memory folder..., Encourage participation in group activities and therapy, provide 1 to 1 as much as possible during meals..., when yelling, provide 1 to 1 with resident and try turning on her over the bed light, soft music..."</p>			

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	<p>A "Medication Administration Schedule" for July 2012 and August 2012, included, but was not limited to, "Ativan 0.5 milligrams [date ordered 3/8/12] three times per day as needed for agitation/yelling..."</p> <p>The as needed Ativan was given on the following dates without documentation of non-pharmacological interventions: 7/2/12, 7/6/12, 7/12/12, 7/13/12, 7/19/12, 7/26/12, 8/15/12, 8/18/12, and 8/20/12.</p> <p>Resident #63's Ativan was discontinued on 9/10/12.</p> <p>On 9/21/12 at 12:00 P.M., documentation of behavior management for July and August 2012 was requested from the DoN.</p> <p>On 9/21/12 at 1:00 P.M., the DoN indicated there was no other behavior documentation for Resident #63.</p> <p>4. On 9/17/12, at 8:40 A.M., during the initial orientation tour, LPN #12 indicated Resident #42 had a history of resisting care, calling out, cursing, experiencing hallucinations, and was receiving psychotropic medications.</p>			

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	<p>On 9/20/12, at 3:30 P.M., the clinical record of Resident #42 was reviewed. Resident #42 was admitted to the facility on 2/6/10. Diagnoses included, but were not limited to, dementia with behavioral disturbance, abnormal posture, generalized muscle weakness, osteoporosis, and anemia.</p> <p>The electronic health record listing medications ordered by the physician included, but was not limited to, an order dated 1/17/12, for "Lorazepam [an anti-anxiety medication] 0.5 mg [milligrams] four times daily PRN [Pro Re Nata--"as needed"] anxiety or agitation."</p> <p>The electronic medication administration record (the eMAR) indicated a PRN dose of the Lorazepam was given as follows:</p> <p>August, 2012--one PRN dose of Lorazepam was given on 8/2 at 3:02 P.M.; 8/3 at 3:20 P.M.; 8/5 at 4:11 P.M.; 8/6 at 4:42 P.M.; 8/8 at 3:15 P.M.; 8/9 at 6:21 P.M.; 8/12 at 4:14 P.M.; 8/13 at 6:19 P.M.; 8/14 at 3:38 P.M.; 8/15 at 3:12 P.M.; 8/16 at 4:33 P.M.; 8/18 at 4:27 P.M.; and 8/31 at 6:16 P.M.</p> <p>An electronic health record "Behavior</p>			

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	<p>sheet," dated 8/2/12 at 3:02 P.M., indicated "Behavior Symptoms" of "Repetitive verbalizations;" with interventions of "Approached in calm manner; established eye contact; called resident by name; used simple sentences; allowed decision making; don't argue or confront; medication."</p> <p>An electronic health record "Behavior sheet," dated 8/3/12, at 3:23 P.M., contained information that was illegible.</p> <p>An electronic health record "Behavior sheet," dated 8/8/12 at 3:15 P.M., indicated "Behavior Symptoms" of "Repetitive verbalizations;" with interventions of "Approached in calm manner; established eye contact; called resident by name; validated resident's feelings; offer fluids; offered a snack; talk with resident; television; medication."</p> <p>An electronic health record "Behavior sheet," dated 8/9/12 at 6:21 P.M., indicated "Behavior Symptoms" of "Repetitive verbalizations" and "Resistant to care;" with interventions of "Approached in calm manner; called resident by name; used simple sentences; allowed decision making; offer fluids; offered a snack; talk with resident; medication."</p>			

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	<p>An electronic health record "Behavior sheet," dated 8/12/12 at 4:14 P.M., indicated "Behavior Symptoms" of "Yelling/screaming;" with interventions of "Approached in calm manner; identified self; established eye contact; called resident by name; don't argue or confront; validate resident's feelings; offer fluids; offered a snack; talk with resident; television; medication."</p> <p>An electronic health record "Behavior sheet," dated 8/14/12, at 3:41 P.M., indicated "Behavior Symptoms" of "Repetitive verbalizations" and "Yelling/screaming;" with interventions of "Approached in calm manner; identified self; established eye contact; called resident by name; explained what they were going to do; used simple sentences; allowed decision making; don't argue or confront; offer fluids; offered a snack; talk with resident; medication."</p> <p>An electronic health record "Behavior sheet," dated 8/16/12, at 4:33 P.M., indicated "Behavior Symptoms" of "Yelling/screaming;" with interventions of "Approached in calm manner; identified self; established eye contact; called resident by name; don't argue or confront; talk with</p>			

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	<p>resident; medication."</p> <p>The electronic medication administration record (the eMAR) indicated one PRN dose of the Lorazepam was given as follows:</p> <p>September, 2012--9/1 at 6:00 P.M.; 9/7 at 3:04 P.M.; 9/12 at 10:00 P.M.; 9/15 at 4:25 P.M.; 9/16 at 4:36 P.M.</p> <p>An electronic health record "Behavior sheet," dated 9/7/12 at 3:39 P.M., indicated "Behavior Symptoms" of "Yelling/screaming" and "Resident was hitting hand rail;" with interventions of "Approached in calm manner; called resident by name." The "Comments" section indicated the nurse got the resident a snack and the resident appeared to have calmed down.</p> <p>There was no other documentation related to the behavior displayed or interventions attempted prior to administering the Lorazepam.</p> <p>On 9/20/12, at 5:00 P.M., the Director of Nursing (DON) was asked to provide copies of the eMAR for July 2012 to present for Resident #42.</p> <p>On 9/21/12, at 10:00 A.M., the DON provided copies of the eMAR for July</p>						

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	<p>to the morning of September 21, 2012.</p> <p>On 9/21/12, at 1:05 P.M., the DON indicated there was no additional documentation that the facility had attempted non--pharmacological interventions for Resident #42.</p> <p>3.1-48(a)(2) 3.1-48(a)(4)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to label food and juices with a date of preparation or "use by" date; in 1 of 1 main kitchen area. This deficiency had the potential to impact 136 of 136 residents who received food from the main kitchen.</p> <p>Findings include:</p> <p>1. On 9/17/12 at 7:00 A.M., initial tour of the kitchen was started. The Dietary Manager was not available and staff did not participate in the initial tour.</p> <p>At that time, the following was observed in the walk-in cooler:</p> <p>A. 1 plastic pitcher of peaches, 1/4 full without a label.</p> <p>B. 1 piece of chocolate pie with whip cream topping and chocolate sprinkles in a small cardboard bowl without a label or secure covering.</p>	F0371	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The unlabeled items were immediately discarded by dietary manager.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents have the potential to be affected. The dietary manager/designee will conduct in-service for all dietary staff on facility food storage policy, labeling and covering as per Title 410 Sanitation code and facility policy.</p> <p>What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The dietary manager/designee will conduct in-service for all dietary staff on facility food storage policy, labeling and covering as per Title 410 Sanitation code and Facility Policy by October 21, 2012. The marking pens, labels and supplies will be available at all times for staff</p>	10/21/2012

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	<p>The following was observed in the reach-in cooler:</p> <p>C. 1 small glass dish of cut lemons without a label.</p> <p>D. 4 glass containers of orange juice without a label.</p> <p>E. 1 glass container of apple juice without a label.</p> <p>F. 1 pitcher of thickened clear liquid [water] without a label.</p> <p>G. 2 plastic pitchers of lemonade without a label.</p> <p>2. On 9/18/12 at 9:00 A.M., in an interview, the Dietary Manager indicated it was policy for all food and drink items to be labeled.</p> <p>At that time, during tour of the kitchen, the following was observed in the walk-in cooler:</p> <p>H. 1 plastic pitcher of peaches, 1/4 full without a label [same location as on 9/17/12].</p> <p>3. On 9/19/12 at 9:35 A.M., the Director of Nursing provided the facility policy and procedure,</p>		<p>to label the items before storage.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>Each evening the PM Cook/Designee will check the walk-in refrigerator to ensure that all foods are covered, labeled and dated. The Dietary Manager/Designee will inspect 5 x a week the refrigerator, walk-in refrigerator and nutrition For labeling and proper storage. The results of the audit will be reviewed during monthly QA by the committee until 100% compliance met.</p>	

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	<p>"Nutritional Services Policy and Procedure Manual," dated 6/12.</p> <p>The policy and procedure included, but was not limited to, "Purpose: To be able to safely reuse food items meeting the State Sanitation Regulations... Process/Procedure: All foods stored for later use shall be covered, labeled with the food name, and dated with the current date as the open date..."</p> <p>3.1-21(i)(2)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that documentation included the amount of insulin given to 1 of 1 resident observed to have blood glucose testing during medication pass. In addition, the facility failed to ensure that documentation included assessment of the access site over a 3-month period for 1 of 1 resident receiving dialysis, and failed to ensure accurate charting related to the location of the access site. These deficient practices affected 2 residents in a sample of 24. [Residents #32, 102]</p> <p>Findings include:</p> <p>1. During an observation of the medication pass on 9/19/12 at 4:30</p>	F0514	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #102 sliding scale insulin order was updated in EMAR to require amount of insulin administered during survey as it was brought to our attention by the Surveyor. Resident #32 clinical record updated with accurate assessment and location information.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All residents utilizing a sliding scale or receiving dialysis have the potential to be affected.</p> <p>What measures will be put into the place or what systemic changes will</p>	10/21/2012	

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	<p>P.M., LPN #2 was observed to perform hand hygiene and to assess the blood glucose of Resident #102. The glucometer indicated the Resident's blood glucose was 134. Physician's orders indicated the amount of insulin to be given for blood glucose of 134 was 4 units. LPN #2 indicated she would be checking other residents' blood glucose levels at that time. LPN #2 was not observed to administer insulin to Resident #102 during this observation of medication pass.</p> <p>On 9/20/12 at 12:30 P.M., the Director of Nursing (DON) was requested to provide a printed copy of the electronic medication administration record (the eMAR) for Resident #102.</p> <p>On 9/20/12 at 3:10 P.M., the DON provided a copy of the eMAR, which indicated LPN #2 had administered insulin to Resident #102 at 4:35 P.M. The eMAR did not indicate how many units of insulin were administered.</p> <p>The eMAR indicated insulin was administered to Resident #102 on the following dates with no indication of how many units of insulin were administered:</p>		<p>be made to ensure that the deficient practice does not recur:</p> <p>Updated dialysis assessment to reflect more options for sites. Each new sliding scale insulin order will be reviewed for accurate input into EMAR to ensure dosage amount will appear for required entry of units administered. This review will be completed by EMAR coordinator /designee 5 days a week.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>DON/Designee to monitor compliance weekly x2 months then thereafter monthly x 2 months and report results to QA committee monthly until 3 months of substantial compliance is met then remain on on-going observation for QA review.</p>		

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	<p>September, 2012--9/1 (three of 3 doses), 9/2 (three of 3 doses), 9/4 (three of 3 doses), 9/5 (three of 3 doses), 9/6 (three of 3 doses), 9/7 (two of 3 doses), 9/8(three of 3 doses), 9/10 (two of 3 doses), 9/11 (three of 3 doses), 9/12 (three of 3 doses), 9/13 (three of 3 doses), 9/14 (three of 3 doses), 9/15 (two of 3 doses), 9/16 (three of 3 doses), 9/17 (three of 3 doses), 9/18 (three of 3 doses), 9/19 (three of 3 doses), and 9/20 (one of 1 dose).</p> <p>2. On 9/17/12 at 8:40 A.M., tour was initiated with Licensed Practical Nurse [LPN] #11.</p> <p>At that time, Resident #32 was described as receiving dialysis services with an access site [catheter] in his left neck. He was described as being interviewable at times.</p> <p>On 9/18/12 at 11:30 A.M., Resident #32's record was reviewed. Diagnoses included, but were not limited to, anemia, insulin dependent diabetes mellitus, end stage renal disease, and depression.</p> <p>Resident #32 was admitted to the facility on 1/19/12.</p>				

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	<p>A dialysis careplan, included, but was not limited to, "Focus: Dialysis related to renal failure... date initiated 1/30/12... Goals: Will have no signs or symptoms of complications from dialysis... Interventions [date initiated 1/30/12]: Do not draw blood or take blood pressure in arm with graft, encourage resident to go for the scheduled dialysis appointments, observe for and report to MD as needed any signs or symptoms of infection to access site... [date initiated 7/12/12]: Administer medications as ordered by MD, observe for renal insufficiency, observe labs and report to doctor as needed...</p> <p>There was no documentation in Resident #32's dialysis careplan regarding his access site [catheter].</p> <p>On 9/18/12 at 3:30 P.M., documentation regarding Resident #32's access sites was requested from the Director of Nursing [DoN] and Assistant Director of Nursing [ADoN].</p> <p>At that time, in an interview, the DoN indicated Resident #32 had a catheter [in neck] as an access site, but would clarify if he had a graft or fistula.</p>			

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	<p>On 9/19/12 at 9:40 A.M., in an interview, Resident #32 indicated he only had the site in his neck for dialysis and had not had a different site [graft or fistula]. During the interview, Resident #32 had geriatric sleeves [protective coverings] on both arms. However, he indicated he did not have an access site anywhere but his neck.</p> <p>On 9/19/12 at 3:30 P.M., in an interview, the ADoN indicated Resident #32 was admitted with a catheter not a graft or fistula.</p> <p>On 9/19/12 at 9:00 A.M., the DoN provided a "Schedule for September 2012" that included, but was not limited to, "Monitor dialysis port [catheter], ensuring dressing clean, dry, and intact... Order date 4/27/12... the dates 1-18 are marked as completed for all shifts..."</p> <p>There was no documentation noted for the dates of 1/19/12 [admission] through 4/26/12.</p> <p>On 9/19/12 at 3:30 P.M., in an interview, the ADoN indicated Resident #32 was admitted with a catheter not a graft or fistula and she did not have any further documentation regarding Resident</p>						

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	<p>#32's access site for the months of January 2012 through April 2012.</p> <p>In addition, documentation was present that indicated nursing staff were checking a bruit and thrill on dialysis days; however, Resident #32 had never had a fistula or graft while in the facility.</p> <p>A "Pre-Dialysis Assessment" with the following dates: 9/3/12, 9/5/12, 9/7/12, 9/10/12, 9/12/12, 9/14/12, and 9/19/12, included, but was not limited to, "Vascular Access Site Assessment... [marked] Thrill present... Bruit present..."</p> <p>Resident #32 did not have a graft or fistula as an access site. Therefore, a thrill or bruit would not be present for assessment and the documentation was incorrect.</p> <p>On 9/20/12 at 2:30 P.M., the DoN provided the facility's policy and procedure on "Monitoring of Dialysis Fistula/Catheter," dated 4/12.</p> <p>The policy and procedure included, but was not limited to, "Purpose: To observe condition and patency of dialysis fistula/catheter... Procedure: If the resident has a catheter for dialysis the nurse will assess the</p>						

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	<p>catheter site for any signs of drainage and condition of the dressing to the site... The results will be documented on the pre and post dialysis assessment that is completed before and after dialysis..."</p> <p>3.1-50(a)(2)</p>			