

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, & 12, 2014.</p> <p>Facility number: 000149 Provider number: 155245 AIM number: 100266840</p> <p>Survey Team: Beth Walsh, RN-TC Karina Gates, Generalist Tom Stauss, RN</p> <p>Census bed Type: SNF: 7 NF: 48 Total: 55</p> <p>Census payor Type: Medicare: 7 Medicaid: 38 Other: 10 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 19, 2014 by Cheryl Fielden, RN.</p>	F000000	<p>Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Healthcare Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of nursing care and services to the residents at Castleton Healthcare Center.</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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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's complaints of "rough treatment" were thoroughly investigated as potential cases of resident abuse. The facility also failed to report the cases to the state agency. This affected 1 of 2 residents out of reviewed for abuse. (Resident #18)</p> <p>Findings include:</p> <p>Resident #18's record was reviewed on 9/8/14 at 10:22 a.m. The resident's diagnoses included, but were not limited to, orthostatic hypotension, atrial fibrillation, hypertension, macular degeneration, history of stroke with right sided weakness, CAD (Coronary Artery Disease), glaucoma, Parkinson's, and a history of gastrointestinal bleeding.</p> <p>An MDS (Minimum Data Set) assessment, dated 8/17/14, indicated Resident #18 had a BIMS (Brief</p>	F000226	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident#18 no longer resides in the facility. It is the policy of this facility to see that all allegations of abuse are thoroughly investigated and reported to the state agency. Any concerns of physical abuse, or other forms of abuse, will be investigated and reported to the state agency. Any allegation of abuse will be thoroughly investigated and will be reported to the Administrator, then state agency, and all other parties as appropriate and required.</p> <p>2.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 have the potential to be affected by the deficient practice. All residents will be interviewed for abuse by 10/12/14. All reports of physical abuse, or any other form of abuse/potential abuse will be thoroughly investigated</p>	10/12/2014

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	<p>Interview for Mental Status) score of 15 which indicated the resident was interviewable.</p> <p>On 9/8/14 at 1:34 p.m., during an observation of Resident #18 she was observed to have a scabbed over area to her outer left bicep area and a bruised area along with an adjacent small open area to the middle part of her left forearm area. The resident also had a bruise to her right forearm area and a bruised area to her right upper forearm area which had Steri-Strips (a wound treatment) covering part of the bruised area.</p> <p>On 9/8/14 at 1:35 p.m., during an interview with Resident #18 and a family member, Resident #18 indicated the scabbed over area to her upper left arm was caused by a CNA being "too rough with me" while the CNA was providing transfer assistance in the bathroom. She indicated "sometimes they grab me by the arms to help me up from the toilet." Resident #18's family member indicated the resident did not have the bruises or scabbed over area to the resident's upper extremities upon her admission to the facility on 8/10/14.</p> <p>On 9/9/14 at 10:12 a.m., during an interview, the Physical Therapy Director indicated he had never been informed by</p>		<p>andreported to the Administrator/Immediate Supervisor for investigation andreporting. This includes abuse or alleged abuse. Going forward, theAdministrator/Designee will spearhead all abuse or allegations of abuse investigations.All allegations of abuse are reported immediately to the Administrator andISDH, reporting to ISDH no later than 24 hours post occurrence. These will bereported to the state agency and all other appropriate parties as indicatedwhich may include the Ombudsman, Adult Protective Services, physician, family,registry or licensing agencies and possibly the police. Incidents of abuse oralleged abuse require immediate initiation of the investigation/reportingprocess by Administration. The Administration is to be informed immediately.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? All staff will be in-serviced on the necessity to immediately report alltypes of abuse or incidents of abuse or alleged abuse immediately to theimmediate supervisor was reviewed. Administrator will in-service residents onabuse at Resident Council meeting by 10/12/14. The immediate supervisor willnotify the</p>	

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	<p>any resident of being treated roughly by any staff member.</p> <p>On 9/10/14 at 1:07 p.m., during an interview with another family member of Resident #18, the family member indicated being aware of a small "nickel sized" skin tear that occurred while the same family member was transferring Resident #18 in a wheelchair on a previous visit to the facility. The family member indicated the resident did not have any other bruises, open areas, or other injuries to her upper extremities.</p> <p>A facility document titled "Concern Form", dated 8/26/14, indicated Resident #18 notified staff of a "CNA "rough" when taking her to the bathroom-causing skin tear." The facility provided no written statement from Resident #18 regarding the incident. The concern form indicated the internal investigation of the incident included "staff statements" and "resident interview." The facility investigation of the 8/26/14 incident included statements, written by the DON (Director of Nursing), as told to her by various staff members which included LPN #12, LPN #13, CNA #14, the SSD (Social Services Director), Physical Therapy Director, and QMA (Qualified Medication Aide) #6 .</p>		<p>Administrator/DON and an investigation will begin immediately.Reporting to all appropriate agencies/parties will be done. Within 24 hours thestate agency needs to be notified with a five day follow-up report to follow.Any staff who fail to comply with their role in reporting/investigating abusewill be disciplined up to and including termination.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? At the monthly Quality Assurance meetings, allincidents of abuse or alleged abuse will be reviewed. Any patterns will beidentified. If necessary, an action plan will be written by the Administrator/Designeeand monitored weekly until resolution and monitored ongoing monthly for 6months through the QA meeting. The facility has a zero tolerance for abuse.</p>				

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	<p>A 9/2/14 "Concern Form" indicated Resident #18 and a family member reported to facility staff that "...Staff threw her (Resident #18) around..." A 9/2/14 physician's order indicated for Resident #18 to be sent to the Emergency Room. The concern form indicated the internal investigation of the incident included "staff statements" and "resident interview." No resident interview regarding the 9/2/14 incident of Resident #18 being thrown around was provided by the facility to the surveyor for review. The facility investigation of the 9/2/14 incident included staff interviews with CNA #'s 15 and 16.</p> <p>On 9/10/14 at 10:25 a.m., during an interview, the DON indicated no other residents were interviewed regarding the 8/26/14 complaint of being treated "rough" by CNA staff. The DON indicated the facility did not report the 8/26/14 event to the state agency, but indicated the facility should have notified the state regarding the incident. She indicated "I see why it was important to interview other residents." The DON indicated she does not have evidence to show the alleged perpetrator of "rough" treatment of Resident #18 was interviewed by facility staff following the alleged incident. She also indicated no residents other than Resident #18 were</p>			

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F000241 SS=D	<p>interviewed regarding the 9/2/14 incident.</p> <p>On 9/12/14 at 12:14 p.m., during an interview, the Administrator indicated the 8/26/14 and the 9/2/14 incidents concerning potential resident abuse did not need to be reported to the state agency.</p> <p>An undated facility policy, titled "Abuse Protection and Response Policy" indicated potentially "...abusive behaviors..." as "...derogatory language, rough handling, ignoring patients..."</p> <p>The facility Abuse policy also indicated "...Any patient event that is reported to any staff by patient, family member, other staff or any other person will be considered as POSSIBLE ABUSE if it meets any of the following criteria..." "...Any patient or family complaint of physical harm..."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that</p>			

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	<p>maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain the dignity of 2 residents observed wearing hospital gowns during daytime hours. (Resident #'s 26, 36)</p> <p>Findings include:</p> <p>Resident #36's record was reviewed on 9/8/14. Diagnoses for the resident included, but were not limited to, HTN, DM, Trigeminal Neuralgia, seizure disorder, MS, BPH, Neurogenic bladder.</p> <p>A 7/2/14 MDS (Minimum Data Set) assessment indicated Resident #36 had a BIMS (Brief Interview for Mental Status) score of 15 out of 15 possible points which indicated the resident did not have a cognitive impairment. The assessment also indicated Resident #36 required "Extensive assistance" with the task of dressing, including requiring assistance from 1 staff member.</p> <p>On 9/8/14 at 10:29 a.m., during an observation, Resident #36 was lying in his bed watching television. The resident was observed wearing a hospital gown while lying in bed.</p>	F000241	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the deficient practice. Residents #26 and #36 were interviewed for preferences on wearing gowns. Care plans were updated accordingly.</p> <p>2.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 have the potential to be affected by the deficient practice.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All new admissions will have preferences addressed. All care plans will be monitored with IDT members quarterly, including a review of care plan dress preferences. DON/Designee will in-service nursing staff to honor resident preferences and choices.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The SSD/Designee will bring care plan audit results to the monthly QA meeting for review and tracking and trending for 6</p>	10/12/2014

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	<p>On 9/11/14 at 10:50 a.m., during an observation, Resident #36 was in his room lying in his bed watching television. The resident was wearing a hospital gown. He was in no distress.</p> <p>On 9/8/14 at 10:31 a.m., Resident #36 indicated he was still wearing a hospital gown as the CNA staff had not been in to assist him with getting dressed.</p> <p>On 9/11/14 at 10:53 a.m., during an interview, LPN #4 indicated "I wouldn't want to be dressed in a hospital gown all day."</p> <p>2) Resident #26's record was reviewed on 9/8/14 at 11:44 a.m. The resident's diagnoses included, but were not limited to, dementia, Hepatitis C, constipation, chronic anemia, hx (history) of falls, HTN, agitation, hallucinations, COPD, paranoid schizophrenia, depression, and anxiety.</p> <p>On 9/12/14 at 11:41 p.m., Resident #26 was lying in his bed with his eyes closed. He was dressed in a hospital gown.</p> <p>3.1-3(t)</p>		months to resolve outstanding issues.				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure a resident had a Pre-Admission Screening/Annual Resident Review (PASRR) completed as needed for 1 of 1 residents reviewed for PASRR. (Resident #6) The facility also failed to ensure a resident's missing items were reported and the complaints were thoroughly investigated by facility staff for 1 of 1 residents reviewed for missing personal property. (Resident #41)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #6 was reviewed on 9/11/14 at 2:05 p.m. The diagnoses for Resident #6 included, but were not limited to, cerebral palsy, mild mental retardation, left hemiparesis, and seizure disorder.</p>	F000250	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Two residents have the potential to be affected by the deficient practice. Resident #6 PASRR paperwork will be corrected by 10/12/14. In regards to resident #41 missing items, a new grievance was completed on residents missing property. It is the policy of this facility that the resident safeguard their personal property. Resident #41 was educated on the facility practice and given the opportunity to safeguard personal property in safe, if desired.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Currently, only two residents have</p>	10/12/2014

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	<p>A Pre-Admission Screening/Annual Resident Review (PASRR), dated 10/19/12, indicated Resident #6 needed a resident review in one year.</p> <p>A PASRR after 10/19/12 was not located in the clinical record.</p> <p>A cover sheet of a PASRR, dated 9/12/13, was received from the SSD, on 9/11/14 at 4:30 p.m. The date in the Level II section on the form was blank. The rest of the PASRR certification packet was requested at this time.</p> <p>During an interview with the Social Services Director (SSD), on 9/11/14 at 4:30 p.m., she indicated the PASRR representative attended a meeting at [Name of Resident #6's day services]. The SSD further indicated the Individualized Support Plan completed on, 11/7/13, by [Name of Resident #6's day services] was the same thing as a PASRR and had the same recommendations as a PASRR.</p> <p>A copy of an email to the SSD from a PASRR representative, dated 9/12/14 at 10:27 a.m., was received from the SSD, on 9/12/14 at 11:20 a.m. The email indicated, "...has not completed a review since 2012. I am requesting...annual</p>		<p>the potential to beaffected by the deficient PASRR practice. A review of the other resident PASRRpaperwork was identified as being complete/updated. In regards to personalproperty, an audit was completed with all grievances and an emergency residentcouncil meeting was held to review policy/procedure on grievances and given anopportunity to safeguard resident property. A review of the grievance log bySSD/Administrator is completed monthly for any unresolved grievances.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? SSD/Designee will complete a PASRR audit upon admission and ongoingmonthly for 6 months or until 100% compliant. In regards to personal property,all new residents, upon admission, will be educated on policy/procedure forsecuring personal items. The SSD/Designee will complete a grievance log auditmonthly for 12 months and ongoing or until 100% compliant with deficientpractice.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? The SSD/Designee will bring results of PASRR audits tothe</p>	

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	<p>review...."</p> <p>The SSD indicated, on 9/12/14 at 11:20 a.m., Resident #6's PASRR was not completed as she thought. The SSD further indicated she thought the PASRR was the same thing as [Name of Resident #6's day services] review/recommendations. The SSD also indicated she was still learning her role as SSD.</p> <p>2. On 9/9/14 at 9:55 a.m., during an interview, Resident #41 indicated she had personal property go missing at various times during her stay at the facility. She indicated sometime in March of 2014 \$160 in cash and a pair of "(Name Brand) slippers" went missing. She also indicated in June of 2014 \$80 in cash and a "\$50 Cheesecake Factory" gift card went missing. Resident #41 indicated speaking to the SSD (Social Services Director), whom she mentioned by first name, about each of the missing items. The resident indicated the SSD "had me fill something out" about the missing items.</p> <p>On 9/11/14 at 12:37 p.m., during an interview, the Administrator indicated he was not aware of any missing personal items for Resident #41 but he indicated the Social Services department handled</p>		<p>monthly QA meeting for review to ensure compliance for 6 months. In regardsto personal property, the SSD/Designee will bring results of personal propertygrievances/audits monthly to QA meeting for tracking/trending of personalproperty grievances for 6 months.</p>		

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	<p>those issues.</p> <p>On 9/12/14 at 10:05 a.m., during an interview, Resident #41's family member indicated the missing slippers were discussed with facility staff, including the SSD, during a care plan meeting "4 or 5 months ago."</p> <p>On 9/12/14, at 9:48 a.m., the SSD indicated the facility policy stated residents were responsible for the safeguarding of their own "expensive items." She indicated the facility discouraged residents from keeping expensive items at the facility. She indicated at no time was she informed, in any manner, of missing slippers, cash, or gift cards for Resident #41.</p> <p>On 9/12/14 at 10: 09 a.m., the SSD indicated the facility has no personal property inventory for Resident #41. She also indicated the facility does not have a policy on services provided by the Social Service Department, but she indicated having a "job description".</p> <p>A facility document titled "Job Description - Social Worker" indicated one of the duties of the Social Services Department was to "...Keep accurate records of complaints, and report complaints and suggested remedies to the</p>			

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F000279 SS=D	<p>administrator..."</p> <p>A facility policy, signed by the SSD on 3/2/14, titled "LOST OR STOLEN PERSONAL PROPERTY OF THE RESIDENTS" indicated "...Should a resident or responsible party report an item as lost or stolen, a REPORT OF CONCERN shall be completed and forwarded to the attention of the Administrator..." The policy also indicated "...Administration shall be responsible to investigate the report and attempt to track at what point the loss was evident, etc., in a good faith effort to recover said items..."</p> <p>3.1-34(a)</p> <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>			

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	<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 interview, and record review, the facility failed to develop a care plan to address a resident's recurrent UTI's (urinary tract infections) for 1 of 22 residents reviewed for care plans. (Resident #25)</p> <p>Findings include:</p> <p>The clinical record for Resident #25 was reviewed on 9/9/14 at 2:00 p.m. The diagnoses for Resident #25 included, but were not limited to, urinary tract infection.</p> <p>The 8/6/14 New Resident Information and Charting Guidelines form indicated Resident #25 was admitted to the facility with a urinary tract infection.</p> <p>The 8/24/14 hospital discharge summary indicated Resident #25 was admitted to the hospital on 8/22/14 from the facility. The discharge summary indicated, "Plan: 1. UTI - started on ceftriaxone 8/22,</p>	F000279	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 25 is recovering from her UTI without complication and completed antibiotic. Careplan was updated for recurrent UTI.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents. No other resident in the facility was affected by the cited practice.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? On admission resident history and active problem list will be reviewed and care plans will be initiated. All new orders will be reviewed daily for appropriate follow up and intervention. Care plans will be developed accordingly.</p> <p>4.How will the corrective actions be monitored to ensure the</p>	10/12/2014

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	<p>urine culture at the time of discharge was growing gram negative rods, her last UTI was pansensitive Ecoli, she was discharged on keflex."</p> <p>The 9/4/14 Physician's Order for Resident #25 indicated an antibiotic to be taken twice daily for 7 days, to obtain a urinalysis, to catheterize if needed, to encourage fluids, and to give 4 oz. of cranberry juice with meals for a UTI. The 9/10/14 Physician's Order for Resident #25 indicated a different antibiotic to be taken once daily for 10 days, to obtain a urinalysis, and to discontinue the antibiotic ordered on 9/4/14.</p> <p>The care plans for Resident #25 were reviewed. No care plan addressing her UTI's was found.</p> <p>An interview was conducted with UM (Unit Manager) #1 on 9/12/14 at 11:53 a.m. She indicated, "I've noticed she has behaviors when the UTI is coming on, because she's usually pretty friendly. She has a history of UTI's. It's noticeable to me when she gets a UTI, because she doesn't eat. She's lethargic. I noticed it the other day, and (name of Resident #25's doctor) went ahead and started her on (name of antibiotic). She was admitted with a UTI, on antibiotics, on</p>		<p>deficient practice will not recur; what quality assurance program will be put into place? ADON/Designee will be responsible for checking any new physician's orders and new admission and implementing care plans. This will be done Monday through Friday. The DON/Designee will also monitor this process 2 times per week to ensure care plans are implemented. Negative observations/audits will be reported to QA committee monthly. Audits will be monitored for 6 months.</p>				

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F000280 SS=D	<p>8/6 (8/6/14)." Regarding whose responsibility it was to create a care plan regarding Resident #25's UTI's, she indicated, "Nursing initiates it, then the DON (Director of Nursing) and ADON (Assistant Director of Nursing) follow up." UM #1 reviewed Resident #25's care plans, and indicated she did not see a care plan addressing Resident #25's UTI on admission, frequent UTI's, or her UTI requiring hospitalization." Regarding whether Resident #25 should have had a care plan to address her UTI's, she stated, "I believe she should have one. Someone in nursing should have made one."</p> <p>An interview was conducted with the ADON on 9/12/14 at 12:15 p.m., regarding lack of a care plan addressing Resident #25's UTI's. The ADON indicated, "It was missed. She should have one."</p> <p>3.1-35 (a)</p>						
	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING						

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	<p>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 interview and record review, the facility failed to ensure bilateral knee splints and bunny boots (soft foot splints) were on Activities of Daily Living (ADL) care plans for 2 of 22 residents reviewed for care plans (Residents #3 & #64).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #64 was reviewed on 9/12/14 at 11:05 a.m. The diagnoses for Resident #64 included, but were not limited to, acute kidney disease and acute metabolic encephalopathy</p> <p>A Physician's Order for Resident #64 was dated 8/25/14. The Physician's Order</p>	F000280	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Resident# 3 has current orders for bilateral knee splints and will be applied pernursing care plan was updated. Resident #64 care plan has been updated toinclude resident's bunny boots.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? An audit of assistive devices was done on all residents.No other resident in the facility was affected by the cited practice.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure</p>	10/12/2014

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	<p>indicated bunny boots (soft foot splints) should be worn daily and removed for showers.</p> <p>All care plans for Resident #64, including an ADL (Activities of Daily Living)/Self Care Deficit care plan, dated 7/28/14, were reviewed. An intervention of bunny boots to be worn daily was not located as an intervention for any of Resident #64's care plans.</p> <p>During an interview with Unit Manager #1, on 9/12/14 at 2:20 p.m., she indicated she was unable to locate any intervention of wearing bunny boots on any of the care plans. Unit Manager #1 indicated, the bunny boots should be an intervention on the ADL care plan.</p> <p>2. The clinical record for Resident #3 was reviewed on 9/11/14 at 4:05 p.m. The diagnoses for Resident #3 included, but were not limited to, renal tubular acidosis, encephalopathy, seizure disorder, and abnormal posture.</p> <p>A review of a PT (Physical Therapy) Discharge Summary, dated 5/29/14, indicated, "...Bilateral knee splints can be applied when patient is sleeping and not when he is awake as he tends to kick legs in resistance....Recommended nursing to apply bilateral knee splints per pt's</p>		<p>that the deficient practice does not recur? All nursing staff will be educated on importance of applying splints, braces, and bunny boots. Also to notify nurse if unable to do so. Nurses will be educated on following up on refusals/missing splints. Therapy will assist in educating staff on applying splints and braces. Nurses will also document any instances of resident refusing to wear/ resistive to care and consult with physical therapy / doctor for further evaluation/ recommendations.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? MAR/TAR will be audited 5 times per week x 4 weeks. Care plans will be audited with all new admissions and IDT meetings quarterly. Audits will be monitored for 6 months. Any deficient practice will be brought to the QA meeting monthly for review.</p>				

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	<p>[patient's] tolerance."</p> <p>During an interview with the Rehab Manager, on 9/12/14 at 9:40 a.m., he indicated he spoke with nursing about wearing the bilateral knee splints at night, back in May when he made the recommendation. The Rehab Manager further indicated the bilateral knee splints should still be part of Resident #3's plan of care, since he had not been notified of any concerns with the Resident wearing the knee splints.</p> <p>All care plans for Resident #3, including an ADL (Activities of Daily Living)/Self Care Deficit care plan, dated 8/30/14, were reviewed. An intervention of bilateral knee splints to be worn nightly was not located as an intervention for any of Resident #3's care plans.</p> <p>On 9/12/14, at 10:15 a.m., the Assistant Director of Nursing (ADON) indicated she was unable to locate an intervention for bilateral knee splints on any of Resident #3's care plans. The ADON indicated the bilateral knee splints should be an intervention on the ADL care plan.</p> <p>3.1-35(d)(2)(B)</p>				

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F000282 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 interview and record review, the facility failed to follow physician's orders for weekly skin assessments, application of a resident's bunny boots (soft foot splint), obtain weekly BMP labs, obtain an albumin lab timely, and obtain/record daily weights for 4 of 22 residents reviewed for following physician's orders. (Residents #64, #71, #41, & #24).</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #64 was reviewed on 9/12/14 at 11:05 a.m. The diagnoses for Resident #64 included, but were not limited to, acute kidney disease and acute metabolic</p>	F000282	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #64 orders were clarified and how bunny boots have to be signed off every shift to ensure that they are in place. Resident #41 orders have been added to the MAR/TAR. Resident #41 weights are now being tracked daily per MAR. Resident #71 lab was contacted immediately and a BMP was obtained.</p> <p>2.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 have the potential to be affected by the deficient practice. A comprehensive review was completed on all resident</p>	10/12/2014
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	<p>encephalopathy.</p> <p>A review of the Admission Physician's Orders for Resident #64, indicated an order for weekly skin assessments.</p> <p>An order clarification, dated 7/23/14, indicated a skin assessment was to be completed every 7 days.</p> <p>Skin Assessment Verification documents indicated Resident #64 had a skin assessment on 7/16/14 and 8/28/14. No other skin assessment during this timeframe were located in the clinical record.</p> <p>During an interview with Unit Manager #1, on 9/12/14 at 2:00 p.m., she indicated she was unable to locate any other completed skin assessments between the dates 7/17/14 and 8/27/14 for Resident #64.</p> <p>A policy titled, Prevention of Pressure Ulcers, dated 10/24/11, was received from the Director of Nursing on 9/12/14 at 1:30 p.m. The policy indicated "...The condition of the resident's skin will be documented weekly...."</p> <p>1b. A Physician's Order for Resident #64 was dated 8/25/14. The Physician's Order indicated bunny boots (soft foot</p>		<p>orders. Those residents that have been found to be affected were corrected.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? DON/Designee will in-service nursing staff on following physician orders. The DON/Designee will audit all new orders Monday through Friday to ensure orders have been implemented correctly and to ensure care plans have been initiated correctly. DON/Designee will audit MAR/TAR daily and C.N.A. worksheets daily for complete interventions and documentation.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? All audits will be completed on all orders, interventions, any negative findings will be reported to QA Committee by DON/Designee and monitored for 6 months.</p>		

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	<p>splints) should be worn daily and removed for showers.</p> <p>The August TAR (treatment administration record) indicated an FYI [for your information] for bunny boots. There was no indication the Physician's Order was being monitored/checked off as completed.</p> <p>During an observation with LPN #5, on 9/12/14 at 2:15 p.m., Resident #64 did not have her bunny boots on and her ankles were noted to be tightly crossed over each other. LPN #5 was unable to locate Resident #64's bunny boots in her room.</p> <p>On 9/12/14 at 2:20 p.m., Unit Manager #1 indicated she was unable to locate Resident #64 bunny boots. Unit Manager #1 also indicated Resident #64 should had have on her bunny boots since she tightly crosses her ankles and the boots can help prevent skin issues.</p> <p>2. The clinical record for Resident #71 was reviewed on 9/12/14 at 10:35 a.m. The diagnoses for Resident #71 included, but were not limited to, end stage renal disease, diabetes mellitus, and anemia.</p> <p>A review of Resident #71's Admission Physician's Orders, indicated an order for</p>			

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	<p>a BMP (basic metabolic panel-routine lab) weekly.</p> <p>A lab from [Name of Lab Company], dated 8/13/14, was located in the clinical record. No other labs were located in the clinical record.</p> <p>During an interview with Unit Manager #1, on 9/12/14 at 11:36 a.m., she indicated labs should be kept in a Resident's clinical record. Unit Manager #1 indicated she will try and look for other completed BMP labs for Resident #71.</p> <p>On 9/12/14, at 1:25 p.m., the Assistant Director of Nursing (ADON) indicated no other labs were done as ordered for Resident #71. The ADON further indicated the Physician's Order sent to lab company was incorrectly written/ordered and the lab was only written/ordered to be done one time, instead of weekly.</p> <p>3. The clinical record for Resident #24 was reviewed on 9/9/14 at 10:45 a.m. The diagnoses for Resident #24 included, but were not limited to, congestive heart failure.</p> <p>The 8/13/14 Physician Telephone Order for Resident #24 indicated an albumin lab to be obtained. The</p>			

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	<p>indication/diagnosis indicated on the order was for wound healing.</p> <p>The laboratory results section of Resident #24's clinical record indicated the albumin lab was obtained on 8/28/14.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 9/10/14 at 11:19 a.m., regarding the 15 day time frame between the albumin lab order date and the specimen collection date. She indicated she was unsure as to the reason for the delay.</p> <p>An interview was conducted with the ADON on 9/10/14 at 2:34 p.m. She indicated, "We didn't realize the albumin wasn't drawn, so we did it on the 28th (8/28/14). The order was for the gluteal fold wound."</p> <p>4. Resident #41's record was reviewed on 9/9/14 at 2:27 p.m. Diagnoses for the resident included, but were not limited to, DM (diabetes mellitus) type II, ESRD (end stage renal disease), and HTN (hypertension).</p> <p>A physician's order, dated 9/4/14, indicated for Resident #41 to be weighed daily.</p> <p>An 8/8/14 MDS (Minimum Data Set) assessment indicated Resident #41's</p>			

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	<p>BIMS (Brief interview of Mental Status) was 15 out of 15 possible points, which indicated the resident did not have a significant cognitive impairment.</p> <p>On 9/11/14 at 9:58 a.m., during an observation and interview, Resident #41 indicated she has not been weighed daily since 9/4/14.</p> <p>On 9/12/14 at 11:09 a.m, during an interview, the DON (Director of Nursing) indicated physician's orders regarding daily weights should be followed at all times. She indicated the facility would indicate on the medication or treatment administration record when daily weights are taken.</p> <p>On 9/12/14 at 11:51 a.m., during an interview, Unit Manager #1 and the ADON (Assistant Director of Nursing) indicated Resident #41 was weighed once between 9/4/14 and 9/12/14. The facility record indicated Resident #41 had a weight on 9/4/14 of 163 lbs. The ADON and Unit Manager #1 indicated the facility had no other weights recorded for the resident.</p> <p>On 9/12/14 at 11:59 a.m., the DON indicated Resident #41 should have been weighed and her weights should have been recorded as ordered between the</p>			

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F000309 SS=D	<p>dates of 9/5/14 and 9/12/14.</p> <p>3.1-35(g)(2)</p> <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 administer Ibuprofen, as ordered, to 1 of 1 resident reviewed for skin conditions. (Resident #24) The facility also failed to ensure a resident's medications were given at the correct time, as ordered, by the physician. This practice affected 1 of 5 residents reviewed for medication administration time. (Resident #36)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #24 was reviewed on 9/9/14 at 10:45 a.m. The diagnoses for Resident #24 included,</p>	F000309	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 24 a new pain assessment was completed. Based on resident assessment and resident refusals of medication, the order was discontinued. To this day, resident continues to have no complaints of pain. Resident# 36, resident physician was notified on untimely medication administration. Resident had no ill effects of resident medication being delivered untimely.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will</p>	10/12/2014

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	<p>but were not limited to, contusion.</p> <p>An interview was conducted with Resident #24 on 9/9/14 at 10:02 a.m. She indicated the wound specialist recently spoke with her doctor about a prescription for her toe. She indicated, "By the time the prescription came, my toe was healed."</p> <p>The 8/29/14 Wound Assessment form for Resident #24 indicated, "Right second toe...contusion...mild pain to ROM (range of motion)...Pt (patient) stubbed toe. Pain 3/10 (on pain scale)...Treatment: Needs NSAID for inflammation."</p> <p>The 8/29/14, 1:27 p.m. Nurses Note completed by the DON (Director of Nursing) indicated, "Patient requested that (name of physician) take a look at her toe stating she stubbed her right second toe patient rated numeric pain 3/10 on scale of 0-10 no open area was noted per doctors' progress note doctor does recommend NSAID. Writer will have assigned nurse to follow up."</p> <p>The 8/29/14, 3:58 p.m. Nurses Note indicated, "Res (resident) seen by wound. SAID recommended, spoke w/(female name) at (name of doctor) office and will get back with me after decision of</p>		<p>be identified and what correctiveactions will be taken? An audit was done on all residents. No other resident inthe facility was affected by the cited practice.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? Nurses will be reeducated on timeliness of medication delivery andfollowing policy/procedure on medication administration. Nurses will reeducatedon appropriate documentation and physician notification on resident refusals.Nurses will be reeducated to notify pharmacy if medication is not deliveredtimely and to notify the DON of untimely deliveries.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? DON/Designee will audit the medication MAR weekly for 4weeks. Audits will be monitored for 6 months. Any deficient practice will bereported to the QA committee for follow up.</p>	

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	<p>NSAID made."</p> <p>The 8/29/14, 4:42 p.m. Nurses Note indicated, "N/O (new order) for Ibuprofen 400 mg PO (by mouth) TID (3 times daily) w/food for inflammation of rt (right) great toe."</p> <p>The 8/29/14 Physician Telephone Order for Resident #24 indicated, "Ibuprofen 400 mg PO TID (symbol for "with") food" for inflammation.</p> <p>The August, 2014 MAR (medication administration record) for Resident #24 indicated the above order for Ibuprofen was not given at all from 8/29/14 through 8/31/14.</p> <p>The September, 2014 MAR for Resident #24 indicated the Ibuprofen was not attempted to be given until 5:00 p.m. on 9/5/14.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 9/10/14 at 11:19 a.m. She reviewed the August and September, 2014 MAR's and stated, "I don't see that the Ibuprofen was given. I don't see any reason the Ibuprofen was not given, as ordered. I'll have to look into whether the Ibuprofen was given, because we were switching pharmacies at that time. It may have</p>			

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	<p>been given, even though it's not documented on the MAR as given. Nurses document on the MAR when they pass meds (medications)."</p> <p>An interview was conducted with the ADON and the DON on 9/10/14 at 12:00 p.m. The ADON indicated the nurse reordered the ibuprofen 4 times from 2 different pharmacies. She stated, "Neither of our EDK's (emergency drug kits) had the correct dosage. She received her first dose on 9/4 (9/4/14), because that is when the med (medication) came. The MAR does not indicate she received it on 9/4 (9/4/14), because she (the nurse) forgot to sign off on it everyday. It was d/c'd (discontinued) on 9/7 (9/7/14)."</p> <p>Regarding a procedure for obtaining and administering an ordered medication to a resident, the ADON indicated, "Our procedure is to order it. If we can't get it, use the EDK. I'm not sure what the discrepancy with the pharmacy was." The DON indicated the nurse referenced as ordering the medication 4 times "did not document in the nurses notes on any of this."</p> <p>The Medication Administration policy was provided by the DON on 9/8/14 at 1:21 p.m. It indicated, "Medications must be administered in a timely manner</p>			

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	<p>and in accordance with the attending physician's written/verbal orders....The individual administering the medication must initial the resident's MAR on the appropriate line and date for that specific day before administering the next resident's medication."</p> <p>2. On 9/11/14 at 10:52 a.m., during an interview, Resident #36 indicated he had not received his morning medications. He identified three medications that he had not received as "Norco, Vitamin B, and Trileptal" (Norco is a pain medication and Trileptal is a seizure medication). He indicated his level of pain was a "6 or 7" on a scale of 0 to 10 with 10 being identified as the highest level of pain possible.</p> <p>On 9/11/14 at 10:53 a.m., during an interview, the LPN #4 indicated Resident #36 had not received his 9 a.m. medications due to being "a little behind." She indicated she did not normally work the hall she was assigned to on 9/11/14.</p> <p>On 9/11/14 at 12:59 p.m., during an interview, LPN #4 indicated she gave Resident #36 his 9 a.m. medications at "around 10:55 a.m." on 9/11/14.</p> <p>A nursing progress note, dated 9/11/14 at</p>			

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	<p>1:54 p.m., indicated "...Resident's (#36) morning medications were administered late..."</p> <p>On 9/11/14 at 1:46 p.m., during an interview, the DON indicated the facility considers it a medication error if a licensed nurse administers medications over an hour from when the medication was scheduled.</p> <p>A physician's order for Vitamin B, dated 8/9/13, indicated for the medication to be administered daily at 9 a.m.</p> <p>A physician's order for hydrocodone (Norco), dated 8/6/14, indicated for "...two tablets by mouth twice daily..." at 9 a.m. and 4 p.m.</p> <p>A physician's order, dated 8/17/13, for oxcarbazapine (Trileptal) indicated for the medication to be administered "...three times daily..." at 9 a.m., 12 p.m., and 4 p.m.</p> <p>A facility policy dated February of 2014 and titled "Med Pass General Guidelines" indicated the purpose of the policy as "...To ensure compliance of the five resident rights..." and "...3. Right time... (of the medication administration). The "Procedure" section of the policy indicated "...Administering medications</p>						

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F000312 SS=D	<p>too early or too late is considered a medication error..."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to assist a resident with eating, in accordance with his assessment, for 1 of 4 residents reviewed for activities of daily living (ADL's). (Resident #26)</p> <p>Findings include:</p> <p>The clinical record for Resident #26 was reviewed on 9/10/12 at 1:00 p.m. The diagnoses for Resident #26 included, but were not limited to, dementia.</p> <p>The 8/13/14 Significant Change MDS (minimum data set) assessment for</p>	F000312	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 26 has been assigned to receive their meals at the assist dining room. Resident #26 continues to remain in therapy and therapies have been requested to review resident for adaptive equipment for eating.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents. No other resident in the facility was affected by the cited practice. A review of all the</p>	10/12/2014

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	<p>Resident #26 indicated he required an extensive assistance of 1 person for eating.</p> <p>The 8/25/14 ADL care plan for Resident #26 indicated, "The resident has an ADL self-care performance deficit r/t (related to) weakness, dementia....The resident requires extensive assist at times by 1 staff to eat."</p> <p>An observation was made on 9/8/14 at 8:58 a.m. of Resident #26 eating breakfast in the dining room. No staff was assisting him. His hands were very unsteady and shaky when scooping food onto his fork, and attempting to reach his mouth. He was using regular silverware. He was continuously dropping food onto his lap. His lap was very messy, with eggs, biscuit pieces, and sausage. 25% of Resident #26's food actually reached his mouth. He dropped his spoon on the floor and yelled, "Dang it". Still, no staff member attempted to assist him. There was food on the table surrounding his plate. There was a puddle of milk on the floor, underneath his wheel chair, on his wheel chair wheels, and on his shoes. The ADON (Assistant Director of Nursing) approached him and stated, "We can get you another milk." He was handed another milk, but no one sat with him to assist him with his meal.</p>		<p>C.N.A.worksheets and care plans have been reviewed to ensure resident are receivingthe highest level of assistance needed.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? Staff was reeducated on following resident care plans and providing thehighest level of assistance needed. Therapy will be notified of any decline inADL and DON/Designee will audit the dining room one meal per day for 5 days toensure residents are receiving the highest level of assistance they require.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? Audits will be completed and any decline will bebrought through QA committee for changes/recommendations. Audits will bemonitored for 6 months.</p>	

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	<p>An observation of Resident #26 eating lunch was made on 9/9/14 at 12:30 p.m. QMA #6 was assisting him. QMA #6 stated, "I normally don't sit with him, but he needs assistance today, because he's a little tired."</p> <p>An interview was conducted with CNA #7 and CNA #8 on 9/10/14 at 2:10 p.m. CNA #7 indicated Resident #26 could feed himself with cueing, and he didn't need someone to assist him. CNA #8 indicated Resident #8 needed supervision and cueing to eat, and she never had to sit and feed him. Both CNA #7 and CNA #8 indicated they worked with Resident #26 everyday.</p> <p>An interview was conducted with the ADON and UM (Unit Manager) #1 on 9/10/14 at 3:05 p.m., regarding Resident #26 needing assistance with eating. The ADON indicated, "It depends on the day. He's been on the decline. Some days, he needs extensive assist of 1. Other days he can feed himself." When informed of the observation of Resident #26 eating breakfast on 9/8/14, the ADON indicated it was a chaotic day. UM #1 indicated she recalled the observation and the ADON bringing him another milk.</p> <p>An interview was conducted with the</p>			

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F000313 SS=D	<p>DON (Director of Nursing) on 9/10/14 at 3:28 p.m. She indicated, "We haven't done an evaluation, but I can have him evaluated to see if a divider plate or the special silverware might help him."</p> <p>The 9/11/14 Physician Order indicated, "O.T. (Occupational Therapy) to evaluate pt (patient) for adaptive equipment to assist (symbol for "with") meals."</p> <p>3.1-38(a)(2)(D)</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based of interview and record review, the facility failed to ensure an optometry exam was followed through with, as recommended for 1 of 1 residents reviewed for Pre-Admission Screening/Annual Resident Review.</p>	F000313	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Allresidents have the potential to be affected by deficient practice. Resident #6will be sent to the optometrist at first available</p>	10/12/2014

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	<p>(Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 9/11/14 at 2:05 p.m. The diagnoses for Resident #6 included, but were not limited to, cerebral palsy, mild mental retardation, left hemiparesis, and seizure disorder.</p> <p>A review of a [Name of Company] Eye Care Consult Report, dated 10/21/13, indicated "...Plan...monitor [sic] 6 months, iop [eye pressure test]."</p> <p>A [Name of Company] Resident Cancelled [sic] Visit Report, dated 6/2/14-Monday, indicated an optometry appointment was not completed because the Resident #6 was out of the facility.</p> <p>A [Name of Company] Resident Cancelled [sic] Visit Report, dated 7/21/14-Monday, indicated an optometry appointment was not completed because the Resident #6 was out of the facility.</p> <p>During an interview with the Social Services Director, on 9/11/14 at 3:00 p.m., she indicated the six month follow-up from 10/21/13 was initially attempted on 3/31/14, which was a Monday. The SSD further indicated</p>		<p>appointment.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? The SSD/Designee will audit all residents that requireancillary services. Any resident found to be needing services will be scheduledat next available appointment.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? The SSD/Designee will complete a monthly audit for all resident whorequire ancillary services. The audit will be completed each month or until100% compliant.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? The SSD/Designee will bring results of audits to themonthly QA meeting for tracking and trending to ensure compliance for 6 months.</p>	

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F000314 SS=D	<p>Resident #6 was not here that day as well, since Resident #6 attended day services on Mondays at an outside facility. The SSD also indicated she did not realize Resident #6 was not in the facility during the optometrist's visits in June and July and she should've "caught" this issue sooner. The SSD indicated if she noticed this issue sooner, she could've made a "special" optometry appointment for Resident #6.</p> <p>3.1-39(a)(1)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review, the facility failed to ensure a resident with a documented open area had weekly wound measurements for 1 of 3 residents reviewed for pressure ulcers. (Resident</p>	F000314	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 12 was discharged from facility. Resident #53 sacral</p>	10/12/2014			

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	<p>#12) The facility also failed to ensure a Physician's order/recommendation for a wound was followed through for 1 of 3 residents reviewed for pressure ulcer. (Resident #53)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #12 was reviewed on 9/11/14 at 3:05 p.m. The diagnoses for Resident #12 included, but were not limited to, end stage kidney disease, hypodense liver lesion, sacral decubitus ulcer, history of cervical cancer, and history of gallbladder cancer.</p> <p>A Hospital Progress Note, dated 3/19/14, indicated a active problem/diagnosis of sacral decubitus ulcer.</p> <p>An Admission Nursing Assessment, dated 3/20/14, indicated a small open area to the coccyx in the skin condition section. On the skin diagram on the Assessment, a small circle was drawn on the sacrum/coccyx, indicating an open area on the resident.</p> <p>The Admission Physician Orders, dated 3/20/14, indicated a diagnosis of sacral decubitus ulcer. The Orders indicated to cleanse the sacral wound with normal saline/gauze and cover with [name of dressing] every 3 days. The Orders also</p>		<p>wound was resolved on 09-17-14 per wound nurse documentation. Resident currently denies pain and has no discomfort related to wounds.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents. No other resident in the facility was affected by the cited practice.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nurses will be reeducated on wound measurements weekly. DON/Designee will audit wound sheets weekly. Treatment and interventions will be audited weekly to ensure appropriateness for wound care. Any decline noted, the physician will be notified immediately.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? All audits will be taken to QA committee monthly for 6 months. Any negative observations will be reported to the QA committee by DON for additional actions.</p>				

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	<p>indicated for weekly skin assessments on Thursday, during day shift.</p> <p>No wound measurements were noted in the clinical record during Resident #12 stay at the facility from 3/20/14-4/2/14.</p> <p>A policy titled, Pressure Ulcers dated 10/24/11, was received from the ADON on 9/11/14 at 10:47 a.m. The policy indicated, "...The nurse will document an eval [evaluation] of the skin weekly including: Date of the observation; Location and staging if pressure ulcer exist; Size, depth, and the presence, location and extent of any undermining or tunneling/sinus tract..."</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 9/11/14 at 4:00 p.m., she indicated she will look for wound measurements for Resident #12.</p> <p>On 9/12/14, at 9:00 a.m., the ADON indicated she was unable to locate any wound measurements/documentation for the dates above for Resident #12.</p> <p>2. The clinical record for Resident #53 was reviewed on 9/10/14 at 2:05 p.m. The diagnoses for Resident #12 included, but were not limited to, paraplegia, cardiomyopathy, chronic obstructive</p>			

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	<p>pulmonary disease, and history of sacral decubitus ulcer.</p> <p>A Telephone Physician's Order, dated 8/4/14, indicated an order to schedule an appointment to see a General Surgeon for Resident #53's sacral wound.</p> <p>A Nurse's Note, dated 8/5/14 at 2 p.m., indicated an appointment was made with a General Surgeon [Name of Physician A] on 8/11/14 at 9:40 a.m.</p> <p>A Physician's Order, dated 8/6/14, indicated an order for the above appointment to be canceled per Resident #53's request and to schedule Resident #53 with another General Surgeon for evaluation of Resident #53's sacral wound.</p> <p>A Nurse's Note, dated 8/7/14, indicated another General Surgeon was called earlier that day and a voicemail was left regarding an appointment for Resident #53. The Nurse's Note also indicated a call back was recently received from General Surgery and the caller indicated the General Surgeon Manager needed to review Resident #53's information and a General Surgeon will then be assigned to Resident #53 and the facility will be called back with the pertinent information.</p>			

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	<p>No further information related to an appointment with a General Surgeon for an evaluation of Resident #53's sacral wound, was noted in the clinical record.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 9/11/14 at 11:40 a.m., she indicated Resident #53 canceled the initial appointment with the General Surgeon/Physician A because Resident #53 did not like that General Surgeon/Physician A. The ADON further indicated she will find out who/when Resident #53 was scheduled with after the initial appointment was canceled.</p> <p>On 9/11/14, at 12:03 p.m., the ADON indicated a call back was never received and the facility never followed up with a call back to the General Surgery Manager/office regarding an evaluation of Resident #53's sacral wound.</p> <p>A policy titled, Pressure Ulcers dated 10/24/11, was received from the ADON on 9/11/14 at 10:47 a.m. The policy indicated, "...implement appropriate treatments per facility protocol and/or physicians [sic] orders...."</p> <p>3.1-40(a)(2)</p>			

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F000315 SS=G	<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 observation, interview, and record review, the facility failed to provide catheter care to a resident resulting in a hospitalization for urosepsis and a UTI (urinary tract infection) for 1 of 2 residents reviewed of 2 who met the criteria for urinary catheter use. (Resident #65)</p> <p>Findings include:</p> <p>The clinical record for Resident #65 was reviewed on 9/11/14 at 10:00 a.m. The diagnoses for Resident #65 included, but were not limited to, congestive heart failure, history of GI (gastrointestinal) bleed, and acute renal failure. He was admitted to the facility on 6/20/14.</p>	F000315	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 65 has been corrected. The MAR has been updated to include catheter care every shift. Care plan has been updated to include catheter care, prevention of UTI and reporting to physician any signs/symptoms of UTI. A review of resident's orders was completed to ensure accuracy.</p> <p>2.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 having urinary catheters have been audited for accuracy of physician orders and catheter care on MAR. Care plans were updated to provide appropriate interventions for UTI</p>	10/12/2014			

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	<p>An interview was conducted with LPN #5, the nurse for the unit on which Resident #65 resided, on 9/8/14 at 1:30 p.m. LPN #5 indicated Resident #65 did not use an indwelling Foley catheter.</p> <p>An observation of Resident #65 was made on 9/10/14 at 2:10 p.m. His catheter tubing was visible underneath his wheel chair.</p> <p>The 6/20/14 hospital discharge records indicated a catheter insertion date of 6/17/14 and to "leave Foley until seen by urology." The hospital discharge orders did not include orders for catheter care.</p> <p>The 6/20/14 Admission Physician's Orders, obtained by LPN #11, did not include orders for catheter care. The June, 2014 MAR (medication administration record) for Resident #65 indicated an order to "monitor and record urine output from Foley Q (every) shift." The MAR indicated this was not done on first shift on 6/21/14, on second shift from 6/23/14 through 6/30/14, or on third shift on 6/26/14 and 6/27/14. The MAR indicated an order for "catheter care Q shift." The MAR indicated this was not done on first shift on 6/21/14, on second shift on 6/22/14 and 6/24/14 through 6/30/14, or on third shift on 6/26/14 and 6/27/14. The MAR indicated an order to</p>		<p>and physician notification of signs and symptoms.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All nursing staff was reeducated on residents entering or currently receiving urinary catheters will receive appropriate physician orders to include catheter care and interventions to prevent UTI's individual to the specific resident. Care plans will be developed on all foley catheters to include catheter care and notification of physician for any signs/symptoms of a possible UTI. C.N.A.'s will be reeducated on placement of catheters.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? DON/Designee will audit treatment records for catheter care Monday through Friday for 4 weeks, then monthly for 6 months. Audits will be monitored monthly for 6 months through QA. Any deficient practice will be brought through QA committee.</p>	

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	<p>"PRN (as needed) change bag & daily."</p> <p>The July, 2014 Physician's Order Sheet for Resident #65, printed on 6/23/14, did not include orders for catheter care. The July, 2014 MAR for Resident #65, printed on 6/23/14, did not indicate any orders for catheter care, nor did they indicate catheter care was provided. No physician order for catheter care was found in the clinical record from 6/20/14 through 7/4/14.</p> <p>The 7/4/14 hospital records for Resident #65 indicated he was admitted to the hospital on 7/4/14. It indicated, "Assessment/Plan: 1. Urosepsis, UTI: likely source for AMS (altered mental status), likely secondary to catheter in place. Tachycardic, Febrile Tm 103.8, BP (blood pressure) stable...UA (urinalysis) positive for Mod (moderate) leukocytes, packed wbc (white blood cell), nitrite positive. Urine and blood cultures sent. Starting on Rocephin (antibiotic). Tylenol prn fever. Hydrate gently tonight IVF (intravenous fluid) but reevaluate for continuation tomorrow due to CHF (congestive heart failure).....History of Presenting Illness:presenting to (name of hospital) emergency department with complaint of AMS. History obtained from ER staff and niece due to pt's (patient's) condition.</p>			

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	<p>Pt reported to have been at nursing home "shutting down" as pt's family understood with altered mental status, started today, constant, no relieving factors, associated complaint of "pain" but couldn't express where, and stated "yes" to some SOB (shortness of breath) and feeling hot/chills. Pt with additional expressive aphasia for approximately 2 weeks, associated possible weakness to R (right) side....Pt recently hospitalized....urology saw pt for bladder outlet obstruction of unknown cause to be worked up outpatient late July, sent to nursing home as instructed with Foley in place until scheduled visit." The 7/4/14 lab values indicated in the records were as follows:</p> <p>"WBC - 6.7 HGB - 12.0 HCT - 40.1 PLT - 281 NA - 142 K - 4.1 CL - 105 CO2 - 22 BUN - 44 CREATININE - 2.22 CALCIUM - 9.9"</p> <p>An interview was conducted with Unit Manager (UM) #1 on 9/11/14 at 11:39 a.m., regarding catheter care orders for</p>			

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	<p>Resident #65's 6/20/14 admission to the facility. She indicated, "When they (nursing) called the doctor on 6/20 (6/20/14), they would normally have catheter orders on the admission orders. I don't see them. I also don't see the original 6/20/14 hospital discharge orders (for catheter care)." Regarding the expectation for catheter care, if there were no orders, she indicated, "We would follow our standard policy for catheter care." Regarding whether catheter care was provided to Resident #65 in July, 2014, prior to his 7/4/14 hospital admission with a UTI, she indicated, "I don't see verification that catheter care was provided, or what the order was."</p> <p>An interview was conducted with UM #1 on 9/11/14 at 1:28 p.m. She indicated, "(Name of LPN #11) got the admission orders from (name of physician), and didn't clarify any catheter care orders. It was our responsibility to get the orders. I'm not sure how the catheter care treatments got on the MAR. Someone must have realized it, and put them on the MAR, but an order was never received."</p> <p>The Urinary Catheter Care policy was provided by the ADON (Assistant Director of Nursing) on 9/12/14 at 9:30 a.m. It indicated the purpose was, "To prevent infection of the resident's urinary</p>			

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F000318 SS=D	<p>tract."</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure therapy recommendations regarding splints were followed through with for 2 of 4 residents reviewed for therapy services. (Resident #3 & #6)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 9/11/14 at 4:05 p.m. The diagnoses for Resident #3 included, but were not limited to, renal tubular acidosis, encephalopathy, seizure disorder, and abnormal posture.</p>	F000318	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? Forresident #3 currently has physician orders for bilateral knee splints which areapplied by nursing and care plan updated. For resident #6 the splint order wasdiscontinued due to resident refusal.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? An audit was performed on all residents requiringsplints and braces. No other residents were identified by the deficientpractice.</p>	10/12/2014	

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	<p>A review of a PT (Physical Therapy) Discharge Summary, dated 5/29/14, indicated, "...Bilateral knee splints can be applied when patient is sleeping and not when he is awake as he tends to kick legs in resistance....Recommended nursing to apply bilateral knee splints per pt's [patient's] tolerance."</p> <p>An Physician's Order was not located in the clinical record for the bilateral knee splints.</p> <p>During an interview with the Rehab Manager, on 9/12/14 at 9:40 a.m., he indicated he spoke with nursing about wearing the bilateral knee splints at night, back in May, when he made the recommendation. The Rehab Manager further indicated the bilateral knee splints should still be part of Resident #3's plan of care, since he had not been notified of any concerns with the Resident wearing the knee splints.</p> <p>During an observation with CNA #2 and CNA #3, on 9/12/14 at 9:50 a.m., both CNAs were unable to locate both knee splints. The CNAs were able to only locate one splint in Resident #3's room and neither CNA could remember the last time they saw Resident #3 wearing his knee splints.</p>		<p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff educated on applying splints and braces and to notify therapy or refusals or missing splints. Therapy will educate appropriate nursing staff on applying splints and braces.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? All residents with orders for splints and braces will be transcribed on the MAR/TAR and observed for compliance 5 days a week for 4 weeks without negative findings. Any negative findings will be corrected immediately with possible disciplinary actions and education. Therapy will communicate any new recommendations for splints/braces to DON/Designee at morning meeting. Any new orders for splints/braces will be care planned and ordered immediately. Audits will be monitored through QA for 6 months.</p>				

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	<p>On 9/12/14, at 10:00 a.m., the Assistant Director of Nursing, indicated there was no order for Resident #3's bilateral knee splints. The ADON further indicated she just created an order for the bilateral knee splints to be worn nightly and will have PT order another knee splint.</p> <p>2. The clinical record for Resident #6 was reviewed on 9/11/14 at 2:05 p.m. The diagnoses for Resident #6 included, but were not limited to, cerebral palsy, mild mental retardation, left hemiparesis, and seizure disorder.</p> <p>The September Physician's Orders indicated an order for Nursing to apply a left hand splint for 3 hours daily, 6 days a week to prevent further contracture.</p> <p>During an interview with Resident #6, on 9/11/14 at 3:20 p.m., she indicated she didn't know where her splint was and she hadn't worn it in a long time.</p> <p>The Annual Minimum Data Set Assessment, dated 4/4/14 indicated Resident #6 had a BIMS (brief interview of mental status) of 14, which was indicative of cognitively intact.</p> <p>A review of an OT (occupational therapy) note, dated 4/15/14, the note indicated, "...OT instructed pt [patient] and nurse</p>			

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	<p>[name of nurse] how to apply splint. Recommend pt wear splint when up....Instructed pt, nurse, & DON [Director of Nursing] to contact OT if discomfort or redness occurs..."</p> <p>During an observation with the Assistant Director of Nursing (ADON), on 9/11/14 at 3:35 p.m., the ADON was unable to locate the splint for Resident #6 in her room. The ADON indicated at this time, that Resident #6 had moved several times within the last couple of months and the splint probably got misplaced. The ADON also indicated she will speak to therapy about replacing Resident #6's splint and will initiate a place on the TAR (treatment administration record), where documentation will indicate when the splint had been applied.</p> <p>During an interview with Occupational Therapist (OT) #10 and the Rehab Manager, on 9/11/14 at 4:10 p.m., OT #10 indicated she saw Resident #6 approximately 2 weeks after the above OT note was written and Resident #6 was not wearing her splint. OT #10 indicated at that time Resident #6 indicated she no longer wanted to wear her splint, so the splint ordered was considered discontinued due to non-compliance. OT #10 indicated she relayed the splint discontinuation to the Rehab Manager.</p>			

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F000323 SS=D	<p>The Rehab Manager indicated OT #10 did tell him about the discontinuation but he was unsure if the recommendation was addressed with nursing.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication was not left unattended on a medication cart in the hallway. This had the potential to affect 1 independently ambulatory, cognitively impaired resident who resided on the hallway. (Resident #16)</p> <p>On 9/8/14 at 12:30 p.m., the MAR (medication administration record) binder was retrieved from the medication cart. No nurse was in the area. After 28 minutes of reviewing the MAR at the nurses station, a packet of Ibuprofen 400 mg tablets was observed in the binder,</p>	F000323	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On the day of discovery, the medication was removed immediately. No resident was affected by this cited practice.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident could have potentially been affected by the cited practice. All licensed nurses and medication aides educated on discontinuing medications.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does</p>	10/12/2014

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	<p>after the last page. A discontinue date of 9/8/14 was written on the packet.</p> <p>An interview was conducted with the DON (Director of Nursing) on 9/8/14 at 1:03 p.m., regarding the medication found in the MAR binder. The DON indicated, "That's not okay. If it's a discontinued med (medication), it needs to be destroyed. She (the nurse) should have pulled it from the cart, and immediately taken to the med room, before she left the cart."</p> <p>The clinical record for Resident #16 was reviewed on 9/8/14 at 12:55 p.m. She had a BIMS (brief interview for mental status) score of 5, indicating cognitive impairment. She was observed on 9/8/14 at 12:00 p.m. to be independently ambulatory.</p> <p>3.1-45(a)(1)</p>		<p>notrecur? All staff in-service was completed on 09-23-14 on discontinued medications, destroying medications, and safe storage of medications.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The DON/Designee will round Monday through Friday for 4 weeks, then monthly x6, or until 100% compliant to ensure all medications are stored properly. All findings will be reported through the QA for 6 months.</p>	

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to provide a nutritional supplement, as ordered, to a resident for 1 of 3 residents reviewed of 5 who met the criteria for nutrition. (Resident #65)</p> <p>Findings include:</p> <p>The clinical record for Resident #65 was reviewed on 9/11/14 at 10:00 a.m. The diagnoses for Resident #65 included, but were not limited to, acute renal failure.</p> <p>An interview was conducted with LPN #5 on 9/8/14 at 1:30 p.m. LPN #5 indicated Resident #65 did not receive a nutritional supplement, defined as a prescribed high protein, high calorie, nutritional supplement between or with meals.</p> <p>The clinical record indicated Resident #65's BMI (body mass index) was 19.7</p>	F000325	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident# 65 nutritional status/plan of care for supplemental usage was reviewed by Registered Dietician. Supplement added to MAR.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents. No other resident in the facility was affected by the cited practice.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff in-serviced on documenting intake/refusals of nutritional supplements. Supplement intake will be audited on a daily basis x's 4 weeks without negative findings.</p>	10/12/2014

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	<p>The Nutrition care plan, reviewed 9/6/14, for Resident #65 indicated he was a nutrition risk, and an approach was to "administer nutritional support as ordered."</p> <p>The 7/30/14 Dietary Progress Note for Resident #65 indicated, "Nutritional note NP wrote order to follow consultant recommendation for (name of supplement). Writer spoke to resident and updated food preferences, he stated he is feeling better and eating better, and will accept supplement...."</p> <p>The 7/30/14 Physician Telephone Order for Resident #65 indicated, "1 can supplement (renal) per registered dietician at hs (night). Document % consumed."</p> <p>The September, 2014 Physician's Order Sheet indicated, "One (1) can renal supplement by mouth at bedtime; chart % consumed."</p> <p>The September, 2014 MAR (medication administration record) indicated the renal supplement had not been given, thus far, the entire month of September, 2014.</p> <p>An interview was conducted with LPN #5 on 9/11/14 at 10:40 a.m., regarding</p>		<p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Audits will be brought to QA committee and monitored for 6 months. Any negative findings will be corrected immediately.</p>		

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F000329 SS=D	<p>whether Resident #65 was administered his renal supplement in September, 2014. She indicated, "It doesn't look like he's been getting it."</p> <p>An interview was conducted with the DON (Director of Nursing) on 9/11/14 at 10:53 a.m. She indicated, "If we're giving it, it's usually documented on the MAR. It should be on the MAR....I expect the nurse to document on the MAR since it's an order. It's not on the MAR for September (2014)."</p> <p>3.1-46(a)(2)</p> <p>483.25(l) 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</p>			

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	<p>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 observation, interview, and record review, the facility failed to monitor potential side effects and resident behaviors related to psychotropic medication use for 2 of 5 residents reviewed for unnecessary medication use. (Resident #'s 7 and 40)</p> <p>Findings include:</p> <p>1. Resident #7's record was reviewed on 9/10/14 at 11:17 a.m.. The resident's diagnoses included, but were not limited to, kidney stones, cardiomyopathy, HTN, PVD, BPH with urinary obstruction, dementia, arrhythmia, depression, CAD, CHF, and chronic pain. Medications for the resident included, but were not limited to, buspirone, cymbalta, lasix, ativan, fentanyl, and trazodone.</p> <p>On 9/8/14 at 11:02 a.m., during an observation, Resident #7 was sitting in a bedside chair in his room. His eyes were closed. A television was on nearby in</p>	F000329	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? DON/Designee will consult with Pharmacy consultant and/or attending physician to assess if medication is appropriate for residents #7 and #40. A monthly behavior flow sheet has been implemented.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents and any residents receiving antipsychotics, antidepressants, anti-anxiety, hypnotic/ sedatives were generated a flow sheet. These flow sheets will be documented on every shift daily.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Pharmacy consultant and physician will review all residents on any type of</p>	10/12/2014

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	<p>front of him.</p> <p>On 9/12/14 at 10:01 a.m., during an interview, the DON indicated the facility has not been completing documentation related to behavior monitoring for Resident #7's cymbalta and trazodone use. She indicated the facility nursing staff should have been completing the monitoring forms as she indicated the logs are what the facility utilizes to determine if there are adverse behavioral trends related to psychotropic medication usage.</p> <p>A 6/30/14 MDS assessment indicated Resident #7's BIMS (Brief Interview of Mental Status) score was 3 out of 15 which indicted he had a significant cognitive impairment.</p> <p>2) Resident #40's record was reviewed on 9/9/14 at 1:19 p.m. The resident's diagnoses included, but were not limited to, occipital cerebral infarction, dementia w/behaviors, CAD (coronary artery disease), and depression. Medications for the resident included, but were not limited to, depakote, hydrochlorothiazide, olanzapine, sertraline, and trazodone.</p> <p>Behavior monitoring logs were observed in the clinical record for Resident #40's</p>		<p>psychoactive medication to ensure appropriateness of medication. Staff reeducatedon documentation on the Behavioral Intervention monthly flow record. All newhires will be educated on this process.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? ADON/Designee manager will audit this flow sheet dailyx's 4 weeks. Then 3 x's a week x's 4 weeks. Any negative findings will bereported to QA committee by DON. Audits will be monitored for 6 months.</p>				

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	<p>use of olanzapine and depakote (an antipsychotic medication and an antidepressant medication), but not for sertraline and trazodone (2 different antidepressant medications).</p> <p>On 9/11/14, at 2:58 p.m., during an interview, Resident #40's LPN indicated she did not complete a behavior monitoring log for Resident #40 regarding use of sertraline. She indicated nursing staff documents resident episodes of behavioral impairment on the "Behavior Monitoring Record", but she indicated there was no such document for Resident #40's sertraline usage.</p> <p>On 9/10/14 at 3:12 p.m., the SSD indicated the facility does not have a policy on psychotropic medication use or PRN psychotropic medication use.</p> <p>A social service progress note, dated 8/14/14, indicated Resident #40 had a BIMS score of 5 out of 15 which indicated the resident was cognitively impaired.</p> <p>A psychotropic medication care plan, dated 8/14/14, indicated nursing staff should monitor for effectiveness of psychotropic drugs. The care plan also indicated for nursing staff to observe for "...Behavioral impairment..."</p>			

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F000334 SS=D	<p>On 9/11/14 at 3:40 p.m., during an interview, the DON indicated nursing staff monitors all residents who are on psychotropic medications for behavior episodes. She indicated staff should be completing the "Behavior Monitoring Record" daily for each psychotropic medication a resident is ordered.</p> <p>On 9/11/14 at 4:12 p.m., during an interview, the DON indicated the facility has no way of verifying if behaviors related to sertraline and trazodone usage were monitored by facility staff as she indicated the facility did not have Behavior Monitoring Logs in place for those medications for Resident #40. She indicated the monitoring logs should have been in place for those medications.</p> <p>3.1-48(a)(3)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives</p>			

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	<p>education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education</p>						

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	<p>regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to offer a resident a flu shot for 1 of 5 residents reviewed for facility influenza and pneumonia procedures. (Resident #3)</p> <p>Findings include:</p> <p>The clinical record for Resident #3 was reviewed on 9/12/14 at 10:45 a.m. The diagnoses for Resident #5 included, but were not limited to, aphasia.</p> <p>The 7/30/14 Quarterly MDS (minimum data set) assessment for Resident #3 indicated a brief interview for mental status was not conducted because Resident #3 was rarely/never understood. It indicated a staff assessment for his mental status was conducted. The staff assessment indicated he had short and long term memory problems, could not</p>	F000334	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident#3/ family/guardian was contacted to receive an influenza vaccine for 2014.</p> <p>2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit was done on all residents and for residents found without consent or documentation of receiving vaccines elsewhere, consents were obtained either declined or accepted. Any resident with consent received the vaccines.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nurses in service on administering the flu vaccine.</p> <p>4.How will the corrective actions</p>	10/12/2014

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	<p>recall the current season, location of his own room, staff names and faces, or that he was in a nursing home. It indicated his cognitive skills for daily decision making were severely impaired.</p> <p>The Immunization Record for Resident #3 indicated he received his last flu shot on 10/7/12. It did not indicate a flu shot was offered to Resident #3 in the 2013/2014 flu season. It did not indicate a flu shot was refused by Resident #3 or a legal representative for Resident #3 in the 2013/2014 flu season.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 9/12/14 at 10:56 a.m., regarding whether Resident #3 was offered a flu shot during the previous flu season. She indicated, "I don't see any verification a flu shot was offered or refused. We should have offered it."</p> <p>The Immunizations policy was provided by the ADON on 9/12/14 at 11:24 a.m. It indicated, "Influenza Vaccination shall be provided to consenting residents before November 30 of each year..."</p> <p>3.1-18(b)(5)</p>		<p>be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? All new admissions will be audited by ADON/Designee for documentation of flu and pneumonia vaccines, consents will be obtained and vaccines will be administered. This will be done on an ongoing basis. Any negative findings will be corrected immediately with education/ disciplinary action. Any negative findings will be reported to QA committee by ADON/Designee. Audits will be monitored for 6 months.</p>				

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F000441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>			
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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to maintain an infection control log to adequately monitor, investigate, and analyze infections in the facility. This had the potential to affect 55 of 55 residents in the facility.</p> <p>Findings include:</p> <p>The infection control log binder, from July, 2013 to present, was requested from and provided by the DON (Director of Nursing) on 9/12/14 at 10:00 a.m. There was no information in the binder from July, 2013 through December, 2013. January, February, and May, 2014 contained information on residents' infections, but there was no verification of analysis of the information to determine trends within the facility.</p> <p>An interview was conducted with the DON on 9/12/14 at 10:20 a.m., regarding the infection control process for monitoring, investigating, and analyzing infections in the facility. She reviewed the binder and indicated, "What I was going to do is to follow what's already in here. I would have a log. January (2014) does not look completed. Regarding the</p>	F000441	<p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by the deficient practice. The corrective action that will be accomplished is to develop a system to track infections throughout the facility. To identify sources of infection and prevent the spread of infection. To prevent and minimize incidence of infection.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? An audit was done on all residents on antibiotic therapy. Lab reports obtained to identify causative organisms for those residents.</p> <p>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? DON audit for all residents on antibiotic therapy. These residents will be added to a list then applied to the infection control log. Once results from the lab are received the specific organism will be listed for that resident as well. Then the resident will be listed by their room</p>	10/12/2014

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F000463 SS=E	<p>purpose of having a map, she indicated, "The purpose of the map is to track, and see if there's any trends on specific halls...." At this time, the DON provided a copy of the Infection Control Policy. It indicated, "The facility shall establish and maintain an infection control program to assure the effectiveness for investigating, controlling, and preventing infections. The infection control program will: Monitor and investigate causes of infection, monitor the manner of spread, analyze clusters, analyze changes in prevalent organisms, and analyze increases in the rate of infection in a timely manner." The DON indicated, "It looks like the last time we followed these instructions for completion of the monthly infection report was in June, 2014. I don't see July, 2013 through December, 2013 logs at all." She indicated the current information did not provide an effective method for monitoring, investigating, and analyzing infections in the facility.</p> <p>3.1-18(b)(1)(a)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p>		<p>number and tracked using the building map to identify possible trends of the organisms, and sites of infections. These trends will be analyzed and proper interventions will be put into place (staff education, further evaluation of residents).</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? This practice will be monitored on an ongoing basis by DON/Designee. Audits will be monitored for 6 months. Results will be presented to the QA by DON/Designee monthly at the QA meeting for tracking and trending.</p>	

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	<p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, interview and record review, the facility failed to ensure a working call lights was available in a resident's room/bathroom for 2 of 27 rooms/bathrooms reviewed. This affected 4 of 32 residents reviewed for working call lights. (Resident #8, #73, #6, & #31)</p> <p>Findings include:</p> <p>1. During an observation, on 9/8/14 at 10:38 a.m., a call light was noted to be missing from Resident #8 and Resident #73's bathroom. The box where the call light was supposed to be located was open with exposed wires.</p> <p>During an interview with Resident #73, on 9/8/14 at 10:39 a.m., he indicated there had not been a working call light in the bathroom since he moved into the room.</p> <p>Another observation of a non-working call light in Resident #73 and #8's bathroom was noted on 9/11/14 at 10:20 a.m.</p> <p>On 9/11/14 at 4:40 p.m., the Social Services Director (SSD) indicated</p>	F000463	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice? The calllight system and cords were replaced immediately for those affected residents#8, #73, #6, and#31.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveactions will be taken? All residents have the potential to be affected bydeficient practice. A functioning call light audit was completed immediatelyfor all residents throughout the facility. No other deficiencies were found.</p> <p>3.What measures will be put into place or whatsystematic changes will be made to ensure that the deficient practice does notrecur? The Maintenance Director/Designee will complete a call light audit thatwill be completed weekly x4, then monthly x3, or until 100% compliant.</p> <p>4.How will the corrective actions be monitored toensure the deficient practice will not recur; what quality assurance programwill be put into place? Results of the audits will be shared at the QA meetingfor 6 months by the Maintenance Director/Designee to ensure</p>	10/12/2014

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	<p>Resident #73 moved into his room on 7/18/14. The SSD also indicated Resident #73 had a BIMS (Brief Interview of Mental Status) score of 11, on his Minimum Data Set assessment on 8/22/14.</p> <p>A BIMS score of 11 was indicative of moderately impaired cognition, but interviewable.</p> <p>During a tour facility with the Maintenance Director, on 9/11/14 at 2:40 p.m., the Maintenance Director noted the missing call light in Residents #73 and #8's bathroom. The Maintenance Director indicated he did not know about the broken/missing call light and the call light had probably been missing for about a month, since that was when the renovations were completed on Resident #73 and #8's hallway. The Maintenance Director further indicated he doesn't understand how he was not notified about the missing call light, when staff was constantly in and out of the Resident's bathroom.</p> <p>2. During an observation of Resident #6 and Resident #31's room, on 9/9/14 at 10:15 a.m., both resident's call light cords were missing from the call light box. The missing call light cords were also observed on 9/11/14 at 10:20 a.m.</p>		compliance.	

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	<p>During a tour of the facility with the Maintenance Director, on 9/11/14 at 2:41 p.m., the Maintenance Director noted the missing call light cords. The Maintenance Director indicated he did not know about the missing call light cords and he should've since staff were in and out of Residents #6 and #31's room constantly.</p> <p>A policy titled, Answering the Call Light, dated 8/14/08, was received from the Assistant Director of Nursing, on 9/12/14 at 9:43 a.m. The policy indicated "...Report all defective call lights to the nurse supervisor promptly...."</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>			