

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 12, 13, 14, 15, 18, 19, 20, 21, 22, 2013</p> <p>Facility number: 012448 Provider number: 155785 AIM number: 201039500</p> <p>Survey team: Diane Hancock, RN TC Amy Wininger, RN 3/12-3/14, 3/18-3/22, 2013 Barbara Fowler, RN 3/12-3/14, 3/18-3/21, 2013</p> <p>Census bed type: SNF 41 SNF/NF 14 Residential 57 Total 112</p> <p>Census payor type: Medicare 24 Medicaid 11 Other 77 Total 112</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations or noncompliance cited during annual survey concluding on March 22, 2013. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before April 21, 2013. We respectfully request a desk review for compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	IAC 16.2. Quality review completed on March 28, 2013, by Jodi Meyer, RN			

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F000164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure personal information at the nurse's station was kept confidential, in that personal information at the nurse's station was visible from the hallway for 29 of 29 residents who resided on Unit 3. (Residents #66,</p>	F000164	All residents cited on the 2567 suffered no adverse effects from the alleged deficient practice and through corrective action and inservicing will ensure residents privacy is maintained. All residents have the potential to be affected and therefore through alterations in provision of care and inservicing will ensure that privacy	04/21/2013	

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	<p>#45, #132, #80, #120, #133, #18, #53, #134, #125, #39, #62, #1, #127, #117, #49, #131, #129, #121, #42, #119, #126, #86, #116, #48, #124, #110, #22, #128)</p> <p>Findings include:</p> <p>1. On 03/14/12 at 2:26 p.m., the following was observed:</p> <p>A form was observed on the top ledge of the nursing station on Unit 3, visible from the hallway. The form indicated a weight for the following residents: Resident #66, Resident #45, Resident #86, Resident #80, Resident #116, Resident #48, Resident #18, Resident #53, Resident #124, Resident #125, Resident #126, Resident #39, Resident #62, Resident #1, Resident #127, Resident #110, Resident #22, Resident #49, Resident #128, Resident #121 and Resident #119.</p> <p>During an interview on 03/14/13 at 2:26 p.m. the ADoN [Assistant Director of Nursing] indicated the form was a worksheet for the March 2013 monthly weights.</p> <p>2. On 03/19/13 at 9:03 a.m. the following was observed:</p>		is maintained. Systemic change to assure forms containing resident information is not visible at nurse's work station by placing resident information in specific folder or binder. All staff will be inserviced regarding HIPPA. DHS or her designee will audit nurse's work station to assure HIPPA compliant five times a week for one month, three times a week for one month, then weekly with results forwarded to QA committee monthly for six months and quarterly thereafter for review and recommendations.				

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	<p>A. A CNA Assignment sheet was observed on the top ledge of the nursing station on Unit 3, visible from the hallway. The CNA Assignment sheet included, but was not limited to the following information: Resident name, diet, appliances/splint use, toileting, fall risk, use of devices/restraints/alarms, and shower/bath/bed bath days for the following residents: Resident #66, Resident #45, Resident #132, Resident #80, Resident #120, Resident #133, Resident #18, Resident #53, Resident #134, Resident #125, Resident #39, Resident #62, Resident #1, Resident #127, Resident #117, Resident #49, Resident #131, Resident #129, Resident #121, Resident #42, Resident #119.</p> <p>B. A form dated 02/11/13 indicated the following, "Below are a list of questions that surveyors are asking each and every nurse during the staff interviews... Falls with injuries in last 30 days: Resident #126, Resident #86, Resident #53... Foley catheters: Resident #18, Resident #45... Pressure ulcers...: Resident #126, Resident #62, Resident #120...</p>			
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	<p>Contractures: Resident #80..."</p> <p>During an interview on 03/20/13 8:44 a.m., the HFA [Health Facility Administrator] indicated it was the policy of the facility to keep personal information confidential and the documents with personal information should be turned over so personal information was not visible.</p> <p>The policy and procedure for HIPPA [Health Insurane [sic] Portability Accountability Act] Executive Summary provided by the HFA on 03/20/13 at 10:07 a.m. indicated, "...Policy [sic] It is ...policy to respect and protect the privacy rights of resident,...All information...associated with medical records...is strictly confidential..."</p> <p>3.1-3(o)</p>				

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure residents who required assistance with eating were given that assistance in a manner that maintained or enhanced each resident's dignity, for 1 of 1 restorative dining room observed, of two dining rooms observed. This affected 6 of 10 residents in the restorative dining room. (Residents #1, #11, #63, #69, #61, #67)</p> <p>Findings include:</p> <p>1. On 3/12/13 at 12:05 p.m., the Restorative Dining area was observed. CNA #3 was observed moving from resident to resident, giving one bite at a time. She picked something off of Resident #1's hand, then moved to Resident #63 and fed her a bite, then to Resident #11, then back to Resident #63 and held her hand while feeding her. Resident #1 was seated at an overbed table; everyone else was at tables. CNA #3 continued to walk between Resident</p>	F000241	Residents #1, 11, 63, 69, 61 and 67 suffered no adverse effects from the alleged deficient practice and through corrective action and inservicing will ensure residents individuality is maintained. All residents have the potential to be affected and therefore through alterations in provision of care and inservicing the campus will promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Systemic change is seating of residents in the restorative dining room has been revised to permit staff to remain seated during the meal as they assist residents. All staff will be inserviced regarding maintaining the dignity and individuality of residents while assisting them in eating. DHS or her designee will audit the restorative dining room meal service to assure dignity and respect of the individual five times per week for one month, three times per week for one month, then weekly with results forwarded to the QA committee monthly for six months and	04/21/2013			

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	<p>#63, Resident #11, Resident #1 and Resident #79.</p> <p>2. On 3/19/13 at 12:19 p.m., the Restorative Dining area was observed again. CNA #4 was observed standing and feeding Resident #11 a bite, then walking to the other side of the table and feeding Resident #67 a bite.</p> <p>At one point, CNA #3 stopped beside Resident #67 and gave him a bite, then went to another table and sat down and fed Resident #63 and Resident #61.</p> <p>CNA #4 continued to stand and move from Resident #11 to Resident #67, giving each a bite at a time, and/or a sip of tea, from 12:19 p.m. to 12:31 p.m. At that time, she exited the room and got a chair to sit in while feeding the residents.</p> <p>On 3/20/13 at 3:30 p.m., the observations were reviewed with the Administrator and the Director of Nurses. Both indicated during the interview the staff should be sitting down to feed residents and not be moving from resident to resident standing.</p>		quarterly thereafter for review and further suggestions/comments.				

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure a resident's right to refuse medications was honored in that, a resident repeatedly refused two medications and a nurse continued to attempt to administer the medication for 1 of 10 residents reviewed during the medication pass. [Resident #35]</p> <p>Finding includes:</p> <p>During a medication observation on 03/20/13 at 9:07 a.m., LPN #5 was observed to attempt to administer 10 [ten] milliliters of liquid Colace [a stool softener] and 8 [eight] ounces of water mixed with 1 [one] packet of Nutrisource fiber mix to Resident #35. LPN #5 was observed to administer approximately half of the stool softener to Resident #35.</p> <p>During the observation, at that time, Resident #35 indicated 6 [six] different times he did not want any more of the medication because it</p>	F000246	Resident #35 suffered no ill effect from the alleged deficient practice and through corrective action and inservicing will ensure resident is able to refuse medication(s). Resident #35's physician has been updated concerning his dislike to certain medication(s) and revisions will be made at the physicians discretion. Resident #35 requires his medications in pill-form to be crushed, therefore colace would not be an option. We spoke with the resident, his physician and family member and they are aware of his right to refuse his medication and consequence. We have also attempted to mask his liquid medication in 120cc of orange juice and he refuses, stating "you have put medicine in here". The risk vs. benefit of the medication has been discussed with the physician, family and resident and it has been determined to continue the medication orders without any changes. The resident has the right to refuse but clinically the physician does not want to discontinue this medication at this time. All residents have the potential to be	04/21/2013	

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	<p>tasted strong. LPN #5 was observed to continue to attempt to administer the remaining medication to Resident #35 after each refusal. Resident #35 was observed to shake his head from left to right while holding his mouth closed during the nurse's attempts.</p> <p>LPN #5 was then observed to attempt to administer 8 ounces of water containing Nutrisource fiber mix from a cup with a straw to Resident #35. During the observation, at that time, Resident #35 indicated 3 [three] different times he did not want any more of the mixture. LPN #5 was observed to continue to administer the mixture to Resident #35 after each refusal. Resident #35 was observed, at that time, to shake his head from left to right while holding his mouth closed before LPN #5 was observed to stop the attempts to administer the medications to Resident #35.</p> <p>During an interview on 03/20/13 at 10:50 a.m. Regional Nurse #1 indicated resident's have the right to refuse medications.</p> <p>The policy and procedure for self determination of care provided by Regional Nurse #1, on 03/20/13 at 10:50 a.m. indicated, "...Procedure:</p>		<p>affected and therefore through alterations in provision of care and inservicing the campus will assure the resident has the right to reside and receive services in the campus with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Systemic change is to inservice nurses to only reattempt once when a resident refuses medication or treatments and to assure education given related to refusal. Nurses will be inserviced regarding self-determination of care. DHS or her designee will audit three random residents during medication pass to assure self-determination of care is followed five times per week for one month then three times per week for one month then weekly with results forwarded to QA committee monthly for six months and quarterly thereafter for review and further suggestions or recommendations.</p>		

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	1. Residents have the right to ...refuse medications..." 3.1-(v)(1)			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for skin conditions, in the sample of 5 who met the threshold, in that protective sleeves were not placed in accordance with the care plan. (Resident #79)</p> <p>Finding includes:</p> <p>On 3/13/13 at 11:23 a.m., fading bruises were observed on the back of Resident #79's hands. The resident had long sleeves on, but the forearms were exposed, sleeves pushed up the arm. There were no protective sleeves being worn.</p> <p>Resident #79's clinical record was reviewed on 3/18/13 at 2:45 p.m. The care plan, dated 11/21/12, for potential alteration in skin integrity included, but was not limited to, the following interventions: Assess/record changes in skin status Report pertinent changes in skin</p>	F000309	Resident #79 suffered no adverse effects from the alleged deficiency. All residents have the potential to be affected by the deficient practice and through alterations in processes and inservicing will ensure each resident receives 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. Nursing staff have been inserviced concerning following plan of care. Systemic change is preventative treatments for skin care will be initiated by licensed charge nurse on Treatment Record in addition to being on CNA assignment sheet. DHS or her designee will perform audits on three random residents to assure skin prevention orders are followed per plan of care five times per week for one month, three times per week for one month, then weekly with results forwarded to QA committee monthly for six months and quarterly thereafter for review and further suggestions	04/21/2013			

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	<p>status</p> <p>Monitor lab results Bilateral gerisleeves [protective covering for arms] to arms Fold back/remove wheelchair leg rest prior to transfers</p> <p>The Treatment Administration Record for March, 2013 was reviewed at that time. Bilateral gerisleeves was indicated as a current treatment. The documented treatment indicated it was "FYI" [For Your Information]. There was no initialing or documentation of the actual use of the gerisleeves.</p> <p>The CNA assignment sheet, dated 3/18/13, was provided by CNA #2 on 3/18/13 at 3:30 p.m. The assignment sheet indicated Resident #79 was to have "BIL [bilateral] GERISLEEVEES."</p> <p>Resident #79 was observed on 3/19/13 at 9:52 a.m. She was in a wheelchair in the lounge area. She had a long sleeved sweater on, but her forearms were exposed, the sleeves were pushed up. She did not have the gerisleeves on.</p> <p>Resident #79 was observed on 3/20/13 at 9:27 a.m. in an exercise activity, in her wheelchair. She had a</p>		or comments.				

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	<p>long sleeved sweatshirt on, but her forearms were exposed, the sleeves were pushed up. No gerisleeves were on.</p> <p>CNA #1 was interviewed on 3/20/13 at 9:29 a.m. She indicated the resident wore tubing on the legs, but no gerisleeves. She indicated she had worked on that hall for a long time and the resident hadn't used gerisleeves during that time.</p> <p>3.1-37(a)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents reviewed for incontinence, in the sample of 3 who met the threshold, were provided assistance with toileting frequently enough, in that the resident was observed to be wet through the clothing. (Resident #103)</p> <p>Finding includes:</p> <p>On 3/12/13 at 11:15 a.m., CNA #1 was observed to enter Resident #103's room and ask the resident to go to the bathroom. His pants were observed to be wet. He was wearing an incontinence brief and had leaked around it. The CNA indicated, "oh, we're too late."</p> <p>On 3/15/13 at 9:10 a.m., Resident #103 was observed in a wheelchair in</p>	F000315	Resident #103 suffered no adverse effects from the alleged deficient practice. Resident #103 has had a three-day toileting pattern completed. All residents who are incontinent of bladder have the potential to be affected by the alleged deficient practice and therefore through corrective actions and inservicing the campus will ensure 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 normal. All nursing staff have been inserviced on using an elimination circumstance when there is an increase in a resident's incontinence. Systemic change is licensed nurses will complete an elimination circumstance when it is noted a resident has increased incontinence and change may be needed in their plan of care. DHS and/or her designee will monitor	04/21/2013

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	<p>the hallway. His clothes were dry. He had an incontinence brief on. The resident was observed to remain in the hallway, or in activities in the Town Center area throughout the morning. At 11:15 a.m., he was observed in the Town Center area in his wheelchair. His pants were observed to be wet in the thigh area on the left side, extending behind the resident. LPN #6 walked by and spoke to the resident but appeared unaware of the resident's pants being wet. CNA #5 walked by and checked the resident. She took the resident to the bathroom in his room. His incontinence brief was saturated and his pants were wet. The CNA indicated the resident drank a lot and urinated a lot. She assisted the resident to the toilet and he urinated a small amount more into the toilet. The resident's peri-area was reddened and wet. CNA #5 cleansed the area and also applied a barrier cream for the redness.</p> <p>Resident #103's clinical record was reviewed on 3/15/13 at 9:35 a.m. The initial Minimum Data Set [MDS] assessment, dated 12/4/12, indicated the resident was frequently incontinent of urine but was not on a toileting program.</p>		<p>three random incontinent residents to assure the most effective toileting plan is implemented five times per week for one month, three times per week for one month, then weekly thereafter with results forwarded to the QA committee for six months and quarterly thereafter for further review and suggestions/recommendations.</p>		

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	<p>The admission nursing assessment, dated 11/27/12, indicated the resident was incontinent and they were planning to take him to the toilet upon rising, before and after meals, and before bedtime.</p> <p>The urinary incontinence care plan, dated 12/7/12, indicated the resident used a diuretic medication, had impaired mobility and decreased awareness due to his diagnosis of dementia. The plan indicated they would toilet upon arising, before and after meals, et at bedtime and as needed. The care plan also included, but was not limited to, a plan to remind/cue the resident to go to the bathroom and use incontinence briefs.</p> <p>There was no indication the resident had been evaluated for a more frequent toileting plan due to the volume of his incontinence.</p> <p>3.1-41(a)(2)</p>			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident reviewed with a tracheostomy, in the sample of 1 who had a tracheostomy, had the inner cannula changed according to physician's orders, in that it was ordered to be done daily and had not been done for 29 days. (Resident #21)</p> <p>Finding includes:</p> <p>Resident #21's clinical record was reviewed on 3/14/13 at 2:20 p.m. The resident was admitted to the facility 3/16/11 with diagnoses including, but not limited to, respiratory failure with tracheostomy tube, chronic obstructive pulmonary disease, coronary artery disease, hypothyroidism, diabetes mellitus, prostate cancer, urinary retention and anxiety.</p>	F000328	Resident #21 no longer resides in the health campus. After review, there were no other residents who have the potential to be affected by the alleged deficient practice. Through alterations in processes and inservicing will ensure appropriate services are provided concerning special services. An inservice was provided to licensed nursing staff concerning tracheotomy care. Systemic change is licensed nurses have completed a competency regarding tracheotomy care. DHS or her designee will perform random audits of one random resident with a tracheotomy to assure care is provided per the physician's orders five times per week for one month, three times per week for one month, then weekly with results forwarded to QA committee monthly for six months and quarterly thereafter for review and further suggestions/recommendations.	04/21/2013			

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	<p>The resident returned from a hospital visit on 2/20/13 with physician's orders for trach care as follows: Tracheostomy care every shift Change tracheostomy ties weekly on Wednesday Change inner cannula daily</p> <p>Review of the Treatment Administration Record for February and March, 2013, indicated the daily inner cannula change had not been done due to the cannula being unavailable.</p> <p>On 3/15/13 at 1:40 p.m., RN #1 was observed providing tracheostomy care to Resident #21. She provided the care using sterile technique. She was observed to remove the inner cannula and place it in peroxide in the sterile tracheostomy care kit. She cleaned the inner cannula using the peroxide and a brush. She rinsed it with normal saline solution, she completed the rest of the tracheostomy care and put the inner cannula back into the tracheostomy tube. She indicated they were cleaning the inner cannula using sterile technique and replacing it due to not having received the right size cannula to change it out daily.</p>			

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	<p>On 3/20/13 at 9:45 a.m., LPN #6 was interviewed. She indicated they had not changed the cannula every day according to physician's orders because they had received the wrong size. He had been changed from a size 4 to a size 6 while in the hospital and they were waiting for the size 6's to come in. At 10:07 a.m., LPN #6 indicated they were getting a new cannula that date. She indicated the one they had re-used was placed at the hospital visit 2/20/13 and was re-usable, but the physician had ordered disposable cannulas to be changed out daily. She was going to check with the physician to see if he still wanted the cannulas changed out daily.</p> <p>At 11:30 a.m. on 3/20/13, LPN #6 indicated she had spoken with the resident's physician and he did want daily cannula changes as ordered and they were getting them that date.</p> <p>The Guidelines for Tracheostomy Care policy and procedure, not dated, was provided by the Administrator on 3/20/13 at 10:20 a.m. The policy and procedure did not address the use of a disposable inner cannula, only addressed the use of sterile technique when cleaning the inner cannula.</p>			

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	3.1-47(a)(4)			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 10 residents reviewed for unnecessary medications was free of unnecessary medications, in that the resident was started on an antipsychotic medication without sufficient indications for its use. (Resident # 33)</p> <p>Finding includes: On 3/12/13 at 11:27 a.m., Resident</p>	F000329	Resident #33 suffered no adverse effects from the alleged deficient practice. Resident #33's physician was contacted and the medication was discontinued. All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure medications are administered with adequate indications for use. An inservice was provided to licensed nursing staff concerning the use of unnecessary drugs. Systemic change is to complete a	04/21/2013			

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	<p>#33 was observed during a brief interview. His answers to questions were appropriate but brisk and he appeared uninterested in answering, although he had agreed to be interviewed initially. Midway through the interview, he indicated he was done and the interview was stopped.</p> <p>On 3/15/13 at 9:40 a.m., Resident #33's clinical record was reviewed. The resident was admitted to the facility on 1/31/12 with diagnoses including, but not limited to, diabetes mellitus, essential hypertension, dysphagia, gastro-esophageal reflux disease, insomnia, chronic obstructive pulmonary disease [COPD], and congestive heart failure [CHF].</p> <p>The resident was hospitalized 12/31/12 to 1/3/13 for congestive heart failure and COPD exacerbation. Review of the hospital history and physical indicated no diagnoses of any psychiatric issues, other than anxiety over his difficulty breathing. The history and physical indicated, under the psychiatric area, "the patient has been experiencing significant anxiety recently in association with his dyspnea [difficulty breathing]..." "alert and oriented X 3 some mild impairment of recall and</p>		<p>mental health circumstance for any addition or dosage change of an antipsychotic to assure appropriate medication. DHS or her designee will perform audits of three random residents medications to assure the resident is free from unnecessary drugs five times per week for one month, three times per week for one month, then weekly with results forwarded to QA committee monthly for six months and quarterly thereafter for review and further suggestions/recommendations.</p>		

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	<p>cognition..."</p> <p>Following the hospitalization, on 1/6/13 at 11:30 a.m., nurse's notes indicated the resident had some confusion, had labored respirations at times and diminished lung sounds. The note indicated he was very weak, unable to ambulate and appetite very poor.</p> <p>On 1/7/13 at 1:15 p.m., nurse's notes indicated the resident was observed "reaching for the air" at times.</p> <p>On 1/9/13, no time, the resident was documented as having increased confusion, trying to stand up without assistance.</p> <p>On 1/10/13 at midnight, nurse's notes indicated the hospice agency was notified of the increased confusion, the resident disconnecting his alarm, and shaking his fist at staff. In addition, the note indicated he had been talking to people who were not there and pulling at his feet, indicating he was putting on socks.</p> <p>Orders were received at that time for the resident's Lyrica [used for seizures, general anxiety and nerve pain] to be discontinued and for the resident to start on Geodon [antipsychotic medication used for bipolar disorder and schizophrenia] 20 milligrams twice a day.</p>			

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	<p>A facility "Assessment Review and Considerations," dated 1/4/13, indicated regarding behavior risk, nothing was documented. Regarding long term memory problems, the assessment indicated the resident was alert and oriented.</p> <p>The resident had a recent Minimum Data Set [MDS] assessment, dated 1/16/13, for a significant change. The MDS indicated a Brief Interview for Mental Status score of 15 out of 15, indicating the resident had no long or short term memory problems.</p> <p>Social Service notes indicated the following: 1/10/13 "SS [social service] called hospice to talk to nurse manager discussed that Resident has never had psyche (sic) issues before and that prior to giving him Geodon that they should review chart...nurse manger will send [name] out to look @ chart." 1/17/13 "Resident was given an add [additional] dx [diagnosis] of of (sic) psychosis 1/23/13 Resident had dx of psychosis added along with Geodon. Resident was referred for level II [screening for psychiatric diagnoses]. Resident was observed to be happy today..." 2/14/13 "[Resident's name] was an</p>			

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	<p>inappropriate level II."</p> <p>The Hospice record was reviewed on 3/15/13 at 10:30 a.m. The resident was admitted to hospice services on 1/8/13 with a terminal diagnosis of heart disease. The admission assessment, dated 1/8/13, indicated, "No immediate psychosocial needs." "Very pleasant talkative resident..." The hospice Social Work Comprehensive Assessment, dated 1/10/13 11:30 a.m., indicated, "pt. increasingly withdrawn due to disease process." "Pt. was not rousable this date. Pt. had had (sic) an anxious night and facility gave pt. Geodon. SW [social worker] attempted to contact family..."</p> <p>A hospice Nursing Comprehensive Update/Visit Note, dated 1/14/13 at 9:45 a.m., indicated, "Reviewed facility chart - no new orders. Pt. sleeping in recliner in his room. Difficult to arouse. Did deny pain...Pt. very sleepy and not conversational this visit..."</p> <p>Further review of the resident's facility record, including histories and physicals and physician progress notes indicated the resident had no history of psychiatric issues.</p>			

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	<p>On 3/19/13 at 10:10 a.m., LPN #6 was interviewed. She indicated the resident had been more confused and agitated after his hospitalization in early January. She agreed he didn't have a history of psychiatric issues. She indicated he was brisk in answering questions and didn't offer a lot, but his family said he had always been that way.</p> <p>3.1-48(a)(4)</p>			

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F000371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served under sanitary conditions, for 1 of 2 dining areas observed (restorative dining), in that staff were touching potentially soiled items and continuing to assist residents with their meals. This was observed during 2 of 2 observations (3/12/13 and 3/19/13). This deficient practice affected 3 of 10 residents eating in the restorative dining room. (Residents #1, #63, #18)</p> <p>Findings include:</p> <p>On 3/12/13 at 12:05 p.m., the restorative dining area was observed through most of the meal. Resident # 1 requested her left leg be repositioned. CNA #2 repositioned her leg, then proceeded to pass out silverware wrapped in cloth napkins to the residents. CNA #3 was observed to take soiled dishes from the residents to the kitchen dishwashing</p>	F000371	Resident #1, #63 and #18 suffered no adverse effects from the alleged deficient practice and through corrective actions will prevent further recurrence of staff touching soiled items while assisting residents with their meals. CNAs #2, #3 and #7 along with all staff have been inserviced on proper food handling and hand sanitizing after touching soiled items during the dining process. Meal manager/designee will monitor restorative meal service every meal for thirty days and daily thereafter of random meals with immediate intervention and counseling of employee of correct sanitary procedure(s). Results of audits will be forwarded to QA committee monthly for six months and quarterly thereafter for review and further recommendations.	04/21/2013	

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	<p>area. She then picked up clean plates of cake and delivered them to the residents. CNA #3 was observed picking something off of Resident #1's hand and then moving to Resident #63 and feeding her a bite of food. She then went to another resident (unknown name), fed that resident a bite of food, and then returned to Resident #63, holding her hand while feeding her. Ten residents were observed in the restorative dining area being cued or assisted by staff with eating.</p> <p>On 3/19/13 at 12:19 p.m., the restorative dining area was again observed. CNA #7 was observed handling the oxygen nasal cannula of Resident #1. She then picked up silverware and fed the resident. She then fed Resident # 18 a bite of food. When the residents were done eating, CNA #7 picked up the soiled dishes, carried them to the kitchen, scraping the food off the plates and placing them in the soiled dish area, then picked up two desserts on clean plates and brought them back to the table without washing or sanitizing her hands.</p> <p>Ten residents were observed dining in the restorative dining area.</p>						

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	<p>The observations were reviewed with the Administrator and Director of Nursing on 3/20/13 at 3:30 p.m. During the interview, they indicated, "they didn't use hand sanitizer or anything?"</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure controlled medications were accurately reconciled, in that</p>	F000431	All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure correct	04/21/2013			

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	<p>narcotics were not reconciled by comparing the medications in the cart to the count sheets for 1 of 3 units. (Unit #3)</p> <p>Findings include:</p> <p>During a random observation of a narcotic count on 03/18/13 at 3:00 p.m. between LPN #7 and LPN #8, LPN #7 was observed to have a binder partially open and was observed to turn through the papers calling out numbers. At that time, LPN #8 was observed to state, "OK" after each number LPN #7 called out.</p> <p>During an interview on 03/19/13 at 1:31 p.m., LPN #6 indicated when doing a narcotic count one nurse should look at the resident's narcotic sheet and note the resident's name, name of the medication, and the amount of the medication available listed on the narcotic sheet. LPN #6 further indicated, at that time, the second nurse should look at the medication card and verify the actual amount of the medication remaining on the card.</p> <p>During an interview on 03/19/13 at 3:25 p.m., LPN #8 indicated if the nurses were in a hurry during the narcotic count they would just call out</p>		<p>actions to reconcile controlled medication upon shift change is followed. LPN #7 and LPN #8 have individualized inservice and counseling on correct reconciling procedure of controlled substances. Licensed nursing staff will be inserviced on proper procedure for reconciling controlled substances at shift change. DHS or her designee will randomly observe narcotic count on varying shifts for correct procedure daily for the next month, weekly for the next month and monthly thereafter. Audits will be forwarded to the QA committee monthly for six months and quarterly thereafter for review and to ensure compliance with requirement.</p>	

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	<p>the number of the medication without verifying the resident's name or the medication name because usually the narcotic medication cards were in the same order as the narcotic count sheets in the book.</p> <p>The policy and procedure for Guidelines for Shift to Shift Narcotic Count provided by the HFA [Health Facility Administrator] on 03/20/13 at 10:00 a.m. indicated, "...3. the narcotics shall be reconciled by comparing the medications in the cart to the count sheets."</p> <p>3.1-25(e)(2)</p>						

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F000441 SS=D	<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> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	Resident(s) #103, #119 and #54 suffered no adverse effects from	04/21/2013			

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	<p>ensure staff washed hands and changed gloves when needed, while giving care to 3 of 6 residents observed receiving care, in that they did not change gloves and wash or sanitize their hands between soiled and clean tasks. (Residents #54, #103, #119)</p> <p>Findings include:</p> <p>1. On 3/19/13 at 8:55 a.m., Resident #54 was observed to receive a partial bath by CNA #1 and CNA #2 . CNA #1 applied gloves and handed the resident a wet washcloth to wash her face, which the resident proceeded to do. CNA #1 removed the resident's gown and stated the resident preferred to leave her bra on. CNA #2 had washed his hands and applied gloves prior to approaching the resident's bed. CNA #1 took a wet washcloth and applied soap to it and proceeded to wash the resident's left axilla. CNA #1 handed the soapy washcloth to CNA #2 and he washed under the resident's right axilla. Resident #54's shirt was applied.</p> <p>The resident requested, at that time, that CNA #2 [a male CNA] leave the room. CNA #2 removed his gloves, and washed his hands before leaving. CNA #1 proceeded to obtain a clean</p>		<p>the alleged deficient practice and staff have been inserviced on glove usage/changing and handwashing procedures.All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed.CNAs #1, #2, #4 and #6 have received directed inservice on glove use, handwashing policy and infection control procedures during ADL care.Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent spreading of infection. Nursing staff will have return demonstration of skills to prevent infection including handwashing and glove application/changing. Skills will be re-evaluated on an annual basis for competency.DHS or her designee will monitor resident care that includes handwashing/glove usage after care and techniques of all care provided daily for five days, three times per week, then weekly. Results of the audits will be forwarded to the QA committee monthly for six months and quarterly thereafter for review and further suggestions/recommendations.</p>	

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	<p>soapy washcloth and do pericare for the resident. CNA #1 changed her gloves but did not wash her hands. CNA #1 then turned the resident to her right side, removed the wet brief from under the resident, and washed and dried the resident's buttocks with another clean soapy washcloth. CNA #1 rolled the resident onto her back and covered her with a towel. CNA #1 applied clean briefs, pants, and shoes to the resident. CNA #1 assisted the resident to sit onto the side of her bed. At that time, CNA #2 came into the resident #54's room, washed his hands, and applied new gloves. CNA #1 discarded her gloves and placed clean gloves on without washing her hands.</p> <p>CNA #1 placed the sit to stand lift in front of the resident and proceeded, with the assist of CNA #2, to apply the lift sling. CNA #2 raised the sit to stand lift and the resident's brief and pants were pulled up by CNA #1. CNA #1 removed her gloves and discarded them. While elevating the resident in the lift, CNA #1 discovered Resident # 54's shoes had come off. CNA #2 lowered the lift and sat Resident #54 onto her bed. CNA #1 and CNA #2 reapplied Resident #54's shoes. The resident was raised again and assisted into her wheelchair.</p>			

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	<p>Resident #54 was transported to her bathroom and the resident completed her oral care.</p> <p>Interview with CNA #1 on 3/20/13 at 9:30 a.m., indicated she did not perform handwashing or glove change routinely during care.</p> <p>2. On 3/15/13 at 9:10 a.m., Resident #103 was observed in a wheelchair in the hallway. His clothes were dry. He had an incontinence brief on. The resident was observed to remain in the hallway, or in activities in the Town Center area throughout the morning.</p> <p>On 3/15/13 at 11:15 a.m., Resident #103 was observed in the Town Center area of the facility in his wheelchair. His pants were observed to be wet. CNA #5 took the resident to the bathroom in his room.</p> <p>The CNA assisted the resident to the toilet. After he finished urinating, she wore gloves and used prepared wet wipes to cleanse the peri-area front and back. There was a smear of feces noted in the back. She wiped the area multiple times with the wipe to cleanse the feces from the skin. She wore the same gloves to pull the</p>			

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	<p>clean incontinence brief up, handle the resident's clean clothes, and transfer the resident back to the wheelchair. She then took off her gloves and washed her hands for less than 5 seconds, before taking the resident from the bathroom and finishing his care.</p> <p>3. During an observation of care on 03/18/13 at 9:31 a.m., the following was observed: CNA #4 and CNA #6 were observed to apply clean gloves. CNA #4 was then observed to empty and irrigate the colostomy of Resident #119. CNA #4 was then observed to remove the gloves and apply new gloves without performing hand hygiene. CNA #6 was observed to cleanse the peri-area of Resident #119, remove the gloves, and apply new gloves without performing hand hygiene. CNA #4 and CNA #6 were then observed to adjust the clothes of Resident #119 and transfer Resident #119 to a wheelchair.</p> <p>During an interview on 03/20/13 at 10:05 a.m., the DoN [Director of Nursing] indicated handwashing should have been performed when the colostomy care was completed and the peri-area had been cleansed.</p>			

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	<p>The policy and procedure for Guidelines for Handwashing provided by the HFA [Health Facilities Administrator] on 03/20/13 at 10:01 a.m. indicated, "...3. Health Care Workers shall wash hands at times such as...d. After removing gloves, worn per Standard Precautions for direct contact with excretions..., mucous membranes..."</p> <p>3.1-18(b)(1)</p>			

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F000464 SS=D	<p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>Based on observation and interview, the facility failed to ensure there was enough space in the restorative dining area, in that during 2 of 2 meal observations 3 of 10 residents had to eat on overbed tables while others dined at regular tables. (3/12/13 noon meal, 3/19/13 noon meal, Residents #1, #119, #80)</p> <p>Finding includes:</p> <p>On 3/12/13 at 12:15 p.m., the restorative dining area was observed. There were 3 tables observed, each set up against a wall in the room. Three residents were seated at two of the tables and two residents were seated at the third table. Resident #1 was observed to be seated in the middle area of the room with an overbed table used for her meal tray. Resident #80 was seated in the corner of the room, assisted by a personal caregiver, with his meal on an overbed table.</p>	F000464	Resident(s) #1, #119, and #80 suffered no adverse effects from the alleged deficient practice and are no longer utilizing the overbed tables in the private dining room. The restorative dining room has been arranged and some furniture removed to accommodate all residents at tables for meal service. The meal manager or his/her designee will monitor the restorative dining meal service at all meals to ensure residents are seated at regular tables. Results of meal audits will be forwarded to the QA committee monthly for review for three months and quarterly thereafter for recommendations.	04/21/2013			

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	<p>On 3/19/13 at 12:19 p.m., the restorative dining area was observed again. The tables were in the same location and had three residents at two tables and two residents at the third table. Resident #119 was observed to be using an overbed table for his meal, seated in the middle area of the room. Resident #80 was observed to be seated in the corner with his meal on an overbed table, assisted by a personal caregiver.</p> <p>On 3/19/13 at 12:53 p.m., CNA #1 entered the restorative dining area and stated, "It's crowded in here."</p> <p>When the observations were reviewed with the Administrator and Director of Nurses on 3/19/13 at 3:30 p.m., they indicated it did seem pretty crowded in the room and they seemed to have more people needing assistance at the current time.</p> <p>3.1-19(w)(4)(B)</p>				

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F009999	<p>STATE FINDINGS</p> <p>3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC-28-13-3.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure references and criminal histories were checked prior to and/or at the time of employment for 2 of 10 personnel files reviewed. (DPO [Director of Plant Operations], SSD [Social Services Designee])</p> <p>Finding includes:</p> <p>Personnel files were reviewed on 3/19/13 at 3:00 p.m.</p> <p>The DPO was hired 6/19/12. Documentation of references being checked was dated 10/24/12.</p>	F009999	<p>There were no residents affected by the alleged deficient practice and through corrective measures will ensure staff have the required references and criminal histories required by state rule. Systemic change will include the Business Office Manager's signature prior to the orientation process attesting the required references and criminal histories are complete and in file. AP/Payroll will monitor all orientation rosters with employee files to ensure the requirement is met for all new employees. If required items are found to be missing or inadequate, the employee will not be permitted to begin work until the paperwork is completed in its entirety. The Business Office Manager will audit all new files and results will be forwarded monthly for six months and quarterly thereafter to the QA committee for review and recommendations.</p>	04/21/2013
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	<p>Documentation of a Criminal History Check was dated 1/21/13.</p> <p>The SSD was hired 7/11/12. The file lacked evidence of any references being checked.</p> <p>During interview with the Business Office employee, on 3/20/13 at 9:10 a.m., she indicated, you won't find some things, we were between Administrators and some things didn't get done. When queried about the DPO Criminal History and references, and the SSD references, she indicated she was sure they were missing or late if they weren't in the file provided.</p> <p>3.1-14(a)</p>			

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations or noncompliance cited during annual survey concluding on March 22, 2013. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before April 21, 2013. We respectfully request a desk review for compliance.		

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the services of supervision was provided for 1 of 3 residents reviewed for falls in the total sample of 7, in that, Resident #136 was left unsupervised while the batteries were being changed in the safety alarm and fell. (Resident #136)</p>	R000217	Resident #136 has a service plan in place with current fall interventions and staff who care for her have been inserviced on them. All residents with alarms have the potential to be affected by the alleged deficient practice and through inservicing and monitoring will prevent residents from being unattended while	04/21/2013
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	<p>Finding includes:</p> <p>During the initial tour on 03/20/13 at 2:30 p.m., Unit Manager #5 indicated Resident #136 experienced frequent falls and was noncompliant with the safety plan.</p> <p>The clinical record of Resident #136 was reviewed on 03/21/13 at 10:00 a.m. The record indicated the diagnoses of Resident #136 included, but were not limited to, senile dementia and frequent falls.</p> <p>On 03/21/13 at 10:25 a.m., Resident #136 was observed lying in bed with a floor alarm mat beside the bed.</p> <p>On 03/21/13 at 10:30 a.m., LPN #9 was observed to step on the alarming floor mat next to the bed of Resident #136 and the alarm was observed to not function. During an interview, at that time, LPN #9 indicated the alarm was broken and would have to be replaced.</p> <p>A Nursing Admission Assessment dated 12/11/12 indicated Resident #136 was admitted to Unit #5 from the Health Care Unit. The assessment further indicated, Resident #136 was a high risk to fall and included, but was not limited to, safety interventions of "...alarm to floor ..." A handwritten note on the Assessment</p>		<p>batteries are changed in alarms. Assisted Living staff will be inserviced on fall prevention plans and interventions with focus on root cause analysis. AL manager or his/her designee will audit alarms daily for function and staff compliance with policy. Nurse management team will audit all falls in daily Resident Clinical Meeting (RCM) for appropriate prevention plan to be in place. The results of audits will be forwarded to our QA committee for review monthly for six months and quarterly thereafter for review and recommendations.</p>				

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	<p>indicated, "Floor alarms...due to recent falls..."</p> <p>The January 2013 Physician's Order Recap included, but was not limited to, an order for "alarm to floor beside bed..."</p> <p>The Evaluation and Service Plan dated 3/14/13 indicated Resident #136 experienced moderate cognitive impairment and required physical assistance and supervision for transfers and mobility. The Service Plan included, but were not limited to, the following interventions: "...(undated) alarm to floor-Resident moves around alarm..."</p> <p>A Fall Circumstance Form dated 01/16/13 at 5:15 a.m., indicated Resident #136 experienced a fall. The assessment indicated Resident #136 was found on the floor. The assessment lacked any documentation related to the "safety equipment in place and functioning at time of incident."</p> <p>During an interview on 03/21/13 at 10:55 a.m., the DoN [Director of Nursing] indicated Resident #136 experienced a fall on 01/16/13. The DoN then indicated a CNA had walked by the room of Resident #136 and heard an alarm "chirping". The DoN further indicated, at that time, the CNA discovered the</p>						

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	batteries in the alarm needed to be replaced, left the room with the alarm to retrieve new batteries, and left Resident #136 unsupervised for an unknown amount of time. The DoN then indicated, upon the CNA's return, Resident #136 was found on the floor of the bathroom. The DoN indicated, at that time, Resident #136 should not have been left unsupervised.			

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R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure PRN [per requisite need, as needed] medications administered by a qualified medication aide [QMA] were administered only upon authorization by a licensed nurse or physician, in that contact with the nurse or physician was not documented and/or QMAs were not always seeking authorization. Two [2] of 4 residents reviewed who had PRN medications administered by QMAs, in the sample of 7, failed to show authorization had been obtained by a licensed nurse before the medications were administered. (Residents #140, #139)</p> <p>Findings include:</p> <p>1. Resident #140's clinical record was reviewed on 3/21/13 at 1:10 p.m. The resident had a physician's order, dated 5/6/12, for hydrocodone/APAP</p>	R000246	Resident(s) #140, #139 suffered no adverse effects from the alleged deficient practice and staff that administer medication have been inserviced on requirements of PRN medication administration. QMA #1 will have directed inservice regarding appropriate authorization for administration of PRN medication. Assisted Living nursing staff will be inserviced on proper procedures for PRN drug administration per policy and procedure. DHS or her designee will audit Assisted Living MAR for documented authorization daily for one month, weekly for two months and monthly thereafter. Results of audits will be forwarded to our QA committee monthly for six months and quarterly thereafter for review and recommendation.	04/21/2013			

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	<p>[acetaminophen] [narcotic pain medication] 7.5/500 [milligrams] give one tablet by mouth every 6 hours as needed for pain.</p> <p>Review of the resident's Medication Administration Record [MAR] for March, 2013, indicated the resident was given the pain medication by Qualified Medication Aides [QMAs] on the following dates and times: 3/2/13 2100 [9:00 p.m.] 3/9/13 2000 [8:00 p.m.] 3/16/13 2300 [11:00 p.m.] 3/17/13 2100 [9:00 p.m.]</p> <p>All that was documented was the initials of the QMA. There was no indication a licensed nurse had been consulted prior to the administration of the medication. The nurses' notes also lacked any documentation regarding the administration of the PRN medication.</p> <p>QMA #1 was interviewed on 3/21/13 at 1:30 p.m. She indicated she usually called and told a nurse she was giving a PRN medication. She indicated the nurses usually signed or initialed the administration of the medication later. She indicated she especially called a nurse if it was something the resident didn't usually ask for, but if it was something the resident used every day, she would not</p>			

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	<p>worry about it as much. She indicated she did not know what happened on evening or night shift.</p> <p>2. Resident #139's clinical record was reviewed on 3/21/13 at 2:15 p.m. The resident's physician orders had been signed on 3/14/13. Resident #139 had an order for Tylenol [medication for pain or temperature] 650 milligrams every 6 hours as needed for pain or fever.</p> <p>Review of Resident #139's Medication Administration Record [MAR] for March, 2013, indicated the medication was given by a QMA on the following dates and times: 3/15/13 11:15 p.m. 3/16/13 5:15 a.m. 3/16/13 8:00 p.m. 3/17/13 5:30 a.m. 3/17/13 8:00 p.m. 3/18/13 2:30 a.m.</p> <p>The record lacked documentation of any consultation with a licensed nurse prior to the administration of the medication.</p>						