STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the investigation of Complaint IN00140424. This visit was in conjunction with the investigation of Complaint IN00140941. Survey dates: December 2, 3, 4, 5, 6 & 10, 2013 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Survey team: Gloria Bond, RN Team Coordinator Janet Stanton, RN Sandra Nolder, RN Census bed type: SNF: 8 SNF/NF: 86 Total: 94 Census payor type: Medicare: 12 Medicaid: 72 Other: 10 Total: 94	F000000	Harcourt Terrace Nursing and Rehabilitation submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors.The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance review in lieu of a Post Survey Review on or after January 9, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on December 17, 2013.			

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident was provided 1:1 activities to prevent social isolation and provide mental stimulation, for 1 of 1 cognitively impaired residents reviewed for Activities. (Resident #124) Findings include: Resident #124's record was reviewed on 12/5/13 at 9:55 A.M. Diagnoses included, but were not limited to, legally deaf, legally blind, mild to moderate dementia, and cerebral vascular accident with right partial hemiparesis. The resident had a current care plan that stated, "Problem: Resident enjoys independent activity pursuits and will receive 1:1 visits." The start date was on 11/26/2013. The goal stated, "Resident will participate in independent activities to	F000248	The facility will make every reasonable effort to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. CORRECTIVE ACTION: This alleged deficient practice was immediately corrected by providing resident #124 15-minutes times 2 of one on one programming per week. IDENTIFICATION OF OTHER RESIDENTS AT RISK: Residents who are cognitively impaired has the potential to be affected by the alleged deficient practice. Cognitively impaired residents with a Brief Interview for Mental Status (BIMS) score of less than 13 were reviewed for activity participation on December 24, 2013 by the Activity Director/Designee. Review of activity participation included evaluation of group and independent activity participation, review of current one on one programming (if applicable), as well as a review of those resident's activity plans of care.	01/09/2014

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	their level of satisfaction and will receive 1:1 activity visits." The approaches dated on 11/26/2013, was listed as "1:1 visits 2 weekly, Encourage daily socialization outside of room, Encourage participation in scheduled programing." The Minimum Data Set Assessment for 11/10/13 indicated the resident had moderate cognitive impairment. His decisions were poor and he required cueing and supervision. On the following day and times the resident was observed: 12/2/13 at 3:15 P.M., he was lying in bed sleeping. 12/3/13 at 8:55 A.M., he was lying in bed sleeping. 12/3/13 at 10:40 A.M., he was lying in bed sleeping. 12/4/13 at 10:15 A.M., he was sitting in his wheelchair in his room watching television. 12/4/13 at 3:45 P.M., he was observed lying in bed sleeping. 12/5/13 at 9:12 A.M., he was observed in the therapy department. 12/5/13 at 11:00 A.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down		Cognitively impaired residents who have less than 30-minutes of documented activity programming per week will be placed on one on one activity programming. This will be placed on the activity plan of care as well as internal communication books. MEASURES/SYSTEMATIC CHANGES: Activity Director was in-serviced by corporate consultant on December 23, 2013 on ensuring residents are provided activities designed to meet their interest and the physical, mental and psychosocial well-being specifically residents who are cognitively impaired. Activity staff was in-serviced regarding providing one on one programming and the one on one communication book by Activity Director on December 24, 2013. Any resident who requires one on one programming as determined by the resident assessment will be added to the internal one on one communication books.These books are to be checked by activity staff at least weekly.There is a communication sign off in the front of the book that activity staff will acknowledge upon a resident being added to one on one programming. Activity care plans will be updated with current one on one programming needs. Activity Director will audit the one on one programming book weekly for appropriate completion of designated one on one program. Corporate consultant will audit	

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	so the resident could not hear the television and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 1:06 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 2:30 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 3:30 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 3:45 P.M., he was observed in his bed being given pericare. His television was on and the volume had been turned up by the CNA #1. The remote controller for his television remained across the room on the bedside stand.		one on one book monthly for completion. Any non compliance with above practices will be corrected with education provided. MONITOR: To ensure compliance, the Activity Director/Designee is responsible for the audit of the one on one programming CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the Executive Director (ED) will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	During an interview on 12/2/13 at 2:56 P.M., a family member indicated she had not heard the facility staff ask the resident to go to any activities when she had been visiting him. She indicated she visited him daily at different times everyday. During an interview on 12/6/13 at 3:44 P.M., the Assistant Activity Director had indicated the resident had come down to one gospel singing activity. She indicated he liked to stay in his room. She indicated the activity staff had not started 1:1 activities with him yet, but they were going to start doing them. She indicated he liked to watch television and if his wife was in the room the activity staff would ask her if he wanted to come to an activity if one was going on. She indicated the activity staff would give the daily chronicle paper to his wife to read to him if she was in the room. On 12/6/13 at 3:44 P.M., the November and December activity calendar for this resident was provided by the Assistant Activity Director. The Assistant Activity Director indicated the only day in November the resident participated in an activity was on 11/9/13, and his wife read the daily chronicle paper to			

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	him that day. She indicated during the month of December he had not participated in any activities. On 12/10/13 at 5:50 P.M., during the exit conference, the Activity Director indicated the resident had been placed on 1:1 activities that started on 12/5/13. He did not indicate what 1:1 activities the activity staff was doing with the resident. 3.1-33(a) 3.1-33(b)(8)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview and record review the facility failed to follow care plans for fall interventions for 1 of 3 residents reviewed for falls, for resident involved in activity participation for 1 of 2 residents reviewed for activity participation, following insulin physician orders, and anti-Alzheimer's medication orders for 1 of 6 residents reviewed for following physician orders. (Resident #124, #70 and Resident #59) Findings Include: 1. Resident #124's record was reviewed on 12/5/13 at 9:55 A.M. Diagnoses included, but were not limited to, legally deaf, legally blind, right hip ORIF (open reduction internal fixation), mild to moderate dementia, CVA (cerebral vascular accident) with right partial hemiparesis, and degenerative disc disease. The resident had a care plan problem that stated, "Resident is at risk for fall due to: decreased mobility, DX of	F000282	The facility will make every reasonable effort to ensure the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. RESIDENT #124 CORRECTIVE ACTION: Personal Alarm: This alleged deficient practice was immediately corrected by turning the alarm on on-position. Resident was not adversely affected by this alleged deficient practice. One on one education immediately provided to staff involved in alleged deficient practice. Activity: This alleged deficient practice was immediately corrected by providing resident #124 15-minutes times 2 of one on one programming per week. IDENTIFICATION OF OTHER RESIDENTS AT RISK: Personal Alarm: Residents utilizing alarms have the potential to be affected by this deficient practice. Staff will ensure that alarms are functioning when in use. All residents with orders for alarms were audited on December 13, 2013. All alarms are in place, functioning, and in the "on" position. Re-education to	01/09/2014

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	insomnia, degenerative disc disease, right side hemi, HX of CVA, dementia, right hip fracture, recent fall, antihypertensive medication." The start date was 11/07/2013. The goal stated, "Resident will be free from fall related injury" The target goal date was 02/21/2014. The approaches included, but were not limited to: 1. The approach start date was 11/15/2013 and stated, "do not leave resident in room in his wheelchair" 2. The approach start date was 11/14/2013 and stated, "bed alarm in place" 3. The approach start date was 11/11/2013 and stated, "bolsters on side of bed" 4. The approach start date was 11/11/2013 and stated, "keep bed in lowest position" 5. The approach start date was 11/11/2013 and stated, "mat on floor next to bed" 6. The approach start date was 11/07/2013 and stated, "call light in reach" 7. The approach start date was 11/07/2013 and stated, "monitor resident and		nursing staff will be completed by December 31, 2013 by the DNS/Designee. Activity: Residents who are cognitively impaired has the potential to be affected by the alleged deficient practice. Cognitively impaired residents with a BIMS score of less than 13 were reviewed for activity participation on December 24, 2013 by the Activity Director/Designee. Review of activity participation included evaluation of group and independent activity participation, review of current one on one programming (if applicable), as well as a review of those resident's activity plans of care. Cognitively impaired residents who have less than 30-minutes of documented activity programming per week will be placed on one on one activity programming. This will be placed on the activity plan of care as well as internal communication books. MEASURES/SYSTEMATIC CHANGES: Personal Alarms: Facility will replace alarms with alarms that do not have an "on" and "off switch. Alarms will be activated when resident is placed in bed/chair. Nursing staff are responsible for checking function of alarms every shift by conducting rounds. Activity: Activity Director was in-serviced by corporate consultant on December 23, 2013 on ensuring residents are provided activities designed to meet their interest	

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	intervene if resident is exhibiting unsafe behavior 8. The approach start date was 11/07/2013 and stated, "non skid footwear" 9. The approach start date was 11/07/2013 and stated, "Personal items in reach" 10. The approach start date was 11/07/2013 and stated, "Therapy screen quarterly and prn" During an observation on 12/2/13, at 3:15 P.M., the resident's bed alarm box was observed in the off position while he was lying in bed sleeping. During an observation on 12/3/13, at 8:55 A.M., the resident's bed alarm box was observed in the off position while he was lying in bed sleeping. During an observation on 12/3/13, at 10:40 A.M., the resident's bed alarm box was observed in the off position while he was lying in bed sleeping. During an observation on 12/3/13, at 1:28 P.M., the resident was observed transferred back to bed with one person physical assist by CNA #4. RN #5 was in the room while the transfer was being executed. The call		and the physical, mental and psychosocial well-being specifically residents who are cognitively impaired. Activity staff was in-serviced regarding providing one on one programming and the one on one communication book by Activity Director on December 24, 2013. Any resident who requires one on one programming as determined by the resident assessment will be added to the internal one on one communication books. These books are to be checked by activity staff at least weekly. There is a communication sign off in the front of the book that activity staff will acknowledge upon a resident being added to one on one programming. Activity care plans will be updated with current one on one programming needs. Activity Director will audit the one on one programming book weekly for appropriate completion of designated one on one program. Corporate consultant will audit one on one book monthly for completion. Any non-compliance with above practices will be corrected with education provided. MONITOR: Personal Alarm: To ensure compliance, the DNS/Designee is responsible for the completion of the Alarm Placement and Functioning CQI tool audit weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is	

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	light was put within reach, the prevalon boots were placed over bilateral feet, bolsters were put on both sides of the bed, the bed alarm box was placed in the on position, the mat was placed on the floor, and the bed was left in high position. Both caregivers left the room. The resident's niece came into the room and sat down in a chair next to the bed. During an interview on 12/3/13 at 1:32 P.M., RN#5 indicated the bed was not in the lowest position and he lowered the bed at this time. During an observation on 12/5/13, at 3:45 P.M., the resident was being given incontinent care. The bed was in high position while CNA#1 and CNA#6 was giving the resident incontinent care. CNA#6 left the room to obtain additional towels and wash clothes. While she was out of the room, CNA#1 left the resident's bedside to rewet wash clothes that had gotten cold. The resident's bed was left up in high position during this timeframe. After the incontinent care was given, both CNA's placed the resident's prevalon boots on and left the room. During an interview on 12/10/13, at		maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Activity: To ensure compliance, the Activity Director/Designee is responsible for the audit of the one on one programming CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. RESIDENT #70 CORRECTIVE ACTION: This alleged deficient practice was immediately corrected on December 9, 2013.Resident was not adversely affected by this alleged deficient practice. The physician will be notified when BS results are not within normal limits and BS will be checked per physician's orders. IDENTIFICATION OF OTHER RESIDENTS AT RISK: Residents receiving sliding scale insulin have the potential to be affected by this alleged deficient practice. Licensed nurses will ensure that they are administering sliding scale insulin per Physician's orders.Licensed nurses will be re-educated on following physician's orders on sliding	

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	12:52 P.M., LPN #7 indicated the resident's bed alarm box was was in the off position. During an observation on 12/10/13, at 1:47 P.M., the resident's bed alarm box was observed in the off position. During an interview on 12/10/13, at 2:26 P.M., Unit Manager #8 indicated the department heads were assigned rooms and they were suppose to check those rooms throughout the day to make sure alarm boxes were turned on. She indicated this resident was one of her resident's rooms to check each day. She indicated she expected the alarm boxes to be in the on position. The resident had a current care plan that stated, "Problem: Resident enjoys independent activity pursuits and will receive 1:1 visits." The start date was on 11/26/2013 The goal stated, "Resident will participate in independent activities to their level of satisfaction and will receive 1:1 activity visits." The target date was on 02/25/2014 The resident's approaches started on 11/26/2013 and stated, "1:1 visits 2 times weekly, Encourage daily		scale insulin on December 31, 2013 by DNS/Designee. DNS/Designee audited all residents who receive sliding scale insulin to ensure that physician's orders were followed. MEASURES/SYSTEMATIC CHANGES: Nurse Managers will audit glucose monitoring records daily for compliance to ensure physician's orders are followed.Any nurse identified not following physician's orders for sliding scale insulin will be subject to disciplinary action. MONITOR: To ensure compliance, the DNS/Designee is responsible for the completion of theSliding Scale Insulin CQI audit tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance. RESIDENT #59 CORRECTIVE ACTION: This alleged deficient practice was immediately corrected by notifying NP. NP evaluated resident and discontinued the medication. Resident was not adversely affected by this alleged deficient practice. Nurses involved in alleged deficient practice were provided with one on one education on facility policy on	

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	socialization outside of room, Encourage participation in scheduled programing." On the following day and times the resident was observed to be doing the following: 12/2/13 at 3:15 P.M., he was lying in bed sleeping. 12/3/13 at 8:55 A.M., he was lying in bed sleeping. 12/3/13 at 10:40 A.M., he was lying in bed sleeping. 12/4/13 at 10:15 A.M., he was sitting in his wheelchair in his room watching television 12/4/13 at 3:45 P.M., he was observed lying in bed sleeping. 12/5/13 at 9:12 A.M., he was observed in the therapy department. 12/5/13 at 11:00 A.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so the resident could not hear television and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 1:06 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand.		administration and ordering of medications. IDENTIFICATION OF OTHER RESIDENTS AT RISK: All resident's have the potential to be affected by this deficient practice. Licensed nurses will process orders completely, ensuring pharmacy notification of new medication orders are received. If medication is not available, licensed nurses will immediately notify the pharmacy to ensure delivery of medication. An audit will be conducted to ensure all medications are available as prescribed on January 6, 2014 by DNS/Designee. MEASURES/SYSTEMATIC CHANGES: DNS and/or designee will re-educate license nurses by December 31, 2013 on proper processing of physician's orders and notification to pharmacy of unavailable medications. Nurse Managers will audit medication administration records daily for compliance to ensure medications are received timely as physicians ordered. If medication is not available, licensed nurses will immediately notify the pharmacy to ensure delivery of medication and notify physician of unavailable medication. MONITOR: To ensure compliance,the DNS/Designee is responsible for the completion of theMedication Availability CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then	

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	12/5/13 at 2:30 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 3:30 P.M., he was observed lying in bed sleeping. His television was on, but the volume was turned down so he could not hear it and his remote controller for the television was across the room on a bedside stand. 12/5/13 at 3:45 P.M., he was observed in his bed being given pericare. His television was on and the volume had been turned up by the CNA #1. The remote controller for his television remained across the room on the bedside stand. During a family interview on 12/2/13 at 2:56 P.M., the resident's wife indicated she had not heard the facility staff asking the resident to go to any activities during her visits. She indicated she visited him daily at different times everyday. During an interview on 12/6/13 at 3:44 P.M., the Assistant Activity		quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	Director had indicated the resident had come down to one gospel singing activity. She indicated he liked to stay in his room. She indicated the activity staff had not started 1:1 activities with him yet, but they were going to start doing them. She indicated he liked to watch television and if his wife was in the room the activity staff would ask her if he wanted to come to an activity if one was going on. She indicated the activity staff would give the daily chronicle paper to his wife to read to him if she was in the room. On 12/6/13 at 3:44 P.M., the November and December activity calendar for this resident was provided by the Assistant Activity Director. She indicated the pink highlighted areas indicated the resident had refused to participate in activities, the blue highlighted areas had indicated the resident was in the hospital, and the green highlighted areas indicated he participated in the activity or the activity staff assisted with the activity. The Assistant Activity Director indicated during the month of November the only day he participated in an activity was on 11/9/13 and his wife read the daily chronicle paper to him that day. She indicated during the month of December he had not participated in			

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	any activities. On 12/10/13 at 5:50 P.M., during the exit conference, the Activity Director indicated the resident had been placed on 1:1 activities that started on 12/5/13. He did not indicate what 1:1 activities the activity staff was doing with the resident. 2. Resident #70's record was reviewed on 12/6/2013 at 11:06 A.M. Resident #70's diagnoses included, but were not limited to, diabetes. The resident's physician orders included, but were not limited to: On 05/22/13: Lantus inject 45 units subcutaneous daily at bedtime On 8/16/13: Accuchecks four times daily call < (less than) 80 or > (greater than) 400. Novolog inject subcutaneous per sliding scale four times daily: 251-300=5 units 301-350=10 units 351-400=15 units On 9/24/13: Accuchecks four times daily call < (less than) 70 or > (greater than) 400. On 9/30/13: Accuchecks four times			

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	daily call < (less than) 70 or > (greater than) 400. Novolog inject subcutaneous per sliding scale four times daily: 251-300=5 units 301-350=10 units 351-400=15 units <70 or >400=Call MD (doctor) for diabetes mellitus type II. On 12/9/13: Discontinue current sliding scale insulin. Humolog 100 units per ml, schedule 4 units subcutaneous with lunch and dinner. Hold for by mouth intake less than 50%. Discontinue Lantus 45 units. Lantus 40 units subcutaneous at bed time (due to fasting blood glucose level < 140). The following dates and times the resident's accuchecks were taken: On 9/3/13 at 11:00 A.M., the resident's blood sugar was 265 and no insulin was administered at this time. On 9/10/13 at 9:00 P.M., the resident's blood sugar was 120 and 5 units of novolog insulin was administered. On 9/12/13 at 4:00 P.M., the resident's blood sugar was 342 and 15 units of novolog insulin was administered.			

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	On 9/20/13 at 9:00 P.M., the resident's blood sugar was 331 and no insulin was administered. On 9/27/13 at 4:00 P.M., the resident's blood sugar was 284 and no insulin was administered. On 9/29/13 at 9:00 P.M., the resident's blood sugar was 117 and 5 units of novolog insulin was administered. On 10/2/13 at 9:00 P.M., the resident's blood sugar was 238 and 10 units of novolog was administered. On 10/9/13 at 4:00 P.M., the resident's blood sugar was 245 and 5 units of novolog insulin was administered. On 10/23/13 at 4:00 P.M., the resident's blood sugar was 363 and no insulin was administered. On 10/26/13 at 9:00 P.M., the resident's blood sugar was 247 and 5 units of novolog insulin was administered. On 10/31/13 at 9:00 P.M., the resident's blood sugar was 220 and 5 units of novolog insulin was administered. On 11/4/13 at 8:00 P.M., the resident's blood sugar was 278 and no insulin was administered. On 11/11/13 at 8:00 P.M., the resident's blood sugar was 306 and no insulin			

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	was documented as being given. A policy titled "Blood Glucose Monitoring" dated 3/10 was provided on 12/10/13 by Unit Manager #3 at 3:35 P.M., and deem current stated, "POLICY: It is the policy of this facility to administer immediate treatment of hypoglycemia...Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record." During an interview on 12/10/13 at 3:07 P.M., the Unit Manager #3 indicated the blood sugars are monitored by documenting the September and October blood sugars on the MARS and the blood sugars after October would be documented on the Capillary Blood Glucose Monitoring Tool. She indicated the nurse who gave the incorrect doses of insulin in September and October was no longer with the facility. 3. On 12/6/13 at 9:19 A.M., RN #2 was observed while administering medications to Resident #59. After dispensing the resident's medications into a medicine cup, the nurse confirmed she had 6 pills, which included the medications of Aspirin, Metoprolol, Vitamin B-12, Florastor, Metformin, and Glimepiride.			

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	A reconciliation (comparison) review of the medications administered by the nurse, with the medications listed in the physician orders, was done on 12/6/13 at 1:45 P.M. On 11/27/13, a physician's order was written to discontinue Namenda XR (an extended-release anti-Alzheimer's agent), and start Namenda 10 mg. (milligrams) by mouth twice a day. The medication was to be administered at 8:00 A.M. and 8:00 P.M. During an interview on 12/6/13 at 2:03 P.M., RN #2 indicated she had not given Resident #59 Namenda that morning. She reviewed the MAR (Medication Administration Record) and found the order, which was written very faintly. The nurse also searched the medication cart, and indicated she could not find a blister/punch card for the Namenda. She indicated there was another place she could look for the card, but at 2:15 P.M. she reported she could not find any other medication blister card for the Namenda. The MAR had no documentation that the Namenda had been given for the month of December, from 12/1 through 12/6/13 for the 8:00 A.M.			

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	dose, for a total of 11 doses. During a conference on 12/6/13 at 2:28 P.M., the issue of the medication order and the omission of the medication was discussed with the interim Director of Nursing, and the Unit Manager, LPN #3. The interim Director of Nursing indicated she thought she knew what happened, but would check and provide more information. During an interview on 12/10/13 at 4:15 P.M., the interim Director of Nursing indicated the order for the Namenda had been written, but the medication had not been ordered. The resident did not receive 6 doses of the Namenda in November, from 11/28 through 11/30/13, in addition to the omitted doses in December. The resident failed to receive a total of 17 doses of the medication between the order date of 11/27/13 and 12/6/13. 3.1-35(g)(2)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on observation, interview and record review, the facility failed to ensure urinary catheter drainage bags were positioned in a manner to prevent the possibility of contamination for 2 of 2 residents observed for urinary catheter drainage bag placement. (Resident #124 and Resident #126) Findings include: 1. Resident #124's record was reviewed on 12/5/13 at 9:55 A.M. Diagnoses included, but were not limited to, urinary retention and mild to moderate dementia. The resident's physician orders included, but were not limited to: 11/13/13 Tamsulosin (treatment for enlarged prostrate) 0.4 milligrams (mg) take 2 tablets 0.8 mg by mouth	F000315	The facility will make every reasonable effort to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. CORRECTIVE ACTION: This alleged deficient practice was immediately corrected by placing foley catheter dignity bag off of the floor. Foley Cather and ostomy bag were placed in separate dignity bags. One on one inservice was provided to nursing staff involved in alleged deficient practice. IDENTIFICATION OF OTHER RESIDENTS AT RISK: Residents with catheters and ostomies have the potential to be affected by this alleged practice.	01/09/2014

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	at bedtime for urinary retention 11/21/13 remove Foley in two weeks in the morning for voiding trial. If the resident is unable to void after six to eight hours then replace the Foley catheter. 11/28/13 Bactrim DS (antibiotic) by mouth every 12 hours times seven days. Discontinue on 12/4/13 for UTI (Urinary Tract Infection). 11/29/13 remove Foley catheter today. Monitor the urine output. If no output in eight hours, reanchor the Foley catheter. On 12/2/13, at 3:15 P.M., the catheter drainage bag was observed lying on the left side of the bed on the mat, which was on the floor, while it was clipped to the bed frame. During an observation on 12/3/13, at 1:32 P.M., the resident's catheter drainage bag was lying on the left side of the bed on the mat, which was on the floor, while it was clipped to the bed frame and RN #5 who had been in the room providing care for the resident, walked out of the room with the drainage bag on the mat. On 12/3/13, at 4:00 P.M., the catheter		DNS/Designee conducted rounds to ensure that foley catheter bags are not touching the floor.DNS/Designee conducted rounds to ensure that all drainage bags have separate dignity bags. Residents with catheters and ostomies were audited on December 13, 2013. Foley catheters are off of the floor and drainage bags are in separate dignity bags. MEASURES/SYSTEMATIC CHANGES:Re-education to nursing staff will be completed by December 31, 2013 by DNS/Designee. Nurse managers and/or designee will conduct rounds daily to check for appropriate infection control practices ensuring foley catheters are kept off of the floor and that each drainage bag has a separate dignity bag. MONITOR: To ensure compliance,the DNS/Designee is responsible for the completion of theInfection Control CQI audit tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	bag was observed lying on the left side of the bed on the mat, which was on the floor, while it was clipped to the bed frame. On 12/5/13, at 2:30 P.M., the catheter bag was observed lying on the right side of the bed on the floor clipped to the bed frame. On 12/5/13, at 3:45 P.M., the catheter bag was observed lying on the right side of the bed on the floor clipped to the bed frame. During an interview on 12/10/13 at 2:16 P.M., CNA #9 indicated she would hang the catheter drainage bag on the bedrail because he was in a low bed. If it was hung on the bed frame, the drainage bag would touch the floor. During an interview on 12/10/13 at 3:27 P.M., Medical Records Clerk #10 indicated she expected the Foley catheter drainage bags to hang so they were not on the floor and they were properly draining. 2. Resident # 126's record was reviewed on 12/6/2013 at 9:45 A.M. Diagnoses included, but were not limited to, diabetes, hypertension, anxiety, insomnia and attention to ileostomy.			

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	On 12/6/2013 at 9:30 A.M., the resident's urinary catheter bag was observed in the same dignity bag as her ileostomy drainage bag. R.N.#2 separated the two promptly, and put the urinary catheter bag in its own dignity bag. In an interview with R.N. #2 at that time, she indicated she did not know why, or who, put the urinary catheter bag in the same dignity bag as the colostomy / ileostomy bag's dignity bag, as it had its own dignity / protective bag. Record review after the observation, indicated Resident #126 was being treated for a urinary track infection since 12/3/2013. 3.1-41(a)(2)			

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F000323 SS=D	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. Based on observation, interview and record review, the facility failed to implement fall prevention interventions, related to a personal alarm, and height of bed, for 1 of 3 residents reviewed for Accidents (Resident #124). In addition, the facility failed to ensure power strip extension cords were utilized in a safe manner, in 2 resident rooms and potentially effecting 2 of 3 residents in those rooms. (Resident #15 in Room 21/Willow Bend, and Resident #35 Room 24/Willow Bend) Findings include: 1. Resident #124's record was reviewed on 12/5/13 at 9:55 A.M. Diagnoses included, but were not limited to, legally deaf, legally blind, right hip ORIF (open reduction internal fixation), mild to moderate dementia, CVA (cerebral vascular accident) with right partial hemiparesis, and degenerative disc disease.	F000323	The facility will make every reasonable effort to 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. 1. PERSONAL ALARMS: CORRECTIVE ACTION: This alleged deficient practice was immediately corrected by turning the alarm on on-position.Resident was not adversely affected by this alleged deficient practice.One on one education immediately provided to staff involved in alleged deficient practice. IDENTIFICATION OF OTHER RESIDENTS AT RISK: Residents utilizing alarms have the potential to be affected by this deficient practice.Staff will ensure that alarms are functioning when in use. All residents with orders for alarms were audited on December 13, 2013. All alarms are in place, functioning, and in the “on” position.Re-education to nursing staff will be completed by December 31, 2013 by the DNS/Designee. MEASURES/SYSTEMATIC CHANGES: Facility will replace alarms with alarms that	01/09/2014

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	The fall event note dated 11/10/13 at 10:20 A.M., indicated the resident had an unwitnessed fall and was observed on the floor in his room, sitting on his bottom with his back against the bed, on the left side of the bed. No new injuries were observed. He had bruising from his previous fall before his admission to the facility. The immediate intervention was to place bolsters on the bed, a mat on the left side of the bed and a wedge on the right side of the bed. The progress notes on 11/10/13 at 4:31 P.M., indicated the resident's family members insisted the facility sent him to the emergency room for a cat scan of his head and an X-ray of his right hip. He was picked up by the ambulance at 1500 (3 P.M.) The progress notes on 11/11/13 at 8:39 A.M., indicated the resident was admitted to the hospital for acute renal failure. The progress notes on 11/13/13 indicated the resident was readmitted to the facility from the hospital. Physician orders included, but were not limited to: 1. 11/7/13 Occupational therapy		do not have an “on” and “off switch. Alarms will be activated when resident is placed in bed/chair. Nursing staff are responsible for checking function of alarms every shift by conducting rounds. MONITOR: To ensure compliance, the DNS/Designee is responsible for the completion of the Alarm Placement and Functioning CQI tool audit weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 2. POWER STRIPS/EXTENSION CORDS: CORRECTIVE ACTION: On December 5, 2013 both the power strip/surge protector in room 21 and 24 was replaced with an 8-foot cord power strip/surge protector. Also, on December 5, 2013 in room 24, the yellow extension cord was removed. Resident was not adversely affected by this alleged deficient practice. IDENTIFICATION OF OTHER RESIDENTS AT RISK: All residents have the potential to be affected by this alleged deficient practice, however none were identified. The Maintenance Director conducted room rounds	

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	evaluation and treat 2. 11/7/13 Physical therapy evaluation and treat order 3. 11/7/13 non skid footwear 4. 11/7/13 wedge cushion in place on right side of the bed for positioning. Please check dycem placement under wedge every shift to prevent movement for safety 5. 11/10/13 keep the bed in the lowest position. Mat on the floor next to the bed on the left side of the bed, bolsters to the bed, continue the wedge on the right side of the bed. 6. 11/13/13 Wedge cushion in place on right side of the bed for positioning. Check dycem placement under the wedge every shift to prevent movement and for safety 7. 11/13/13 Keep the bed in the lowest position. 8. 11/13/13 Mat on the floor on the left side 9. 11/13/13 Bolsters on the bed 10. 11/13/13 Non skid footwear 11. 11/13/13 WBAT (Weight bear as tolerated) RLE (Right lower extremity) 12. 11/14/13 Occupational therapy evaluation and treat order was written 13. 11/14/13 Physical therapy evaluation and treat order was written 14. 11/15/13 Bed alarm. Check placement/function every shift.		on December 5, 2013 and replaced all short power strip/surge protectors with 8-foot cord power strip/surge protector and removed any extension cords. MEASURES/SYSTEMATIC CHANGES: On December 13, 2013 the ED inserviced staff regarding immediate reporting of short-corded power strip/surge protectors and extension cords found in residents rooms to the Maintenance Director for replacement or removal. The Maintenance Director will conduct weekly Maintenance Safety room rounds to ensure residents rooms are free from short-corded power strip/surge protectors and extension cords. MONITOR: To ensure compliance, the Maintenance Director/Designee is responsible for completion of theMaintenance Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	15. 12/5/13 A clarification order was written to discontinue the wedge cushion. The Minimum Data Assessment dated 11/10/13, indicated the resident had moderate cognitive impairment (decisions were poor and cues and supervision were required). He required two staff to assist him with turning in bed and transferring to the wheelchair. A care plan problem dated 11/07/2013 addressed Resident is at risk for falls. The resident had a care plan problem dated 11/07/13 that stated, "Resident is at risk for fall...." The approaches included, but were not limited to: 1. 11/15/2013 do not leave resident in room in his wheelchair 2. 11/14/2013 bed alarm in place 3. 11/13/2013 prevalon boots in place on bilateral feet when lying in bed 4. 11/11/2013 bolsters on side of bed 5. 11/711/2013 keep bed in lowest position 6. 11/11/2013 mat on floor next to bed 7. 11/07/2013 call light in reach			

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	8. 11/07/2013 monitor resident intervene if resident is exhibiting unsafe behavior 9. 11/07/2013 non skid footwear 10. 11/07/2013 Personal items in reach 11. 11/07/2013 Therapy screen quarterly and prn A Resident Care/Need Sheet dated 12/4/13, indicated he was an assist of two WBAT RLE for mobility, assist of two for ADL's (Activities of daily living) assist needs, he had a bed alarm. The sheet indicated he was not to be left alone in his room in his wheelchair, his personal items were to be within reach, the mat was to be beside his bed, the bed was to be in the lowest position, prevalon boots were to be on when in bed, bolsters to his bed, and nonskid footwear was to be on his bilateral feet. On 12/2/13, at 3:15 P.M., the bed alarm box was observed in the off position while he was lying in bed sleeping. On 12/3/13, at 8:55 A.M., the bed alarm box was observed in the off position while he was lying in bed sleeping.			

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	On 12/3/13, at 10:40 A.M., the bed alarm box was observed in the off position while he was lying in bed sleeping. On 12/3/13, at 1:28 P.M., the resident was observed transferred back to bed. After he was transferred back to bed, both caregivers left the room. The bed was left in high position. On 12/3/13 at 1:32 P.M., during an interview, RN #5 indicated the bed was not in the lowest position and he lowered the bed at this time. On 12/5/13, at 3:45 P.M., CNA #1 and CNA #6 was observed while giving the resident incontinent care. The bed was in high position when CNA #6 left the room to obtain additional towels and wash clothes. While she was out of the room, CNA #1 left the resident's bedside to rewet wash clothes that had gotten cold. The resident's bed was left up in high position during this timeframe. After the incontinent care was given, both CNA's placed the resident's prevalon boots on his bilateral barefeet and left the room. On 12/10/13, at 1:47 P.M., the bed alarm box was observed in the off position.			

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	On 12/10/13, at 12:52 P.M., LPN #7 indicated the bed alarm box was in the off. During an interview on 12/10/13, at 2:26 P.M., LPN #8 indicated the Department Managers were assigned rooms to check throughout the day to make sure alarm boxes were turned on. She indicated this resident was one of her resident's rooms to check each day. She indicated she expected the alarm boxes to be in the on position. 2. On 12/2/13 at 10:32 A.M., in Room 21 on the Willow Bend unit, a power strip/surge protector extension cord with multiple electrical outlets was observed hanging down over the top of a recliner chair, and right next to the neck and touching the upper right arm of Resident #15, who was sitting in the chair. There were 2 cords from other electrical appliances plugged into the power strip. On 12/3/13 at 10:59 A.M., in Room 24 on the Willow Bend unit, a cord from a TV was plugged into an electrical outlet in the bathroom. The cord extended from the TV, which was on a dresser next to the bathroom door,			

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	around the bathroom door frame and into the bathroom at a 4 foot height. An extension cord was also plugged into outlet in the bathroom. The yellow extension cord extended from the outlet in the bathroom, around the bathroom door frame and behind the dresser and other furniture items against the wall in the bedroom. On 12/3/12 at 11:00 A.M., in Room 24 on the Willow Bend unit, a multi-outlet surge protector/extension cord, with a 3-foot cord, was observed to be plugged into a wall outlet by the call-light outlet. The electrical outlet was at a 4-foot height the on wall, and the surge protector was hanging down along the side of the wall. The outlet strip was observed tightly wedged between the wall and the resident's bed, at a 2 foot height. There was a cord from an electrical appliance plugged into one of the outlets. Resident #35, who was in bed at the time, indicated her "bed" was plugged into the unit, and that it had been that way for "some time." On 12/5/13 at 10:15 A.M., with the Executive Director and the Maintenance Director in attendance, the placement of the power strips in Rooms 21 and 24 were observed.			

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	In an interview on 12/5/13 at 10:20 A.M., the Environmental Services Director indicated he had power strip extension cords available with 8 foot cords, and if a family or staff requested additional power outlets, those would be the ones he provided. He indicated his preventive maintenance program did not include checking the power strips currently in use to determine length of cord, and that he did not know why the strips with the 3 foot cords were being used. He indicated he had not, and did not, specifically look for the power strips that had the shorter cords. Both he and the ED agreed the usage of the strips with the shorter cords might not be safe when placed as the ones in Rooms 21 and 24 had been placed. In an interview on 12/5/13 at 1:00 P.M., the Maintenance Director indicated he had done an audit of all resident rooms in the building, and had found several more of the power strips with the short cords being utilized in resident rooms. He indicated he had replaced all of them with the units that had the 8-foot cords. 3.1-45(a)(1) 3.1-45(a)(2)			

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F000329 SS=D	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. 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. Based on observation, interview and record review, the facility failed to ensure a Gradual Dose Reduction for a resident with dementia on psychotropic medications was followed. Further, the facility failed to ensure specific behaviors were identified and quatitatively monitored to support the use of psychotropic medications. This deficient practice affected 2 of 5 residents reviewed for Unnecessary Medications. (Residents #63 and #70).	F000329	The facility will make every reasonable effort to ensure each resident's drug regimen must be free from unnecessary drugs. CORRECTIVE ACTION: RESIDENT #63: Gradual Dose Reduction (GDR) was requested on December 27, 2013 and physician will justify use if GDR is declined or provide reasons that GDR is contraindicated. RESIDENT #70: Antipsychotic medication was discontinued on December 12, 2013 and monitoring system was put in place to monitor for signs	01/09/2014

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	Findings include: 1. Record review of Resident #63 was completed on 12/5/13 at 2:30 P.M. Diagnoses included, but were not limited to, end stage renal disease, generalized anxiety disorder, depressive disorder, hypertension, and dementia. The December 2013 physician order recap (recapulation) sheet included, but were not limited to, the following medications and original prescription dates: 4/03/12 Seroquel XR (an anti-psychotic medication) 150 mg (milligrams) one tablet by mouth daily at bedtime; and 4/21/12 Mirtazapine (an antidepressant medication) 15 mg. one tablet by mouth daily at bedtime. On 2/10/2013 the Consultant Pharmacist indicated, " This resident has been taking: Seroquel XR 150 mg daily at bedtime since April 2012. Please consider a gradual dose reduction at this time,..." The physician responded on 2/18/13 by marking an "x" on the record indicating, "Receiving optimal dose that benefits the resident's function and activities of daily living, continued use is in, accordance with relevant		and symptoms of depression and adverse effectives of the antidepressant. IDENTIFICATIO N OF OTHER RESIDENTS AT RISK: Residents on psychotropic medications have the potential to be affected by this alleged deficient practice. Social Service Director (SSD) and Memory Care Facilitator (MCF) will review all potentially affected residents to ensure that a GDR has been attempted when indicated and physician will justify use if GDR is declined or provide reasons that GDR is contraindicated. DNS/Designee will conduct an audit to ensure that an Abnormal Involuntary Movement Scale (AIMS) Assessment is completed for residents on psychotropic medications. MEASURES/SYSTE MATIC CHANGES: On December 13, 2013 SSD and the MCF attended an inservice on Behavior Monitoring and Gradual Dose Reduction. The inservice was provided by Social Service corporate consultant. SSD and MCF will re-educate licensed nursing staff on December 31, 2013 on the Behavior Management Program specifically monitoring of behaviors and adverse effects of residents on antipsychotic medications. Residents that are on psychotropic medications will have a GDR attempted per physician's order or will have appropriate documentation indicating why the GDR is	

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	standards of practice." No discussion was documented of how the physician determined this, or what information he based his decision on. On 2/15/13 an, " ASC (American Senior Communities) Request for Gradual Dose Reduction," indicated the following: "The resident is receiving the medication : Seroquel XR 150 mg. Supporting Diagnosis : Insomnia. Behaviors exhibited in past three months : None - Resident has been sleeping well through the night..." An "x" on the record marked the explanation, "Receiving optimal dose that benefits the resident's function and activities of daily living, continued use is in, accordance with relevant standards of practice." A signature by the attending physician was dated 2/18/13. A request by the Consulting Pharmacist on 4/7/2013 indicated, " This resident has been taking: Mirtazapine 15 mg daily at bedtime for appetite / anxiety / depression since April 2012 (annual review). Please consider a gradual dose reduction at this time,..." The physician responded on 4/16/13 by marking an "x" on the record indicating, "Receiving optimal dose that benefits the resident's function		contraindicated by reviewing Pharmacy recommendations. SSD/MCF/Designee will review the documentation weekly for residents receiving antipsychotic medications to ensure behaviors are identified and documented to support the use of medication. MONITOR: To ensure compliance, SSD and/or MCF is responsible for completion of the Behavior Management CQI audit tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	and activities of daily living, continued use is in, accordance with relevant standards of practice." No discussion was documented of how the physician determined this, or what information he based his decision on. A request on 4/12/13 by ASC for a gradual dose reduction indicated, "The resident is receiving the medication: Mirtrazapine (sic) 15 mg. Supporting Diagnosis: Appetite / Depression. Behaviors exhibited in past three months 3/20/13 PHQ-9 score = 05/27 indicating few signs / symptoms of depression." An "x" on the record was marked with the explanation, "Receiving optimal dose that benefits the resident's function and activities of daily living, continued use is in accordance with relevant standards of practice." A signature by the attending physician was dated 4/16/13. During an interview on 12/05/13 at 2 P.M., the Memory Care Program Facilitator, indicated she was being oriented to her role and would be involved in the monitoring for behaviors and gradual dose reductions in the future. She could not comment on the reasoning for not following the gradual dose reduction recommendations in the past.			

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	Behavior monitoring flowsheets, provided by the Director of Nursing, indicated there were no problem behaviors in the past three months for Resident #63. The behaviors listed as being monitored included, but were not limited to: "Resident is resistant to care as evidenced by refusing meds and treatment. Resident is verbally / physically aggressive with staff during care." There were no episodes of these behaviors marked as occurring. 2. Resident #70's record was reviewed on 12/6/13 at 11:06 A.M. Diagnoses included, but were not limited to, vascular dementia with delusions, Alzheimer's disease, coronary vessel artherosclerosis, cerebrovascular disease, and depression. The resident's physician orders included, but were not limited to: 6/21/13 Sertraline 50 milligrams (mg) take 1 and 1/2 tablets (75 mg) by mouth daily. 9/12/13 risperidone 0.25 mg by mouth daily for dementia with delusions. A Consultant Psychiatrist's note dated 9/22/13, indicated the resident had			

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	shown significant improvement with his hypersexuality and wandering. His Risperdol was decreased on 9/12/13 from 0.5 mg to 0.25 mg. The notes indicated his appearance was disheveled, his mood was anxious and irritable due to not being able to hear the questions he was being asked because he was hard of hearing, his thought processes was illogical and scattered, affect was labile (flat), he was having paranoid delusions without hallucinations. The resident's quarterly Minimum Data Set (MDS) assessment, dated 8/30/13, indicated the resident was cognitively impaired. A care plan dated 02/11/2013 addressed a problem Behavior: Resident exhibits episodes of being combative towards staff as evidence by hitting, scratching, kicking, cursing, and yelling, usually during periods of refusing care (ADL's and meds). The approaches included, but were not limited to: 1. 10/14/13 Check for unmet needs such as hunger, thirst, etc. 2. 02/11/13 Behavior: the resident exhibits episodes of being combative towards staff as evidenced by hitting, scratching, kicking, cursing, and			

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	yelling, usually during periods of refusing care (ADL's and meds). 3. 02/11/2013 Allow the resident time to calm down and approach him later. 4. 02/11/2013 Alternate staff when providing care for the resident during episodes of aggression. A care plan entry dated 09/23/2013, addressed a problem of the resident is at risk for side effects of psychotropic medications. The approaches included, but were not limited to: 1. 09/23/2013 Dose reductions as able. 2. 09/23/2013 Medications to be given as ordered. 3. 09/23/2013 Doctor to be notified as needed. 4. 09/23/2013 observe for side effects of medications. A care plan entry dated 08/20/2013 addressed a problem of the resident had sad facial expressions related to depression. The approaches included, but were not limited to: 1. 08/20/2013 Ask the resident open-ended questions that encourage him to express himself. 2. 08/20/2013 Attempt to identify any			

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	situational causes for sadness. 3. 08/20/2013 Eliminate the cause if possible. 4. 08/20/2013 Interact with the resident during care and activities. A document titled, "Behavior Flowsheet," dated 10/1/2013-10/31/2013 indicated the following behaviors were being monitored by the staff: 1. Behavior: Resident exhibits episodes of physical/verbal aggression towards staff. 02/11/2013. Interventions included, but were not limited to and indicated: Intervention #1 The staff will allow resident time to calm down and will reapproach later. 02/11/2013. Intervention #2 The staff will alternate when they provide care for the resident during episodes of aggression. 02/11/2013. Intervention #3 The staff will offer the resident a snack during episodes of aggression. 02/11/2013. 2. Behavior: Resident was resistive to care at times. 05/24/2013.			

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	Interventions included, but were not limited to and indicated: Intervention #1 The staff would reapproach the resident at a later time. 05/24/2013. Intervention #2 The staff would be rotated. 05/24/2013. Intervention #3 The staff would offer the resident a snack when he refused care. 05/24/2013. 3. Behavior: Resident makes sexually inappropriate comments towards peers and staff at times during masturbation. 06/04/2013. Interventions included, but were not limited to and indicated: Intervention #1 The resident would be separated from others when he made sexually inappropriate comments. 06/04/2013. Intervention #2 The resident would be reminded that it was inappropriate to make sexual comments to others in the facility. 06/04/2013. Intervention #3 The resident would be redirected to independent activity such as reading a magazine or			

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	listening to music when he begins making sexually inappropriate comments towards others. A document titled, "Behavior Flowsheet" dated 12/1/2013-12/31/2013 indicated the following behaviors were being monitored by the staff: 1. Behavior: Resident exhibits episodes of physical/verbal aggression towards staff. 02/11/2013. Interventions included, but were not limited to and indicated: Intervention #1 The staff will allow resident time to calm down and will reapproach later. 02/11/2013. Intervention #2 The staff will alternate when they provide care for the resident during episodes of aggression. 02/11/2013. Intervention #3 The staff will offer the resident a snack during episodes of aggression. 02/11/2013. 2. Behavior: Resident is resistive to care at times. 05/24/2013. Interventions included, but were not			

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	limited to and indicated: Intervention #1 The staff would reapproach the resident at a later time. 05/24/2013. Intervention #2 The staff would be rotated. 05/24/2013. Intervention #3 The staff would offer the resident a snack when he refused care. 05/24/2013. There were no monitoring systems found to monitor the resident for signs or symptoms of depression, adverse effects of the antidepressant or antipsychotic medication or for the monitoring of the resident's delusions. A policy titled "Social Services Matrix Behavior Program" undated and deemed current, stated, "Behavior care plans...There are prompts under each section i.e. under problem it will state Behavior: (Give a detailed description of the behavior...The flow sheet will target 1-3 behaviors that have been identified as associated with a medication or otherwise in need of quantification. The flow sheets will be kept on the MARs. All staff should be inserviced to inform the nurse when a behavior occurs so that he/she can record it on the flow			

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	sheet or New/Worsening Behavior Event as appropriate...." During an interview on 12/6/13 at 3:18 P.M., the Social Service Director (SSD) indicated the resident was placed on Risperidol for dementia with delusions. She indicated his delusions were that he talked to people that were not there and those kinds of "behaviors". She indicated she used the term behavior and mood interchangeably. She indicated he was resistive to care, and physically and verbally aggressive to staff. She indicated the behavior sheets in the Medication Administration Records were the behaviors she was monitoring him for presently. She indicated he was on Zoloft (antidepressant) for depression and he had care plans in place for this medication. She indicated there are no monitoring log in place for the antidepressant other than nursing monitoring him for signs and symptoms of depression. She indicated she reviews the progress notes daily and on Mondays for the weekend behaviors to monitor whether residents were having behaviors. During an interview on 12/10/13 at 4:06 P.M., LPN #3 indicated she did			

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	not have a monitoring system in place to monitor for signs and symptoms of depression or for adverse reactions of antidepressants or antipsychotics. 3.1-48(a)(3) 3.1-48(b)(2)			

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview and record review, the facility failed to ensure foods were dated and labeled properly, a kitchen appliance was cleaned, and dented cans were removed from stock, for 1 of 1 kitchens observed for sanitation and food storage. This deficit practice had the potential to affect 88 residents out of 94 residents in the facility. Findings include: A tour of the kitchen was conducted on 12/2/13 at 9:55 A.M., with the Dietary Manager and the Consultant Registered Dietician (RD) in attendance. 1. The walk-in cooler was observed with 12 clear plastic dessert dishes with brown colored, shriveled frozen substances with ice crystallization formed on them. The dessert dishes were partially covered with plastic wrap. The substance did not have a	F000371	The facility will make every reasonable effort to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and service food under sanitary conditions. CORRECTIVE ACTION: 1. The items in the walk-in cooler that were not label were discarded upon discovery. 2. The dented cans were discarded upon discovery. 3. The convection oven was cleaned immediately upon discovery. IDENTIFICATION OF OTHER RESIDENTS AT RISK: All residents are potentially affected; however no other residents were identified. RD with the Dietary Manager inspected the walk-in cooler to ensure all items were labeled, inspected the dry storage room to ensure that there were no dented cans and inspected the kitchen appliances to ensure cleanliness. MEASURES/SYSTEMATIC CHANGES:Re-education regarding food storage and kitchen sanitation specifically labeling of foods/beverages removed from the original	01/09/2014

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	label or a "Date prepared" on them. Another serving tray was observed with one clear plastic dessert dish with white colored, shriveled frozen substance with ice crystallization formed on it. The dish was not covered. There was no label or a"Date prepared" on it. During an interview, at this time the Dietary Manager indicated the brown substances were chocolate ice creams and the white substance was vanilla ice cream. She indicated the ice creams were leftovers that had been in the walk-in cooler since last week, and they should have been thrown out already. She indicated the ice creams did not have labels or prepared dates on them. 2. Three dented cans were observed on the shelves in the dry storage room. The Dietary Manager removed one dented can of baked beans and two dented cans of cherry pie filling. During an interview, at this time the Dietary Manager indicated the staff member assigned to place dry stock away would set the dented cans aside to be thrown away. 3. The convection oven was		container and the disposal of dented cans and cleaning the oven was conducted for dietary staff by the Dietary Manager. The Dietary Manager/Designee will complete a sanitation survey of the kitchen on a daily basis which includes ensuring items in the walk-in cooler are labeled, ensuring the integrity of cans delivered by vendor and cleanliness of kitchen appliance. MONITOR: To ensure compliance, Dietary Manager is responsible for completion of the Kitchen Sanitation CQI audit tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the ED will review the results of these audits.If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	observed to have had brown dried debris on both of the upper and lower glass doors and on the ledge of the upper and lower ovens where the doors open and close. During an interview, at this time the Dietary Manager indicated the ovens had debris stuck on the doors of the upper and lower ovens and the ledges. She indicated the ovens were cleaned weekly on Wednesdays. A policy titled "Food Storage" and deemed current with a revised date of 7/2011, was provided by the Dietary Manager on 12/6/13 at 3:20 P.M. The policy stated, "POLICY... PROCEDURE...5. Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods...14. Leftover prepared foods are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the produce, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 F or less for no more than 3 days. The day the food was prepared shall be counted as Day 1...."			

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	3.1-21(g)(3)			