

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2014
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 8, 9, 10, 13, 14, 15, 16, and 17, 2014</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Survey team: Virginia Terveer, RN TC (January 8, 9, 10, 13, 14, 15 and 16, 2014) Sue Brooker, RD Julie Call, RN Martha Saull, RN</p> <p>Census bed type: SNF/NF: 114 Residential: 34 Total: 148</p> <p>Census payor type: Medicare: 14 Medicaid: 78 Other: 56 Total: 148</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 23,</p>	F000000	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. WE ARE ALSO FAXING AND MAILING ADDITIONAL SUPPORTIVE DOCUMENTATION. WE HAD SOME DIFFICULTY UPLOADING THE DOCUMENTS. IF YOU HAVE ANY QUESTIONS REGARDING THE ADDITIONAL SUPPORTIVE INFORMATION, PLEASE CONTACT THE ADMINISTRATOR.</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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F000223 SS=D	<p>2014 by Randy Fry RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident did not experience abuse for 1 of 3 allegations of abuse reviewed. Resident #10</p> <p>Findings include:</p> <p>On 1/13/14 at 10:40 A.M., Resident #10 was interviewed. She indicated a CNA (Certified Nursing Assistant) had told her to "shut up" and called her "a liar." Resident #10 indicated she had talked to the Social Worker and Administrator about the incident and things were better now as the CNA no longer worked on the hall Resident #10 resided on. Resident #10 indicated the alleged incident had occurred "about a month ago."</p>	F000223	F223The facility promotes the resident's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Corrective action for residents affected: Resident #10 – As stated in the alleged citation, the resident informed the survey team that the facility acted upon her concern and removed CNA #12 from her hall. The surveyor also indicated in the alleged citation the resident told him/her that "things were better now". The facility immediately suspended CNA #12 after Resident #10 reported the incident to Social Services. The facility reported the allegation of abuse to the Long Term Care Division of ISDH within 24-hours after the Administrator was notified of the incident, which is in accordance	02/16/2014	

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	<p>On 1/14/14 at 11:05 A.M., the Administrator was interviewed. He indicated on 12/31/13, the Social Worker had made him aware of the allegation of verbal abuse , which involved Resident #10 and CNA #12. At the time, he provided documentation of the investigation of the incident. The documentation included, but was not limited to, the following: "On 1/1/14 at approximately 9:40 A.M....the Administrator asked (Resident #10) if she had recent problems with the staff providing her care. She stated "No." The Administrator then told (Resident #10) he had spoken with the (name of Social Service Director) and that he had been told she had a complaint about one of the CNA's telling her to "shut up." (Name of Resident #10) said "Oh yes, that happened months ago...On 1/1/14 at approximately 11:10 A.M., (Resident #10) came to the administrator's office. She stated that she had been sitting in her room and she remembered about two weeks ago...she had requested that a staff CNA take her to the toilet. She said the CNA refused and told her she would have to wait...She further stated that this delay...caused her to be incontinent of bowel in her clothing. Per her statement this was very embarrassing to her..." He indicated an investigation had been</p>		<p>with 410 IAC 16.2-3.1-13(g)(1) and with the ISDH Division of Long Term Care Policy and Procedure – Reportable Unusual Occurrences (effective 11/15/97, revised 11/20/01, 11/3/05, 1/25/06). The facility conducted a thorough investigation in accordance with regulatory requirements and facility policy, was unable to substantiate the allegation of abuse, but did make staffing assignment changes and provided additional training for CNA #12 on the abuse policy, residents rights, treatment of residents, customer service, etc., as prudent corrective action. This training record was shown to surveyor. The facility believes appropriate corrective actions have been taken for this occurrence. Other residents having the potential to be affected and corrective actions:All residents have the potential to be affected by this deficient practice.. Mandatory training / in servicing has been provided to staff members regarding the updated facility abuse prohibition policy SEE Attachment J1, identifying abuse, reporting of abuse, resident treatment, etc. SEE Attachments J2 and J3. Any allegation of abuse will be immediately reported to ISDH per our abuse prohibition policy. Social Services and/or Designee will conduct resident satisfaction interviews on a monthly basis; interviewing 1/3 of</p>				

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	<p>started immediately and after a thorough investigation of the allegation, the facility had not been able to substantiate the allegation of abuse. The Administrator indicated the CNA involved no longer worked on the unit Resident #10 resided on.</p> <p>On 1/14/14 at 2:20 P.M., the Administrator was interviewed. He indicated Resident #10 was alert and oriented. At the time, the Administrator provided a current copy of the facility policy and procedure for "Abuse Prohibition." This policy and procedure was dated 11/15/13 and included, but was not limited to, the following: "It is the intent of Lutheran Life Villages to maintain an abuse-free environment for the residents entrusted in our care. It is our policy to assure that all residents are free from verbal...abuse...Verbal abuse is defined as any use of oral...language that willfully includes disparaging and derogatory term to residents...to describe residents..."neglect" is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish..."</p> <p>3.1-27(b)</p>		<p>the interviewable residents each month for the next 3 months and quarterly thereafter. Resident concerns identified as abuse per policy will be noted on our resident concern form SEE Attachment J4 and will be addressed immediately per our resident abuse prohibition policy.Measures to ensure practice does not recur:Facility policy addressing abuse prevention and reporting has been revised and approved. Facility staff has received additional training on actions that could be deemed as abuse, as well as employee responsibility to report any observations or reports of potential abuse to the Administrator immediately. Staff was informed that the facility maintains a zero tolerance policy regarding abuse, and that immediate disciplinary action up to and including termination if abuse is substantiated will be strictly enforced. This corrective action will be monitored by:The results from our resident interviews will be reviewed in our monthly Social Services Meeting as well as in our quarterly QA meeting. Administrator to monitor for compliance.</p>		

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other</p>			

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	<p>officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report immediately an allegation of abuse to the state agency for 1 of 3 allegations of abuse reviewed. Resident #10</p> <p>Findings include:</p> <p>On 1/14/14 at 11:05 A.M., the Administrator provided a copies of the facility's investigation of three allegations of abuse. The information included, but was not limited to, the following:</p> <p>1. On 12/31/13 at approximately 3:30 P.M., the facility Administrator was notified by Social Services that Resident #10 stated that approximately two weeks ago, a CNA (Certified Nursing Assistant) had been rude to her, that she had called her a "liar" and told her to "shut up." The accused CNA was placed on administrative leave and an investigation was immediately begun. The copy of the "Indiana State Department of Health, Health Care Quality and Regulatory Commission Incident Report Form, indicated a fax was sent to the state agency on 1/1/14 at 1:12 P.M., which</p>	F000225	F225The facility does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents of misappropriation of their property...The facility ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately, are investigated, and results of investigations are reported in accordance with state law. Corrective action for residents affected: Resident #10 – As stated in the alleged citation, the facility immediately suspended CNA #12 after Resident #10 reported the incident to Social Services. The facility reported the allegation of abuse to the Long Term Care Division of ISDH within 24-hours after the Administrator was notified of the incident, which is in accordance with 410 IAC 16.2-3.1-13(g)(1) and with the ISDH Division of Long Term Care Policy and Procedure – Reportable Unusual Occurrences (effective 11/15/97, revised 11/20/01, 11/3/05, 1/25/06). The	02/16/2014			

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	<p>included the initial report of the allegation.</p> <p>On 1/14/14 at 2:20 P.M., the Administrator was interviewed. He indicated he started employment at the facility on 12/30/13 so was not at the facility when the 12/14/13 incident occurred. He indicated that he did report the incident, which occurred on 12/31/13 to the state agency on 1/1/14 at 1:12 P.M. The Administrator indicated he was not aware he had to report the allegations of abuse to the state agency immediately.</p> <p>At the time, the Administrator provided a current copy of the facility policy and procedure for "Abuse Prohibition." This policy and procedure was dated 11/15/13 and included, but was not limited to, the following: "It is the intent of Lutheran Life Villages to maintain an abuse-free environment for the residents entrusted in our care...There will be seven components of abuse prohibition...6. reporting/response...Reporting/Response: All suspected or alleged incidents of abuse will be reported to the Indiana State Department of Health, Local Ombudsman and Adult Protective Services."</p> <p>3.1-28(c)</p>		<p>facility conducted a thorough investigation in accordance with regulatory requirements and facility policy, was unable to substantiate the allegation of abuse, but did make staffing assignment changes and provided additional training for CNA #12 on the abuse policy, resident's rights, treatment of residents, customer service, etc., as a prudent corrective action. The facility believes appropriate corrective actions have been taken for this occurrence. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this deficient practice. Mandatory training / in servicing has been provided to staff members regarding the updated facility abuse prohibition policy SEE attachment J1; identifying abuse, reporting of abuse, resident treatment, etc., SEE attachment J2 and J3. Any allegation of abuse will be immediately reported to ISDH per our abuse prohibition policy. Social Services and/or Designee will conduct resident satisfaction interviews on a monthly basis; interviewing 1/3 of the interviewable residents each month for the next 3 months and quarterly thereafter. Resident concerns identified as abuse per policy will be noted on our resident concern form, SEE attachment J4 and will be addressed immediately per our</p>				

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the facility	F000226	resident abuse prohibition policy.Measures to ensure practice does not recur:Facility policy addressing abuse prevention and reporting has been revised to ensure it reflects all current federal and state requirements. Facility staff has received additional training on actions that could be deemed as abuse, as well as employee responsibility to report any observations or reports of potential abuse to the Administrator immediately. The urgency of immediate reporting was stressed. Staff was informed that the facility maintains a zero tolerance policy regarding abuse, and that immediate disciplinary action up to and including termination if abuse is substantiated will be strictly enforced. This corrective action will be monitored by:The results from our resident interviews will be reviewed in our monthly Social Services Meeting as well as in our quarterly QA meeting. Administrator to monitor for compliance. F226The facility developed and implemented written policies and	02/16/2014	

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	<p>abuse policy and procedure indicated the facility was to notify the state agency immediately of an allegation of abuse.</p> <p>Findings include:</p> <p>On 1/14/14 at 2:20 P.M., the Administrator was interviewed. He indicated the facility had just updated the abuse policy and procedure on 11/15/13. He indicated he had started employment at the facility on 12/30/13. The Administrator indicated he was not aware he had to report allegations of abuse to the state agency immediately.</p> <p>At the time, the Administrator provided a current copy of the facility policy and procedure for "Abuse Prohibition." This policy and procedure was dated 11/15/13 and included, but was not limited to, the following: "It is the intent of Lutheran Life Villages to maintain an abuse-free environment for the residents entrusted in our care...There will be seven components of abuse prohibition...6. reporting/response...Reporting/Response: All suspected or alleged incidents of abuse will be reported to the Indiana State Department of Health, Local Ombudsman and Adult Protective Services."</p> <p>Documentation was lacking in the current</p>		<p>procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies reflect Indiana State Administrative Code 410 IAC 16.2-3.1-13(g)(1).Corrective action for residents affected:There were no residents identified as being affected by the alleged deficit action in the citation. Facility policy regarding abuse and reporting to ISDH at the time of the survey did reflect requirements at 410 IAC 16.2-3.1-13(g)(1) and with the ISDH Division of Long Term Care Policy and Procedure – Reportable Unusual Occurrences (effective 11/15/97, revised 11/20/01, 11/3/05, 1/25/06). The survey team informed the Administrator that abuse must be reported immediately to the Long Term Care Division of ISDH; however, they were unable to produce any written statutory or regulatory changes in Indiana Code, Indiana Administrative Code, or changes in the aforementioned ISDH division of Long term Care Policy and Procedure to substantiate the need to report immediately rather than within 24 hours after the Administrator has been notified of any allegation of abuse. Other residents having the potential to be affected and corrective actions:All residents have the potential to be affected by this deficient practice.. Mandatory</p>				

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	abuse policy and procedure regarding the time frame to notify the state agency of an allegation of abuse. 3.1-28(a)		training / in servicing has been provided to staff members regarding the updated facility abuse prohibition policy SEE Attachment J1, identifying abuse, reporting of abuse, resident treatment, etc., See Attachments J2 and J3. Any allegation of abuse will be immediatley reported to the ISDH per our abuse prohibition policy. Social Services and/or Designee will conduct resident satisfaction interviews on a monthly basis; interviewing 1/3 of the interviewable residents each month for the next 3 months and quarterly thereafter. Resident concerns identified as abuse per policy will be noted on our resident concern form J4, and will be addressed immediatelyper our resident abuse prohibition policy.Measures to ensure practice does not recur:Facility policy addressing abuse prevention and reporting has been revised to ensure it reflects all current federal and state requirements. Facility staff has received additional training on actions that could be deemed as abuse, as well as employee responsibility to report any observations or reports of potential abuse to the Administrator immediately. The urgency of immediate reporting was stressed. Staff was informed that the facility maintains a zero tolerance policy regarding abuse, and that immediate disciplinary		

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to assess and treat 1 resident (Resident #90) diagnosed with diabetes mellitus and suffering from low blood sugars according to facility protocol. This deficient practice resulted in a severe hypoglycemic reaction and subsequent hospitalization.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #90 on 1/14/14 at 8:48 a.m., indicated the following: diagnoses included, but were not limited to, CVA (cerebrovascular accident), hx (history) of CVA, COPD</p>	F000309	<p>action up to and including termination if abuse is substantiated will be strictly enforced. This corrective action will be monitored by: The results from our resident interviews will be reviewed in our monthly Social Services Meeting as well as in our quarterly QA meeting. Administrator to monitor for compliance.</p> <p>The facility requests a face to face Informal Dispute Resolution for F309. We respectfully disagree with the deficient practice statement and we disagree that our staff caused harm through care practices. We request F309 to be stricken from form CMS 2567. Additional, supportive documentation will be faxed and mailed today. The facility provides all 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 Corrective action for residents affected: Resident #90</p>	02/16/2014

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	<p>(chronic obstructive pulmonary disease), diabetes mellitus, and hypertension.</p> <p>Admission physician orders for Resident #90, dated 11/26/13, indicated the following: Metformin HCL (oral diabetes medication) 850 mg (milligrams) TID (three times a day) with meals; Humalog insulin at HS (hour of sleep) with the sliding scale of: 2 units for blood sugars of 100-150 mg/dl (milligrams per deciliter), 4 units for blood sugars of 150-200 mg/dl, 6 units for blood sugars of 201-250 mg/dl, 8 units for blood sugars of 251-300 mg/dl, and 10 units for blood sugars of 300 mg/dl and above; Humalog insulin TID before meals with the sliding scale: 2 units for blood sugars of 100-150 mg/dl, 4 units for blood sugars of 151-200 mg/dl, 6 units for blood sugars of 201-150 mg/dl, 8 units for blood sugars of 251-300 mg/dl, 10 units for blood sugars of 300 mg/dl and above; and accucheck QID(four times a day) before meals and at HS.</p> <p>A physician order for Resident #90, dated 11/27/13, indicated to discontinue Humalog insulin and to start Novolog insulin with the same sliding scale.</p> <p>An assessment for Resident #90, dated 12/4/13 and written by the Nurse Practitioner, indicated her blood sugars</p>		<p>was transferred to an acute care emergency department immediately after her condition deteriorated. As stated in the alleged citation, nursing staff monitored the resident's condition very closely on 1/8/14 from 9:56am when the resident first reported not feeling well through 12:36pm when emergency medical personnel arrived at the facility. Nursing staff notified the nurse practitioner in a timely manner of nursing assessment findings during the aforementioned time frame, and implemented orders received. Nursing staff notified the resident's daughter of the condition change in a timely manner. Resident #90 was admitted to the hospital on 1/8/14 with a primary diagnosis of Severe Sepsis with Septic Shock. Other residents having the potential to be affected and corrective actions: All residents who demonstrate a low blood sugar have the potential to be affected by this deficient practice. The facility is monitoring resident condition changes including any low blood sugar results obtained through routine or random capillary blood glucose testing. No other residents have been identified to be affected by the alleged deficit practice, thus the facility is unable to provide any additional corrective actions taken. The facility has put prevention measures in place as</p>				

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	<p>routinely averaged between 92 mg/dl to 209 mg/dl, with an average of 127 mg/dl. The assessment also indicated to discontinue the insulin coverage and to continue to monitor her blood sugars.</p> <p>A physician order for Resident #90, dated 12/4/13, indicated to discontinue coverage, but to continue accuchecks ac (before meals) and HS.</p> <p>A Nurse Practitioner Progress Note for Resident #90, dated 12/16/13, indicated nausea during the past 3-4 months.</p> <p>A physician order for Resident #90, dated 12/18/13, indicated to discontinue accuchecks, may do PRN (as needed). Review of the vital signs section in her clinical record indicated no PRN blood sugars had been recorded since 12/18/13.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 12:04 a.m., indicated a chronic pain level of 0 out of 10 and an acute pain level of 0 out of 10.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 12:07 a.m., indicated her respirations were 18 per minute, a pulse oximeter of 97%, respirations even and unlabored, nail beds pink, no edema, and pulses equal bilaterally.</p>		<p>stated below. Measures to ensure practice does not recur: Facility policy related to hypoglycemia has been revised and approved. The policy reflects current evidence-based practice related to appropriate nursing interventions when low capillary blood glucose results are obtained. Licensed nursing staff has received intensive training on the current policy. Evaluation of learning was accomplished through a written test. The approved policy and hypoglycemia protocol is available for easy reference on all nursing units. This corrective action will be monitored by: Unit Coordinators and Shift Supervisors are primarily responsible for monitoring resident condition changes through oral and written communication with licensed nursing staff on all assigned units throughout their tour of duty. These nursing supervisors are alerted when hypoglycemic reactions are identified, and it is their responsibility to ensure facility policies and protocols are followed. This has been, and will continue to be the facility-wide plan to monitor the alleged deficit practice. Additional monitoring will be accomplished through Quality of Care and 24-hour report audits. Unit Coordinators or designees will review 24 Reports daily Monday through Friday for condition changes related to low</p>		

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	<p>A Progress Note for Resident #90, dated 1/8/14 at 12:10 a.m., indicated her pupils were equal and reactive to light, she moved her extremities, her pedal pulses were equal, her respirations were even and unlabored, and she was responsive to verbal stimuli.</p> <p>A Dietary Progress Note for Resident #90, dated 1/8/14 at 9:00 a.m., indicated the resident had vomited the day before and did not accept lunch or supper.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 9:56 a.m., indicated she was not feeling well with a complaint of abdominal pain. The note also indicated emesis (vomit) was on the bed and dried on the floor. Vital signs were, blood pressure of 157/102, pulse of 95, respirations of 20 per minute, and temperature of 96.8 degrees were noted and her oral mucosa was pink and moist. The note further indicated her blood pressure was elevated, but the resident had refused her blood pressure medicine the day before. The note also indicated the resident attempted to take all her medications, except for the glucophage, with small sips of water, but immediately vomited the pills and water into the trash can. The note indicated the resident was lethargic and refused to be cleaned up by aide. The note further indicated the</p>		<p>CBG results. Any applicable resident's clinical record will then be audited to ensure facility hypoglycemia protocol was followed. Any non-compliance found will be addressed immediately and reported to the Director of Nursing. Trends in audit results will be reported to the QA Committee. Additional corrective actions will be developed by the committee as deemed necessary. Completion Date February 16, 2014</p>		

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	<p>writer informed the resident the Nurse Practitioner would be notified. The note indicated the Nurse Practitioner was notified and a new order was received to start Phenergan every 4 hours PRN for nausea and vomiting. The Nurse Practitioner did not give any new orders related to Resident #90's increased blood pressure, stating she would see her when she was on the floor where she resided.</p> <p>A physician order for Resident #90, dated 1/8/14 at 10:00 a.m., indicated to give glucagon for low blood sugar <50 mg/dl and to give glucogel for low blood sugar <60 mg/dl if not able to swallow.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 10:12 a.m., indicated the resident's family member was called to the facility.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 11:04 a.m., indicated her family member was in the facility. The note also indicated Resident #90's breathing was shallow and labored with respirations at 22 and a blood pressure of 101/99. No emesis was noted at the time. The note further indicated a new order was received by the Nurse Practitioner for STAT (immediate) labs.</p> <p>A physician order for Resident #90, dated</p>			

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	<p>1/8/14 at 11:05 a.m., indicated a STAT BNP (Brain Natriuretic Peptide), a STAT CMP (Comprehensive Metabolic Panel), a STAT CBC (complete blood count), accuchecks ac and HS x 1 week, and to give glucagon for low blood sugar.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 11:23 a.m., indicated she had a blood sugar reading of 58 mg/dl and glucose was administered. The note also indicated the resident was requesting ice water. She took a few sips and had emesis.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 11:30 a.m., indicated she had a blood sugar of 49 mg/dl. The note also indicated the resident was unresponsive. The note further indicated glucagon was administered.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 11:45 a.m., indicated she had a blood sugar of 41 mg/dl. The note also indicated the Nurse Practitioner was notified. The note did not indicate additional glucose had been administered.</p> <p>A physician order for Resident #90, dated 1/8/14 at 11:55 a.m., indicated to recheck her blood sugar in 30 minutes, if lower than 45 mg/dl send to ER (emergency</p>			

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	<p>room) to evaluate and treat, if higher than 45 mg/dl give glucogel until blood sugar was at 70 mg/dl.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 12:16 p.m., indicated resident's family member was updated on resident's condition and verbalized understanding after explanation of CBC, BMP and CMP all ordered STAT, and accucheck to be done ac and HS for 1 week.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 12:25 p.m., indicated a blood sugar of 39 mg/dl. The note also indicated the resident was crying out in pain. The note further indicated the resident was agreeing to go to the ER. The note did not indicate additional glucose had been administered.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 1:58 p.m., indicated 911 was called. Oxygen was placed per nasal cannula for nursing measure. The note also indicated vital signs were attempted but the resident was calling out in pain, rocking back and forth. The note did not indicate additional glucose had been administered.</p> <p>A Progress Note for Resident #90, dated 1/8/14 at 2:08 p.m., indicated Resident #90 was sent to the hospital and the</p>			

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	<p>STAT labs were canceled.</p> <p>A late entry Progress Note for Resident #90, dated 1/8/14 at 3:05 p.m., indicated her skin turgor was checked, tinting (sic) noted, and eyes sunken.</p> <p>A report from the ambulance company, provided by the Corporate Nurse on 1/15/14 at 1:00 p.m., indicated the call was received from the facility on 1/8/14 at 12:26 p.m. and the ambulance arrived at the facility at 12:36 p.m. The report also indicated they arrived on the scene to hear Resident #90 screaming down the hallway. Staff reported the resident woke up from sleeping and started screaming saying her side hurt. Staff tried to get her to take medication and she was unable to keep them down. Staff stated she had not eaten or kept anything down in days. When checked her blood sugar was 39 mg/dl. Staff tried to get her to take oral glucose and was not able to get her to keep it down. Staff then gave her 3 mg glucagon. The report further indicated Resident #90 was found sitting up screaming and rocking back and forth. They attempted to communicate with patient, however she would not respond to responders and was unable to be understood. The report also indicated attempts were made to check her blood sugar but the meter read "error" several</p>						

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	<p>times. An attempt was made to use the facility meter but it was not working as well. At 1:42 p.m., the ambulance had arrived at the hospital ER.</p> <p>A hospital report for Resident #90, dated 1/8/14, indicated she arrived in the ER unresponsive to painful stimuli. The report also indicated she was admitted in critical condition with a guarded prognosis.</p> <p>A facility care plan for Resident #90, with a start date of 11/26/13, indicated the problem area of diabetic alert. Approaches to the problem included, but were not limited to, diet as ordered, meds as ordered, labs as ordered, monitor for signs/symptoms of hypo/hyperglycemia, glucose scan as ordered, if blood sugar <70 mg/dl give simple carbohydrates orally or give 1 tube glucose gel, and if unable or unwilling swallow give Glucagon 1 mg IM (intramuscular).</p> <p>A family member of Resident #90 was interviewed on 1/9/14 at 11:21 a.m. During the interview she indicated she was called into the facility on 1/8/14 when resident became ill. She also indicated resident was up in a chair in the lounge area when she arrived due to vomiting in her room. She indicated resident had been experiencing nausea</p>			

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	<p>and vomiting and was not eating. The family member indicated resident did not look well, was experiencing labored breathing, and did not recognize her. She indicated she requested her blood sugar be checked due to resident previously receiving insulin and now receiving the oral medication of Metformin for her diabetes. The family member further indicated her blood sugar was checked by staff and was low. Resident was given something for her low blood sugar, but her blood sugar kept dropping. The family member also indicated resident then began screaming due to pain. The EMS was called and resident was admitted to the hospital in critical condition.</p> <p>Registered Nurse #1 was interviewed on 1/14/14 at 9:44 a.m. During the interview she indicated on 1/8/14, Resident #90 was not feeling well in the morning. The Nurse Practitioner was notified and STAT labs were ordered. She also indicated before the labs could be drawn, Resident #90 began to experience extreme pain and was immediately sent to the ER and admitted to the hospital. She further indicated Resident #90 had not been eating well and refused to take her medication at times.</p>			

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	<p>The Corporate Nurse was interviewed on 1/15/14 at 10:30 a.m. During the interview she indicated blood sugar levels should be documented in the progress notes for each resident.</p> <p>The Corporate Nurse was interviewed on 1/15/14 at 11:40 a.m. During the interview she indicated it was not automatically indicated to check the blood sugar of a resident who was not feeling well. She also indicated the nurse who took care of Resident #90 on 1/8/14, checked her blood sugar every 15 minutes according to facility policy on hypoglycemia until the order was received by the Nurse Practitioner to check her blood sugar after 30 minutes. She further indicated staff should have continued to follow the facility policy to check blood sugars every 15 minutes according to facility policy.</p> <p>The Nurse Practitioner was interviewed on 1/15/14 at 2:00 p.m. During the interview she indicated she had received a telephone call concerning the low blood sugar of Resident #90. She also indicated the resident was given glucose at 11:23 a.m., but had vomited. She further indicated she gave instructions to give Resident #90 glucose by another route and to re-check her blood sugar in 30 minutes. She indicated if Resident #90</p>			

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	<p>had not been sent to the ER, she had planned to see her but had not been able to, due to the events happening so quickly. The Nurse Practitioner did not indicate why she instructed the facility staff not to re-check her blood sugar for 30 minutes after an alternative source of glucose was given.</p> <p>A current facility policy "Hyper/Hypoglycemia Treatment", revised on 8/30/06 and provided by the Corporate Nurse on 1/15/14 at 10:00 a.m., indicated "...It is the policy of this facility to identify those residents with the potentiality of exhibiting signs/symptoms of hyper/hypoglycemia and provide effective nursing management of symptomatology...Hypoglycemia (low blood sugar)...generalized muscular weakness...diaphoretic...confusion...For Hypoglycemia (low blood sugar)...check blood glucose level...If <70, provide simple carbohydrates, then call physician...Recheck blood glucose after 15 minutes...Re-treat if blood glucose if <70 mg/dl...Administer Glucagon if resident is unable or unwilling to swallow...."</p> <p>A current undated facility policy "Diabetes, Unstable or Potential for Instability", provided by the Corporate</p>			

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	<p>Nurse on 1/15/14 at 10:55 a.m., indicated "...Hypoglycemia...rapid shallow respirations...unconsciousness...low blood sugar by finger stick...Monitor the resident's blood sugar immediately at any time that the resident shows signs or symptoms of diabetic crisis (decreasing level of consciousness, signs or symptoms of infection, increasing confusion or disorientation, rapid, shallow respiration, rapid, weak pulse, warm to hot, dry, flushed skin, increased thirst, decessed skin turgor)...Report abnormalities in blood sugar to the physician immediately and provide emergency treatment as indicated or ordered...Document/describe nursing actions and intervention...describe the resident's response to nursing intervention..."</p> <p>3.1-37(a)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure safe bed siderails for 2 of 45 of residents observed for use of siderails. (Residents # 10 and # 57) Findings include:</p>	F000323	F323 The facility ensures that the resident environment remains as free of accident hazards as is possible, and that each resident received adequate supervision and assistance devices to prevent accidents. Corrective action for residents affected: The enablers observed by the survey team were immediately removed from	02/16/2014

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	<p>1. On 1/9/13 at 2:20 p.m. during observation of Resident # 57's bed's siderails, the space between the mattress and siderail appeared too large and measured 5 inches between the siderail and the mattress. The siderails on both sides of the mattress were attached to each other and were not attached to the bed frame. The siderails moved freely from side to side and up and down under the mattress. The siderails were in an up position and could not be lowered.</p> <p>An interview with LPN #2 on 1/9/14 at 3:00 p.m., indicated Resident # 57's siderails were not like any other siderails used in the facility and also indicated the facility had many different types of beds and siderails. LPN #2 indicated she did not look at the siderails on the residents' beds and also indicated she was not aware she needed to check for too large of a space between the mattress and siderail.</p> <p>An interview with the ADON on 1/9/14 at 3:30 p.m., in Resident #57's room, indicated the rails on the resident's bed were enablers and not siderails. She indicated the rails fit under the mattress and were not attached to the bed frame and indicated the rails were adjustable. She indicated the enablers needed to be closer to the mattress and would be</p>		<p>the beds of Resident #57 and #10 upon identification of the potential safety risks. The enablers were discarded, and this device model will not be utilized at the facility. Both residents were assessed to determine whether bed rails were needed to enable or enhance independent bed mobility and transfer from bed to chair. Bed frames for both residents were replaced to frames with bed rails firmly attached, and gaps between the mattress and the rails were within safe margins. Other residents having the potential to be affected and corrective actions: All residents determined to benefit from the use of bed rails have the potential to be affected by this deficient practice. As stated in the alleged citation, all occupied bed frames with bed rails attached were measured on 1/9/14. Temporary measures were put in place to ensure the gap between the mattress and the bed rails did not exceed 2.5 inches on each side. Wider mattresses were ordered and have been placed on several beds as a permanent measure to ensure the gaps between the mattress and the rails remain within safe margins. Measures to ensure practice does not recur: The enabler devices observed by the survey team were discarded and this device model will not be utilized at the facility. Licensed nursing staff received training on bed rail entrapment hazards and</p>				

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	<p>adjusted when the resident got out of bed.</p> <p>An interview with Assistant Maintenance Director on 1/9/14 at 4:40 p.m. indicated Resident #57's enablers were not attached to the bed frame and indicated the bed was to be exchanged for a bed with siderails attached to the frame.</p> <p>An interview with the Administrator on 1/9/14 at 5:05 p.m. indicated Resident #57's bed siderails were broken and the bed was replaced with siderails attached to the frame. The Administrator indicated all bed siderails would be checked in the facility today.</p> <p>A review of Resident #57's clinical records on 1/10/14 at 2:15 p.m., indicated his diagnoses included but were not limited to chronic ischemic heart disease, HTN (hypertension), cardiac pacemaker, hyperlipidemia, dementia, depression, BPH (benign prostatic hyperplasia), incontinence. Resident # 57's BIMS (Brief Interview Mental Status) score was 03, which indicated severe cognitive impairment.</p> <p>On 1/10/14 at 2:15 p.m., a review of Resident # 57's MDS (Minimum Data Set, an assessment tool for long-term care), dated 10/29/13 indicated the following: Bed Mobility and Transfers,</p>		<p>safety protocols that must be followed when a resident is determined to benefit from the use of bed rails. Evaluation of learning was accomplished through a written test. This corrective action will be monitored by: Maintenance staff or designee will complete environmental audits to ensure bed rails gaps are within safe margins every two weeks. The audits will continue at this frequency until 100% compliance is achieved and maintained for at least one calendar quarter. The Administrator or designee will review audit results and address any non-compliance immediately. Tends in audit results will be reported to the QA Committee. Additional corrective actions will be developed by the committee as deemed necessary. Completion Date February 16, 2014</p>	

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	<p>Resident #57 required extensive assistance of 1 person, did not ambulate, used wheelchair for locomotion and also indicated bed rails were not used.</p> <p>On 1/10/14 at 2:15 p.m., a review of Resident 57's Falls Risk Assessment dated on 10/30/13 indicated a score of 19, which indicated the resident was "At Risk for Falls."</p> <p>2. During observation of the siderails on residents' beds in the facility on 1/9/14 from 2:20 p.m. to 2:55 p.m., Resident #10's bed had siderails not attached to the bed frame. The bilateral side rails were attached to each other and placed under the mattress. The side rails could move up and down the bed underneath the mattress and when the siderail was pushed downward the other siderail raised up off of the bed frame.</p> <p>Observation of Resident #10's side rails on 1/10/14 at 11:30 a.m. and 2:05 p.m., the siderails were unchanged and were not attached to the bed frame. The siderails could be moved freely under the mattress.</p> <p>An interview with Resident #10 on 1/10/14 at 4:05 p.m. indicated she had the siderails for a long time and indicated her</p>			

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	<p>fingers had been pinched by the siderails in the past. The resident also indicated she used the siderails to reposition herself in bed and also indicated the rails moved around and were not stable. She indicated she was not aware if the staff had checked her siderails recently.</p> <p>An interview with the Administrator and the DON on 1/10/14 at 4:10 p.m., indicated the staff had checked all of the siderails in the facility for spacing between the siderails and the mattress and were not aware of any other siderails not attached to the bed frame.</p> <p>A review of Resident #10's clinical records on 1/13/14 at 10:00 a.m. indicated her diagnoses included but were not limited to chronic ischemic heart disease, cardiac pacemaker, diabetes mellitus Type II (adult onset), peripheral vascular disease, above knee amputation of lower limb, peripheral neuropathy, osteoarthritis, chronic airway obstruction, anemia, chronic kidney disease, obesity. Resident # 10's BIMS (Brief Interview Mental Status) score was 15, which indicated she was cognitively intact.</p> <p>On 1/13/14 at 10:00 a.m., a review of Resident # 10's MDS (Minimum Data Set, an assessment tool for long-term</p>			

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	<p>care),dated 10/4/13 indicated the following: Resident # 10 required extensive assistance of 1 person for bed mobility; extensive assistance of 2 person for transfers and did not ambulate; used wheelchair for locomotion and indicated bed rails were not used.</p> <p>On 1/13/14 at 10:00 a.m., a review of Resident 10's Falls Risk Assessment dated on 9/28/13 indicated a score of 18, which indicated the resident was "At Risk for Falls."</p> <p>An interview on 1/14/14 at 5:00 p.m. with the Administrator, indicated he could not find any manufacturer's instructions for the siderails/enablers that were on Resident # 57 and Resident #10's beds. He indicated those siderails were discarded in the trash.</p> <p>On 1/14/14 at 1:43 p.m., the DON provided the non-dated manufacturer's instruction manual for "Mounting the Half Rails" for the Zenith Beds which indicated, "...All Half Rails mount to the bed...Attach the Half Rail to the bed frame...."</p> <p>On 1/14/14 at 1:43 p.m., the DON provided the facility's Policy and Procedure for "Siderail Evaluation" dated 7/13/04, which indicated, "...To ensure</p>						

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F000406 SS=D	<p>residents are provided a safe environment and that the use of siderails is carefully assessed and monitored to protect resident rights, personal comfort , safety and assist with greater independence...."</p> <p>3.1-45(a)(1)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on interview and record review, the facility failed to ensure a Level II PASRR (Pre-admission Screening and Resident Review) assessment was completed as recommended for 1 of 1 residents reviewed for PASRR services. Resident #63</p> <p>Findings include:</p>	F000406	F406The facility provides specialized rehabilitation services as required in the resident's comprehensive plan of care. Corrective action for residents affected: Resident #63 – As stated in the alleged citation, the SSD immediately notified the local agency responsible of the need to perform the annual Level II PASRR assessment. The survey team was shown a copy of the letter sent to the agency on	02/16/2014

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	<p>On 1/15/14 at 10 A.M., the clinical record of Resident #63 was reviewed. Diagnoses included, but were not limited to, the following: severe depression with psychosis and anxiety. The resident was admitted to the facility on 10/16/12. The Level II PASRR/MI Mental Health Assessment form, dated 10/17/12 was reviewed. This form indicated the following: "Services of less intensity than specialized services: This individual needs the following mental health services...Yearly RR (record review) required." The clinical record was reviewed and documentation was lacking of an assessment having been completed for 2013.</p> <p>On 1/14/14 at 1:50 P.M., the Social Service Director (SSD) was interviewed. She reviewed the clinical record at this time. She indicated the resident should have had a record review done in 2013 as indicated on the Level II Mental Health Assessment Form. She indicated documentation was lacking of the 2013 Mental Health record review having been completed.</p> <p>On 1/15/14 at 10 A.M., the SSD was interviewed. She indicated she had notified the (name of center to perform the record review) of the lack of</p>		<p>1/14/14 requesting the assessment. Facility has continued to follow the additional recommendations on the PASARR level II. The local agency responsible for such assessments came to facility on 2-3-2014 and interviewed resident # 63. Other residents having the potential to be affected and corrective actions: All residents who need an annual Level II PASRR assessment have the potential to be affected by this deficient practice. Results of an audit for all residents in this category have been communicated to local agency responsible of the need to perform the annual Level II PASRR assessments on 1-28-2014. Measures to ensure practice does not recur: Social Services Staff were in serviced on 1-31-2014 regarding the updated policy SEE Attachment A1, on the importance of the annual Level II PASRR assessment process. The need for future PASRR Level II assessments will be reviewed in conjunction with the quarterly MDS; with necessary reviews being communicated to the local agency responsible. A Level II PASRR log, SEE attachment A2 has been created to ensure timely reviews with timely follow up. Social Services will audit this log on a monthly basis for the next 90 days and quarterly thereafter; reporting results / findings during our monthly QA</p>				

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F000431 SS=E	<p>documentation for the 2013 record review. At the time, she provided a copy of the letter she had sent to the (name of center). The letter was dated 1/14/14 and included, but was not limited to, the following: "In review of (name of Resident #63) PASRR Level II assessment, she was due for a yearly review in 2013...Thank you for your assistance in providing the yearly review for her..."</p> <p>3.1-23(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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,</p>		meeting. This corrective action will be monitored by: The results from PASRR Level II log will be reviewed in our monthly Social Services Meeting as well as in our monthly QA meeting. SSD to monitor for compliance.		

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	<p>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 the proper labeling of Over the Counter Medication and removal of expired medications from 4 of 9 medication carts observed, affecting 5 Residents. (Resident #10, #30, #76, #126 and #109)</p> <p>Findings included:</p> <p>1. During an observation on 1/15/14 at 9:20 a.m., three medications were found to be expired on the 2 medication carts on Gardenia Grove West. The expired medications included the following: -For Resident # 126, Novolog Insulin (for Diabetes) was labeled with an open date of 12/13/13 and an expired date of 1/9/14. -For Resident # 76, Novolog Insulin was labeled with an open date of 12/15/13</p>	F000431	F431 Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include appropriate and cautionary instructions and the expirations date when applicable. Corrective action for residents affected: Resident #126 and #76 – The expired Novolog insulin vials were immediately discarded and replaced with new vials. Resident #30 – The expired Advair Inhaler was immediately discarded and replaced with a new one. The expired Novolin R insulin vial was immediately removed from the medication cart on Lilac East and discarded. The unlabeled bottle of OTC artificial tears was immediately removed from medication cart #2 on Tulip Lane and discarded. The expired bottle of Centrum A to Zinc for Resident #109 was immediately removed from medication cart #2	02/16/2014

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	<p>and an expired date of 1/11/14.</p> <p>-For Resident # 30, Advair Inhaler (Respiratory medication) was labeled with a open date of 12/13/13 written on the inhaler and a "DO NOT USE AFTER" date was written on prescription label with a dated of 1/13/14.</p> <p>Interview with LPN #2 on 1/15/13 at 9:32 a.m., indicated it was the responsibility of all of the nurses who administer medications, including herself, to check the expiration dates on the medications given to the residents.</p> <p>A review of Residents' EMAR(Electronic Medication Administration Record) Medication Documentation provided by ADON (Assistant Director of Nursing) on 11/15/14 at 10:45 a.m., indicated the following:</p> <p>-For Resident #126, Novolog insulin was given 17 times after the insulin's expiration dated of 1/9/14.</p> <p>-For Resident #76, Novolog insulin was given 2 times after the insulin's expiration dated of 1/11/14.</p> <p>-For Resident #30, Advair Inhaler was given 5 times after the expiration date of 1/13/14.</p> <p>A review of the facility's Policy and Procedure provided by the DON (Director of Nursing) on 1/15/14 at 1:25</p>		<p>on Tulip Lane and discarded. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this deficient practice. A technician from the contracted pharmacy completed an extensive search of all medication carts and medication rooms throughout the facility to ensure all medications and biologicals were properly labeled and not expired. Measures to ensure practice does not recur: All pharmacy and facility policies related to medication storage, labeling, and disposition of expired and discontinued medications were reviewed to ensure they reflected evidence-based practices. Licensed nursing staff has received training on these policies. Evaluation of learning was accomplished through a written test. Reference materials on products with shortened expiration dates, such as insulins, are available on all nursing units as a resource. This corrective action will be monitored by: Licensed charge nurses will be responsible for completing a thorough audit of all medication and treatment carts and medication rooms twice weekly until 100% compliance is achieved and maintained for at least one calendar quarter. Unit Coordinators will be responsible for review of the audit results, and</p>		

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	<p>p.m., titled, "Administering Medications through a Metered Dose Inhaler", dated October 2010, indicated, "...Check the expiration date on the inhaler. Return any expired medications to the pharmacy...."</p> <p>A review of the facility's Policy and Procedure provided by the DON on 1/15/14 at 1:25 p.m., titled, "Instructions for Insulin Administration, dated 4/1/01, indicated, "...Check dosage and units at least three times before giving..."</p> <p>Interview with the Corporate Nurse on 1/16/14 at 9:40 a.m., indicated the nurse was to check for the expiration date on the medication before the medication was administered to the resident.</p> <p>2. During an observation on 1/15/14 at 10:00 a.m., one medication was found to be expired on the medication cart on Lilac East. The expired medication was Novolin R Insulin (for Diabetes). The insulin was not labeled with an open date. An expiration date of 12/17/13 was written on the insulin vial.</p> <p>An interview on 1/15/13 at 10:00 a.m. with QMA (Qualified Medication Aide) #4, indicated she was not aware the insulin was expired and also indicated she can not administer insulin to the</p>		<p>for addressing any non-compliance with medication storage and labeling. Unit Coordinators will report trends in the audit results to the QA Committee monthly. Additional corrective actions will be developed by the committee as deemed necessary. Completion Date February 16, 2014</p>	

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	<p>resident. She indicated the nurse is responsible for the administration of injectable medication and to check for expiration dates.</p> <p>A review of Resident #10's Physician's Orders provided by the Corporate Nurse on 1/16/14 at 9:40 a.m., the Physician's Order dated 12/12/13 indicated, "D/C (discontinue) Novolog Sliding Scale...."</p> <p>3. During an observation of Tulip Lane #2 medication cart on 1-15-2014 at 9:55 a.m. with QMA #3, the following was observed:</p> <ul style="list-style-type: none"> - An unlabeled bottle of an over the counter brand of "Artificial Tears" was in the top drawer of the medication cart. -A bottle of Centrum A to Zinc for Adults 50+ with an expiration date of December 2013 for Resident #109 was located in the bottom drawer of the medication cart. <p>A review of Resident #109's physician orders on 1-15-2014 at 3 p.m. indicated the Centrum A to Zinc for Adults 50+ was discontinued on 12-11-2013.</p> <p>An interview with QMA #3 on 1-15-2014 at 9:56 a.m., indicated QMA #3 did not know which resident used the unlabeled bottle of artificial tears.</p>			

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	<p>An interview with LPN #5 on 1-15-2014 at 1:50 p.m., indicated any medication that had been discontinued by the physician should not be in the medication cart.</p> <p>A review of the facility's Policy and Procedure provided by the DON on 1-15-2014 at 10:00 a.m. titled "Physician Medication Orders", indicated "...all Over the Counter medications stored in facility medication carts must be labeled with, at least, the resident's name and attending physician...."</p> <p>A review of the facility's Policy and Procedure provided by the DON on 1-15-2014 at 1:54 p.m. titled "Disposal/Destruction of Expired or Discontinued Medications dated 1-1-2013, indicated "...once an order to discontinue a medication is received, Facility staff should remove this medication from the resident's medication supply...."</p> <p>A review of the facility's Policy and Procedure provided by the ADON on 1-15-2014 at 1:27 p.m. titled "General Dose Preparation and Medication Administration", indicated "...prior to administration of medication...check the expiration date on the medication...."</p>			

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F000514 SS=E	<p>3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(o) 3.1-25(r)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview,</p>	F000514	F514 The facility maintains	02/16/2014

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	<p>the facility failed to ensure physician orders were signed timely for 4 of 39 records reviewed for physician orders. (Residents #7, #63, #135 and #30)</p> <p>1. On 1/13/14 at 12:00 p.m. the clinical record of Resident #7 was reviewed. The October 2013 physician orders were reviewed. The Physician's Monthly Recapitulations, dated 10/7/13, were signed as reviewed by the nurse on 10/7/13. The documentation was lacking on the 10/7/13 monthly Physician Recapitulation Orders of the physician signing and dating the orders.</p> <p>2. On 1/15/14 at 2:50 P.M., the clinical record of Resident #63 was reviewed. The October 2013 physician orders were reviewed. Documentation indicated the nurse had signed the October 2013 orders as having been reviewed on 9/30/13. Documentation was lacking on the October 2013 Physician Order Sheet of the physician signing and dating the orders.</p> <p>On 1/16/14 at 11:20 A.M., the DON (Director of Nursing) was made aware of the lack of documentation on the physician orders. She indicated this resident sees her physician at the doctor's office and is to have the physician order rewrites signed every 60 days.</p> <p>3. On 1-10-2014 at 2:41 p.m., the</p>		<p>clinical records that are complete, accurately documented, readily accessible, and systematically organized. Corrective action for residents affected: Physician signatures were obtained on all physician orders for Residents #7, #63, #135, and #30. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this deficient practice. All charts for the current in-house residents were audited and physician signatures obtained as per federal and state requirements. Measures to ensure practice does not recur: The current system for obtaining signed physician orders has been reviewed and additional steps added to ensure physician orders are signed in accordance with federal and state requirements. Medical Records and licensed nursing staff received additional training on the system to ensure clear understanding of each department's responsibility. This corrective action will be monitored by: Medical Records Coordinator or designee will complete chart audits monthly for required physician signatures. The Director of Nursing or designee will review audit results and address any non-compliance immediately. Trends in audit results will be reported to the QA Committee monthly. Additional corrective actions will be</p>		

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	<p>clinical record of Resident #135 was reviewed. The September and November 2013 physician orders were reviewed. The Physician's Monthly Recapitulations dated 9-1-2013 were signed as reviewed by the nurse without a date recorded. The November 2013 Physician's Monthly Recapitulation orders were signed by the nurse and dated 11-3-2013. The Physician's signature and date was lacking on the 9-1-2013 and the 11-3-2013 Physician's Recapitulation.</p> <p>4. On 1-14-2014 at 9:37 a.m., the clinical record for Resident #30 was reviewed. The November 2013 physician orders were reviewed. The Physician's Monthly Recapitulations dated 11-1-2013 were signed as reviewed by the nurse on 11-11-2013. The Physician's signature and date was lacking on the 11-1-2013 Physician's Recapitulation.</p> <p>An interview with LPN #5 on 1-15-2014 at 9:20 a.m. indicated Resident #135 had an outside physician and the physician orders and recapitulations will be sent with the resident to her appointment on 1-20-2014. The LPN indicated the policy was to have physician orders signed within 90 days.</p> <p>An interview with the DON on 1-15-2014 at 10:30 a.m., indicated an</p>		developed by the committee as deemed necessary. Completion Date February 16, 2014		

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	<p>explanation of the policy "Content of the Clinical Record" regarding the time frame physician orders must be signed. The DON indicated the physician recapitulations have to have the physician's signature every 60 days plus there is a 10 day grace period.</p> <p>An undated facility policy titled "Content of the Clinical Record" provided by the DON on 1-15-2014 at 8:30 a.m., indicated "...the physician shall review a recapitulation of the resident's total program of care, including medications, treatments, and ancillary orders, every (30) days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter. These reviews shall be considered timely if they occur not later than ten (10) days after the due date."</p> <p>3.1-50(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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