

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2013
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NAME OF PROVIDER OR SUPPLIER VERMILLION CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 S MAIN ST CLINTON, IN 47842
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 10, 11, 12, 13, 14, 17, and 18, 2013</p> <p>Facility number: 000052 Provider number: 155124 AIM number: 100290340</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF/NF 85 Total: 85</p> <p>Census payor type: Medicare 7 Medicaid 65 Other 13 Total: 85</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 06/25/2013 by Brenda Nunan, RN.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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

TITLE

(X6) DATE

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

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F000252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, interview, and record review, the facility failed to provide a homelike environment for 1 of 4 dining rooms. This had the potential to affect all 18 residents of the Expressions unit.</p> <p>Findings include:</p> <p>1. On 6/12/13 from 11:38 a.m. to 12:20 p.m., the noon meal was observed on the closed, Expressions dining room. One round table was in a corner of the activity/dining room with three residents seated together. Three rectangular tables were placed end to end in the center of the room. The room was utilized for dining, activities, and a sun room, with little room in which to move around. Ten residents, one family member, and one staff member, were seated along the tables. Some of the residents were observed eating their meals while others seated closely had not been served. The residents were seated sporadically on both sides of the entire lengths of the tables. Resident #30, seated at a table, was</p>	F000252	<p>1. Eighteen residents had the potential to be affected, no residents were harmed. Upon notification of the concern, the dining tables were rearranged and the dining seating arrangement was revised for a more homelike environment. Additionally staff were re-educated on serving meals to residents at the same table at the same time and interventions to address disruptive behaviors.2. All residents residing on the memory care unit have the potential to be affected. The dining tables and lobby area furniture have been rearranged to provide a more homelike environment with additional seating. Additional space is now being utilized for the memory care unit to make the dining experience more homelike. The dining seating arrangement has been revised to provide more appropriate seating for residents. Meals are delivered to residents table by table. All nursing staff will be in-serviced on the facility's behavior management program (including but not limited relocating a resident to a quiet area as per plan of care if warranted), providing a homelike</p>	07/03/2013			

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	<p>repetitively yelling "hey, hey" throughout the meal. Resident #78, also seated at the dining table, had repetitive verbalizations throughout the meal, a period of 45 minutes. Resident #95, seated across from the residents with repetitive loud verbalizations, was asked if the behavior bothered him. The resident responded: "It is better than a kick in the head."</p> <p>During the same meal, Resident #55's wife, was interviewed. The family member stated she was at the facility, "pretty much two times a day," and fed the resident. She indicated Resident #30 and #78 frequently had behaviors of repetitive verbalizations during meal, but didn't know what could be done about it.</p> <p>On 6/14/13 at 4 p.m., the Administrator was interviewed. The Administrator indicated an additional room, adjoining the closed unit dining/activity/sun room, with an access to the area, was not utilized by the residents of the unit for dining or activities, but could have been utilized. The Administrator indicated they would like for them to use it more, but guessed they had to watch them [residents] too closely.</p>		<p>environment, and meal tray service.3. As a measure of ongoing compliance, the Social Services Director or Designee will monitor the Memory Care unit weekly ongoing to ensure a homelike environment is being provided to the residents, meals are served concurrently, and staff is responding to resident behaviors, as per plan of care (attachment A).4. As a means of quality assurance, the Social Services Director will review any findings and initiate subsequent corrective action, if warranted. Findings and any interventions shall be reported to the Quality Assurance Committee during quarterly meetings and the corrective action plan revised, if warranted.</p>		

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	<p>2. On 6/17/13 at 10 a.m., the Expressions dining room was observed to have the dining room tables separated and positioned perpendicular to each other, in the sun room dining/activity room, which allowed seating on all sides of the tables.</p> <p>On 6/17/13 at 12:00 p.m., Resident #30 was seated at a dining table with other residents, making repeated verbalizations through out the meal.</p> <p>On 6/18/13 at 10 a.m., RN #1 was interviewed. She indicated she thought the tables were rearranged over the weekend. The dining area did have a more home like atmosphere, but limited space, and residents with verbalization behaviors continued to be assisted with meals with the rest of the population.</p> <p>On 6/18/13, the Administrator was interviewed at 4:35 p.m. The Administrator indicated she had been notified of a water leak in the roof, over the weekend, and that is probably when the furniture was rearranged. The Administrator indicated the room had been arranged in that manner in the past and staff indicated it was too hard for residents to get around the tables.</p>						

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	<p>Resident #78's clinical record was reviewed on 6/18/13 at 12:20 p.m. A plan of care with most recent date of, 4/29/13, addressed the problem of exhibits behavioral symptoms such as "...verbal/vocal symptoms like screaming, disruptive sounds, incessant talking ..." Interventions included, but were not limited to, "Remove resident or others from the area as appropriate or necessary...."</p> <p>Resident #30's clinical record was reviewed on 6/18/13 at 2:51 p.m. A plan of care with most recent date, 4/16/13, addressed exhibits other behavioral symptoms...verbal/vocal symptoms like screaming, disruptive sounds.: Interventions included, but was not limited to, "...Remove resident or others from the area as appropriate or necessary. Provide calm quiet environment until the resident has calmed down. ..."</p> <p>A facility in-service training form (no date) titled "Dementia in Long Term Care," was reviewed on 6/18/13 at 3:15 p.m. The training information included, but was not limited to, "Limit noise, move to quiet place."</p> <p>A Policy and Procedure, titled "Dining Room Assist Procedure," dated 7/05,</p>						

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	<p>provided by the Medical Records staff, on 6/18/13 at 3:15 p.m., did not address serving residents at same table during meal at same time.</p> <p>3.1-19(f)(5)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a consistent and comprehensive plan of care for constipation and/or diabetic protocol for 2 of 24 residents reviewed for plans of care [Resident #12 and Resident #95].</p> <p>Findings include:</p> <p>1. On 6/17/13 at 11:16 a.m., Resident #12 was observed to have accucheck completed by RN #5. The accucheck result was 183.</p>	F000279	<p>1. Resident #12 and #95 were affected. No residents were harmed. Resident #12's care plan was revised to be more individualized to include her specific care for diabetes. Resident #95 had a care plan added to address constipation, which included utilizing prune juice as a dietary intervention. 2. All residents with diabetes and/or constipation diagnosis have the potential to be affected. All medical records for residents with a diagnosis of diabetes and/or constipation were reviewed to ensure a care plan was in place addressing such diagnosis with</p>	07/03/2013	

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	<p>Upon interview of RN #5 on 6/17/13 at 11:20 a.m., the RN indicated she would not give the resident her sliding scale insulin until after she had eaten to ensure the resident ate at least 50% of her meal. On 6/17/13 at 12:30 p.m., RN #5 indicated the resident's insulin had been held due to the resident ate only 25% of her meal.</p> <p>Upon review of the clinical record of Resident #12 on 6/17/13 at 2 p.m., the resident's diagnoses included, but were not limited to, diabetes mellitus type II, atypical psychosis, and insulin dependent diabetes mellitus.</p> <p>A current physician order was noted of Novolog [insulin] sliding scale before meals, dated 4/8/13, with parameters of 150-200=2 units; 201-250=4 units; 251-300= 6 units; 301-350= 9 units; 351-400= 11 units; greater than 400 =call MD. Another current physician order was noted of Novolog bedtime coverage, dated 1/2/12, with parameters of 61-150= 0 units; 151-200= 2 units; 201-250=3 units; 251-300= 4 units; 301-350= 5 units; 351-400= 6 units; 401-999= 7 units.</p> <p>The "Blood Glucose Monitoring</p>		<p>individualized interventions. Dietary interventions such as prune juice and wheat bread have been added for all residents with constipation. The Registered Dietician will address constipation diagnosis forthcoming and recommendations will be addressed and care plans updated accordingly. The output records will be reviewed daily to ensure interventions are implemented as appropriate. Nursing staff will be in-serviced on the facility's policy on care plan development, as well as BM tracking and intervention.³ As a measure of ongoing compliance, the DON or designee will review all new orders daily on regularly scheduled days of work ongoing. The DON or designee will then ensure care plans are updated as appropriate addressing the new orders received daily on regularly scheduled days ongoing, (attachment C & D). Additionally, the DON or designee will review the orders of newly admitted residents to ensure the plan of care addresses specific areas of concern (such as diabetes and constipation). Administrative nursing staff shall be responsible to track BMs and monitor for interventions to be implemented per facility policy on a weekly basis, (attachment E). Should non-compliance be noted, corrective action shall be taken. ⁴ As a means of quality assurance, the DON or designee</p>		

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	<p>Records" dated April 2013, May 2013, and June 2013 had documentation of the insulin coverage being held due to "poor intake" on 4/23/13 at 9 p.m.; 4/29/13 at 9 p.m., 5/21/13 at 4:30 p.m., 6/12/13 at 7 a.m.; and 6/17/13 at 11:30 a.m.</p> <p>Upon interview of RN #5 on 6/17/13 at 2:12 p.m., the RN indicated it was the physician's protocol to hold the sliding scale insulin coverage when the resident ate less than 50% and that the resident was a brittle diabetic. The RN also indicated the physician was notified each time the insulin was held.</p> <p>Upon review of information posted for the Nurses in the medication rooms on 6/17/13 at 3:10 p.m., the documentation indicated the physician wanted all insulins given after meals to prevent hypoglycemic reactions and that the staff were to hold the insulin if the resident had not eaten or were sick and to notify the physician.</p> <p>Upon review of information provided by the Assistant Director of Nursing on, 6/17/13 at 3:10 p.m., was dated 6/17/13 with fax time of 2:23 p.m. indicated, "It is standard protocol to hold insulin if a patient eats less than</p>		will report and findings from ongoing reviews and corrective actions taken to the Quality Assurance Committee during quarterly meetings, and the corrective action plan revised, if warranted.				

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	<p>50% of a meal. Accucheck will be done before next meal et [and] in order to control blood sugars the Dr. [doctor] will be called if any questions et [and] insulin dose adjusted."</p> <p>Upon review of the resident's current plan of care, the problem of the resident had diagnosis of Diabetes Mellitus and was at risk for experiencing hypoglycemia and hyperglycemia was noted with date of 5/14/13. The careplan did not indicate the resident was a brittle diabetic and that the staff was to follow protocol to hold insulin coverage if the resident ate less than 50% of a meal.</p> <p>Upon interview of the Corporate RN on 6/17/13 at 3:10 p.m., the Corporate RN indicated the resident's current plan of care did not include that the resident was brittle diabetic and the use of the facility protocol for holding insulin.</p> <p>2. Resident #95's clinical record was reviewed on 6/18/13 at 11 a.m. The resident's diagnosis included, but was not limited to, constipation.</p> <p>A physician's order, dated 5/8/13, was noted for Dulcolax [laxative] 5 mg tablet EC [enteric coated] give 2 tablets (100 mg [milligrams]) by mouth at bedtime DX [diagnosis]</p>			

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	<p>constipation." Documentation on the June, 2013 medication administration record, indicated the resident received the medication every evening.</p> <p>An initial dietary assessment, dated 5/1/13, did not address the diagnosis of constipation and a plan of care to address the problem was not developed.</p> <p>An activities of daily living (ADL) record for the month of June, 2013 was reviewed. Documentation for recording resident's bowel movements was done each shift. The time frame from June 1 to the 14th documented the resident had only five bowel movements in 13 days. The resident was documented to have no bowel movements on June 2, June 3, June 5, June 8, June 9, June 12, June 13th, and June 14th. Documentation of prune juice being given was not maintained.</p> <p>The record lacked documentation of giving prune juice with regard to bowel elimination record. The record also did not indicate a comprehensive plan of care for constipation.</p> <p>Upon review of the facility's current policy and procedure titled, "Bowel</p>				

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	Elimination Procedure," dated 7/05, on 6/17/13 at 1:43 p.m., documentation indicated "PURPOSE: to ensure that each resident maintains a safe and healthy bowel elimination pattern. PROCEDURE: 1. Each resident will be assessed at admission for a usual bowel history. 2. If on the 3rd night, the resident has not had a bowel movement, the nurse will give the laxative or stool softner that is ordered by the Physician and chart accordingly. 3. If on the 4th afternoon, the resident has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the Physician. Any orders given will be carried out. 5. After the Physician orders from the 4th afternoon have been followed, an abdominal assessment is to be done (whether or not resident had or did not have results) and documented. 6. If resident continues to have problems (i.e. no BM by the 4th afternoon and resident is in distress) notify the physician accordingly. 7. If no laxative has been administered and if resident has 2 consecutive loose stools or a liquid oozing stool 2 bedchecks in a row, check to see if there is an order for digital exam. If there is an order, check for stool. Document in the nurses notes and report to Physician						

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	<p>findings."</p> <p>On 6/17/13 at 1:35 p.m. RN #1 was interviewed. The RN indicated when residents on the Expressions unit didn't have a bowel movement for a day, they gave prune juice.</p> <p>On 6/17/13 at 1:45 p.m., CNA #6 was interviewed. The CNA indicated she made a "Lax" [laxative] list of residents throughout the building and provided the list to nurses of residents going without a bowel movement for three days, when she was there.</p> <p>On 6/18/13 at 2 p.m., the Assistant Director of Nursing indicated a plan of care for constipation was lacking.</p> <p>3.1-35(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and review of records, the facility failed to ensure care plans/policies and procedures were followed for 2 of 2 residents reviewed for Hemodialysis plans of care. (Resident # 54 and #96)</p> <p>Findings include:</p> <p>1. Resident #54's clinical record was reviewed on 6/17/13 at 9:54 a.m. A diagnosis was noted of, End Stage Renal Failure.</p> <p>A physician's order was noted, dated 3/23/13, indicating "Hemodialysis on Mon [Monday], Wed [Wednesday], Fri [Friday], @ [at] North Clinic 5:30 pm."</p> <p>Documentation indicated dialysis pre and post vital signs and weights, as well as labs drawn and medication administered was not provided to the facility for each dialysis visit. The record indicated data from 6/10/13 and 6/12/13 was faxed to the facility on 6/15/13. The record lacked documentation of the facility obtaining</p>	F000282	<p>1. Resident #54 & #96 were affected. The residents were not harmed. A post dialysis assessment was completed each time the residents returned from dialysis. If a concern was noted during dialysis, the dialysis center would notify the facility. The dialysis center provided the facility documents regarding the residents' care during dialysis upon request. These documents are maintained in the dialysis book at the facility.2. All residents receiving dialysis services have the potential to be affected. All nursing staff have been re-educated on caring for residents receiving dialysis which included completing post dialysis assessments, receipt and review of communication with the dialysis center, and maintaining documents from the dialysis center (for each dialysis center visit) in the dialysis book. Should the center fail to send said communication, the nurse must then request said information.3. As a measure of ongoing compliance, the DON or designee will complete an audit three times weekly for 3 months, then weekly for 3 months, then monthly ongoing to ensure there is</p>	07/03/2013	

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	<p>dialysis data from March 29, 2013 through 6/10/13.</p> <p>Upon interview of the Director of Nursing [DON] on, 6/13/13 at 12:15 p.m., the DON indicated the dialysis unit had not sent information from each dialysis treatment for Resident #54. The DON indicated the facility should have contacted the dialysis unit each time for the data if it was returned with the resident. The DON stated the dialysis unit, when contacted 6/13/13, stated they knew they should have been sending the information.</p> <p>2. During interview of Resident #96 on, 6/12/13 at 10:35 a.m., the resident indicated he went to hemodialysis on Monday, Wednesday, and Friday. The resident also stated he had a arterial-venous fistula on his left forearm.</p> <p>The resident's fistula was observed on 6/12/13 at 10:35 a.m.</p> <p>Upon review of the "Dialysis" book for Resident #96 on, 6/13/13 at 11:35 a.m., documentation was noted of the facility completing a post dialysis assessment after each dialysis visit. Documentation from the dialysis unit</p>		<p>adequate communication between the facility and the dialysis center. This will include noting the post dialysis assessment is completed and the document(s) noting the resident's care received during dialysis treatment is obtained from the dialysis center with each dialysis visit and maintained in the dialysis book, (attachment B). Should non-compliance be noted, corrective action shall be taken.4. As a means of quality assurance, the DON or designee will report the findings of aforementioned audits and any corrective action taken to the Quality Assurance Committee during quarterly meetings and the corrective action plan revised, if warranted.</p>		

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	<p>included pre and post vital signs and weights, as well as labs drawn, medications administered, and physician order changes; however, the only documentation from the dialysis unit visits since 1/1/13 was dated 1/23/13, 2/22/13, 4/11/13, 4/13/13, and 4/16/13. Documentation from each dialysis visit from 4/16/13 to 6/13/13 was lacking.</p> <p>Upon review of the clinical record of Resident #96 on, 6/14/14 at 2 p.m., a current physician's order was noted dated, 1/13/12, of Aranesp [treatment of anemia from chronic renal failure] 60 mcg [micrograms]/ml [milliliters] inject 1 ml subcutaneously weekly at dialysis. Documentation to ensure the medication was administered at the dialysis unit weekly was lacking.</p> <p>Upon interview of RN #5 on, 6/13/13 at 11:40 a.m., the RN indicated the dialysis unit had not been sending information regarding the resident's status and/or treatment given while at dialysis. The RN stated that if the resident indicated something had been changed upon return, then the facility staff would have contacted the dialysis unit.</p> <p>Upon interview of the Director of Nursing [DON] on, 6/13/13 at 12:15</p>				

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	<p>p.m., the DON indicated the dialysis unit had not sent information from each dialysis treatment for Resident #96. The DON indicated the facility should have contacted the dialysis unit each time for the data if it was returned with the resident. The DON stated the dialysis unit when contacted 6/13/13 stated they knew they should have been sending the information.</p> <p>Upon review of the facility's current policy and procedure titled "Policy and Procedure for Management of Dialysis----Peritoneal and Hemo" dated 9/05 on, 6/13/13 at 12 p.m., documentation was noted of "...7. Routine communication via written and/or telephone will occur between the facility charge nurses and the clinic nurses to assure that the care is continuous and consistent...."</p> <p>3.1-35(g)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure non medication interventions for relieving constipation were implemented for 2 of 10 residents reviewed for unnecessary medications [Residents #95 and #74].</p> <p>Findings include</p> <p>1. Resident #95's clinical record was reviewed on 6/18/13 at 11 a.m. The resident's diagnosis included, but was</p>	F000329	<p>1. Resident #95 and #74 were affected. The physicians for said residents were contacted for further orders addressing medication use and/or rationale for continued use. The residents care plans will be updated accordingly. Non-medication interventions implemented as appropriate.2. All residents utilizing routine laxative medications have the potential to be affected. All residents' medication regimens will be reviewed. Any residents found to be on routine laxatives will have a</p>	07/03/2013			

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	<p>not limited to, constipation.</p> <p>A physician's order, dated 5/8/13, was noted for Dulcolax [laxative] 5 mg tablet EC [enteric coated] give 2 tablets (10 mg [milligrams]) by mouth at bedtime DX [diagnosis] constipation." Documentation on the June, 2013 medication administration record, indicated the resident received the medication every evening.</p> <p>An initial dietary assessment, dated 5/1/13, did not address the diagnosis of constipation and a plan of care to address the problem was not developed.</p> <p>An activities of daily living (ADL) record for the month of June, 2013 was reviewed. Documentation for recording resident's bowel movements was done each shift.</p> <p>The record lacked documentation of giving prune juice with regard to bowel elimination record. The record also did not indicate a comprehensive plan of care for constipation.</p> <p>Non-medication interventions to prevent/treat constipation were not included and/or implemented in plans of care for constipation for Resident</p>		<p>medication review completed by the physician. Physician orders and/or rationale for continued use will be obtained. Dietary interventions such as prune juice and wheat bread have been added for all residents with a diagnosis of constipation. The Registered Dietician will address constipation diagnosis forthcoming and recommendations will be addressed and care plans updated accordingly. The output records will be reviewed daily to ensure interventions are implemented as appropriate. All nursing staff will be educated on the use of laxatives and non-medication interventions. The pharmacy consultant will continue monthly medication regimen reviews, which will include monitoring for unnecessary medication use, ongoing.3. As a measure of ongoing compliance the DON or designee will complete an audit, (attachment C) monthly ongoing to ensure all pharmacy recommendations have been addressed by the physician timely with orders obtained and/or explanations documented, as indicated.4. As a means of quality assurance, the DON or designee will report any findings and subsequent corrective action from the aforementioned audits to the facility's Quality Assurance Committee during quarterly plan</p>		

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	<p>#95. Documentation to indicate attempt to decrease the daily use of laxatives was lacking.</p> <p>On 6/18/13 at 2 p.m., the Assistant Director of Nursing indicated a plan of care for constipation was lacking.</p> <p>2. Resident #74's clinical record was reviewed on 6/17/13 at 3:00 p.m. The resident's diagnosis included, but was not limited to, constipation.</p> <p>Physician's orders included, but were not limited to, Dulcolax (laxative) 10 mg (milligram) suppository prn (as needed) every 3 days, hold if loose stools for diagnosis of constipation. The order date was 3/5/13. Documentation on the June, 2013 Medication Administration Record (MAR) indicated it was given as ordered.</p> <p>Another physician's order dated, 4/26/13, was for " Dulcolax 5 mg tablet EC (enteric coated) ...give 2 tablets (10) mg by mouth every other day at bedtime DX [diagnosis] constipation." Documentation on the June, 2013 MAR indicated the medication was administered daily.</p> <p>A plan of care with most recent update of, 5/14/13, addressed the</p>		will be revised, if warranted.		

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	<p>problem of resident at risk for constipation. Approaches included: "monitor bowel movements prn; administer medications as ordered; encourage resident to drink fluids as diet permits; if no BM for three days, complete further evaluation and administer medications as ordered; Notify MD [medical doctor] and responsible party as needed; Assist resident to toilet as needed." Non-medication interventions to prevent/treat constipation were not included and /or implemented in plans of care for constipation for Resident #74.</p> <p>Upon review of the facility's current policy and procedure titled, "Bowel Elimination Procedure," dated 7/05, on 6/17/13 at 1:43 p.m., documentation indicated "PURPOSE: to ensure that each resident maintains a safe and healthy bowel elimination pattern. PROCEDURE: 1. Each resident will be assessed at admission for a usual bowel history. 2. If on the 3rd night, the resident has not had a bowel movement, the nurse will give the laxative or stool softner that is ordered by the Physician and chart accordingly. 3. If on the 4th afternoon, the resident has not had results, the nurse will do an abdominal assessment, chart the</p>			

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	<p>results of the assessment, and notify the Physician. Any orders given will be carried out. 5. After the Physician orders from the 4th afternoon have been followed, an abdominal assessment is to be done (whether or not resident had or did not have results) and documented. 6. If resident continues to have problems (i.e. no BM by the 4th afternoon and resident is in distress) notify the physician accordingly. 7. If no laxative has been administered and if resident has 2 consecutive loose stools or a liquid oozing stool 2 bedchecks in a row, check to see if there is an order for digital exam. If there is an order, check for stool. Document in the nurses notes and report to Physician findings." The policy and procedure lacked documentation of non medication interventions.</p> <p>3.1-48(a)(3)</p>						

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based observation, record review, and interview, the facility failed to ensure a complete and coordinated clinical record for 1 of 2 residents reviewed for a sliding scale for insulin administration (Resident #12).</p> <p>Findings include:</p> <p>On 6/17/13 at 11:16 a.m., Resident #12 was observed to have accucheck completed by RN #5. The accucheck result was 183.</p> <p>Upon interview of RN #5 on 6/17/13 at 11:20 a.m., the RN indicated she would not give the resident her sliding scale insulin until after she had eaten to ensure the resident ate at least 50% of her meal. On 6/17/13 at 12:30 p.m., RN #5 indicated the resident's</p>	F000514	<p>1. Resident #12 was affected. The physician was notified of the insulin being held and agreed that it was his protocol for the insulin to be held in the situation at hand which was documented in the nurses notes. An order was obtained and written to hold the resident's insulin if her blood sugar is less than 250 and she eats less than 50% of her meal/HS snack. Resident #12's care plan was updated to include her specific diabetic care.2. All residents that utilize insulin and exhibit poor intake have the potential to be affected. All medical records for residents with orders for insulin will be reviewed to ensure the orders are clear and the care plan is individualized with specific interventions. All nursing staff will be re-educated on the facility's policy on care plans, blood sugar monitoring, physician</p>	07/03/2013			

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	<p>insulin had been held due to the resident ate only 25% of her meal.</p> <p>Upon review of the clinical record of Resident #12 on 6/17/13 at 2 p.m., the resident's diagnoses included, but were not limited to, diabetes mellitus type II, atypical psychosis, and insulin dependent diabetes mellitus.</p> <p>A current physician order was noted of Novolog [insulin] sliding scale before meals, dated 4/8/13, with parameters of 150-200=2 units; 201-250=4 units; 251-300= 6 units; 301-350= 9 units; 351-400= 11 units; greater than 400 =call MD. Another current physician order was noted of Novolog bedtime coverage, dated 1/2/12, with parameters of 61-150= 0 units; 151-200= 2 units; 201-250=3 units; 251-300= 4 units; 301-350= 5 units; 351-400= 6 units; 401-999= 7 units.</p> <p>The "Blood Glucose Monitoring Records" dated April 2013, May 2013, and June 2013 had documentation of the insulin coverage being held due to "poor intake" on 4/23/13 at 9 p.m.; 4/29/13 at 9 p.m., 5/21/13 at 4:30 p.m., 6/12/13 at 7 a.m.; and 6/17/13 at 11:30 a.m. Physician orders to hold the sliding scale insulins as well as documentation in the nursing</p>		<p>notification, obtaining orders and documentation.3. As a measure of ongoing compliance, the DON or designee will complete an audit, (attachment D) daily on regularly scheduled days for 3 months, then three times weekly for 3 months, then weekly for three months, then monthly ongoing to ensure sliding scale insulin is documented as ordered, the physician is notified as indicated, and orders obtained as appropriate with such documented appropriately. Should concerns be noted corrective action shall be taken.4. As a quality measure the DON or designee will report any findings and subsequent corrective action taken from the aforementioned audits in the facility's Quality Assurance Committee meetings on a quarterly basis and the corrective action plan revised, if warranted.</p>				

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	<p>notes were lacking for 4/23/13, 4/29/13, 5/21/13, 6/12/13, and 6/17/13 due to poor intake.</p> <p>Upon interview of RN #5 on 6/17/13 at 2:12 p.m., the RN indicated it was the physician's protocol to hold the sliding scale insulin coverage when the resident ate less than 50% and that the resident was a brittle diabetic. The RN also indicated the physician was notified each time the insulin was held.</p> <p>Upon review of the facility's current policy and procedure titled "Physician & Family Notification Procedure," dated 1/06, on 6/17/13 at 3:30 p.m., documentation indicated the following: "...4. Document the information reported to the physician in the nurses notes including the time and date of notification. Be thorough and explicit. 5. Document the response from the physician in the nurses notes. 6. Verbal orders must be written on the Telephone order form for the physician to sign at next visit...."</p> <p>3.1-50(a)(1)</p>						