STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ROCHESTER	827 W 13TH ST ROCHESTER, IN 46975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: April 16, 17, 18, and 19, 2012 Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300 Survey Team: Julie Wagoner, RN-TC Christine Fodrea, RN Carol Miller, RN Shelly Vice, RN Tim Long, RN (04/16, 04/17, 04/18) Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 11 Medicaid: 71 Other: 21 Total: 103 Sample: 21 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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

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

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	Quality review completed 4/26/12 Cathy Emswiller RN			

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F0157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, interview and record review, the failed to notify the physician when changes were noted in the AIMS (Abnormal Involuntary Movement Scale) for 2 of 10 residents reviewed for	F0157	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the*	05/19/2012

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	psychotropic medication use in a sample of 21 (Resident #77, and Resident #35). In addition, the facility failed to notify the physician of the need to discontinue a lab test for a blood level after the medication had been discontinued for 1 of 1 residents reviewed for medication blood levels in a sample of 21 (Resident #35). The facility also failed to notify the physician of numerous medication refusals for 2 of 7 residents reviewed for medication administration in a sample of 21. (Resident #8, and Resident #68) Findings include: 1. a. Resident #77's record was reviewed 4-16-2012 at 2:15 p.m. Resident #77's diagnoses included but were not limited to psychosis, dementia with behavioral disturbances and chronic pain. On 4-16-2012 at 11:30 a.m., Resident #77 was observed in the resident lounge area sitting in an easy chair. Resident #77 was observed to have repeated lip puckering. On 4-18-2012 at 9:19 a.m., Resident #77 was observed sitting in an easy chair in the resident lounge area. Resident #77 was observed to have repeated lip puckering and foot tapping. An Abnormal Involuntary Movement		*residents found to have been affected by the deficient practice was:*The AIMS assessment and associated changes from prior assessment were communicated to physician for resident #77 on 4-23-12 and for resident #35 on 4-25-12 with no new orders received. The Depakote lab order for resident #35 was reviewed with physician on 4-17-12 and orders received to discontinue Depakote labs every 6 months. Physicians were notified for each of the residents identified regarding multiple medication refusals. Resident #68's doctor was notified on 4-18-12 and new orders received to discontinue all oral medication. Resident #8's doctor was notified on 4-18-12 and no new orders received. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*The AIMS assessments for all residents receiving antipsychotic medications will be reviewed to identify changes in assessment outcomes and appropriate physician notification by IDT on or before 5-19-12. The physician orders for laboratory draws for all residents will be reviewed to ensure no unnecessary laboratory draws were ordered for medications that had been discontinued by DON or designee(s) on or before 5-19-12.A review of medication administration records and	

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	Scale (AIMS) dated 6/2/2011 indicated Resident #77 had no abnormal involuntary movements. An AIMS dated 1/23/2012 indicated Resident #77 had new onset of involuntary movements in the lip and foot areas; scoring a 1 in each area. The legend at the top of the form indicated a score of 1 was minimal or normal. Under the section Interpretation of the AIMS score indicated no single score exceeding 1 indicated the resident may be at low risk for movement disorders. The form did not indicate an interpretation for a score of 1 in more than 1 area. A review of nurse's notes dated 1-23, 24, and 25-2012 did not indicate the physician had been notified of the new onset of involuntary movements. In an interview on 4-17-2012 at 10:05 a.m. Unit Manager #3 indicated the physician was not called with the new onset of involuntary movements because the top of the form indicated a score of 1 was considered normal. 1. b. Resident # 35's record was reviewed 4-17-2012 at 2:00 p.m. Resident #35's diagnoses included Alzheimer's dementia, delusions, and dementia with behavioral disturbances.		treatment administration records for all residents in the past 30 days will be reviewed by DON or designee(s) on or before 5-19-12 to identify resident medication refusals and to ensure associated physician notification has been made.*The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Licensed nursing staff will be in-serviced by the Staff Development Coordinator by 5.19.12 related to the policy and procedure for physician notification to include changes in the AIMS assessment, discontinuation medications with associated required laboratory draws and medication refusal. *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates compliance with physician notification. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.	

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	On 4-17-2012 at 8:45 a.m., Resident #35 was observed walking in the hall. Resident #35 was observed to have irregular purposeless movements with her arms. On 4-17-2012 between 2:50 and 2:55 p.m., Resident #35 was observed resting in bed. Resident #35 was observed to have repeated lateral foot movement. An Abnormal Involuntary Movement Scale (AIMS) dated 1/31/2012 indicated Resident #35 had no abnormal involuntary movements. An AIMS dated 4/16/2012 indicated Resident #35 had new onset of involuntary movements in the upper and lower extremity areas; scoring a 1 in each area. The legend at the top of the form indicated a score of 1 was minimal or normal. Under the section Interpretation of the AIMS score indicated no single score exceeding 1 indicated the resident may be at low risk for movement disorders. The form did not indicate an interpretation for a score of 1 in each of the sections of a specific areas. A review of nurse's notes dated 4-16, and 17, 2012 did not indicate the physician had been notified of the new onset of			

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	involuntary movements. In an interview on 4-17-2012 at 10:05 a.m. Unit Manager #3 indicated the physician was not called with the new onset of involuntary movements because the top of the form indicated a score of 1 was considered normal. In an interview on 4-17-12 at 10:10 a.m. Pharmacy representative #5 indicated the physician should have been notified when a change in the AIMS score was noted. A policy titled Simplified Diagnosis for Tardive Dyskinesia dated 10-12-2004 indicated under #2 be alert for any change from the baseline, and movements on two items located in different body area. The policy also indicated the physician should examine any individual who has movements not explained by other factors. 2. Resident #35's physician's order sheet dated 12-11 indicated Depakote levels were to be drawn every 6 months. Resident #35 did not have an order to receive Depakote. Resident #35's Depakote level was less than 3 on the lab result taken 12-9-2011. In an interview on 4-18-2012 at 9:32 a.m.			

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	Unit Manager #3 indicated Resident #35 had received Depakote in the past, but was unable to provide the original order or the date the Depakote was discontinued. Unit Manger #3 further indicated the physician should have been notified to discontinue the lab test. 3. Resident #68's clinical record was reviewed on 4/18/12 at 9:30 A.M.. The record indicated the resident had numerous medication refusals in March and April which were not reported to the physician. The Medication Administration Record (MAR) for March 2012 and April 2012 indicated the resident did not receive physician's ordered medications of: Miralax 17 grams in 8 ounces water at 9:00 P.M. on: 3/13; 3/14; 3/16; 3/17; 3/18; 3/20-3/31; 4/1; 4/2; 4/3-4/11; 4/14; 4/18. Levothyroxine 50 micrograms (mcg) at 6:00 A.M. on: 3/24; 4/10; 4/16. Carvedilol 3.125 milligrams (mg) at 6:00 P.M. on: 3/23; 4/6; 4/7; 4/9; 4/10; 4/11; 4/13; 4/14; 4/15; 4/17. Carvedilol 3.125 milligrams (mg) at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Docusate Sodium 100 mg at 6:00 P.M. on: 3/23; 3/24; 4/6-4/11; 4/13-4/17. Docusate Sodium 100 mg at 9:00 A.M. on: 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17.			

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	Lipitor 80 mg at 9:00 P.M. on: 3/23; 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/15; 4/16; 4/17. Lopid 600 mg at 6:00 P.M. on: 3/23; 4/6; 4/7; 4/9; 4/10; 4/11; 4/13-4/17. Lopid 600 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Lactulose solution 30 milliliters (ml) at 9:00 A.M. on: 4/2; 4/3; 4/5; 4/6; 4/7; 4/10; 4/15; 4/16; 4/17. Nexium 20 mg at 9:00 A.M. on: 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Plavix 75 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Aspirin 81 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. The nurse's notes for March and April 2012 were also reviewed and indicated there was no physician notification for medication refusals noted. An interview with the Director of Nursing (DN) on 4/18/12 at 11:10 A.M. indicated the physician was not notified of the medication refusals if it was not in the nurse's notes. 4. Resident #8's clinical record was reviewed on 4/16/12 at 2:15 P.M.. The record indicated the resident had numerous medication refusals in March and April which were not reported to the physician.			

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	The Medication Administration Record (MAR) for March 2012 and April 2012 indicated the resident did not receive physician's ordered medications of: Metoprolol 50 mg at 9:00 A.M. on: 3/11; 3/17; 3/18; 4/1; 4/2; 4/4. Namenda 10 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2 l 4/4. Namenda 10 mg at 6:00 P.M. on: 4/4. Omeprazole 20 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4. Omeprazole 20 mg at 6:00 P.M. on: 4/4. Spiriva inhaler 18 mcg, 1 cap at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/4. Docusate Sodium 100 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4. Lisinopril 10 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4. Mylanta 30 milliliters (ml) at 9:00 A.M. on: 3/17; 3/18; 3/22; 3/23; 4/1 4/4. Mylanta 30 milliliters (ml) at 6:00 P.M. on: 4/1; 4/4; 4/5. Systane eye drops, 1 drop into each eye at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/4. Systane eye drops, 1 drop into each eye at 1:00 P.M. on: 3/17; 3/18; 4/1. Systane eye drops, 1 drop into each eye at 6:00 P.M. on: 3/17; 4/4; 4/5. Travatan eye drops, 1 drop into each eye at 9:00 P.M. on: 3/17/12; 4/1-4/4. Trazadone 50 mg at 9:00 P.M. on: 3/17/12. Gabapentin 600 mg at 9:00 A.M. on			

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	3/17/12; 4/1; 4/2; 4/4. The nurse's notes for March and April 2012 were also reviewed and indicated there was no physician notification for medication refusals noted. An interview with the Director of Nursing (DN) on 4/18/12 at 11:10 A.M. indicated the physician was not notified of the medication refusals if it was not in the nurse's notes. 3.1-5(a)(3)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other 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. Based on record review and interviews, the facility failed to ensure 1 of 3	F0225	It is the practice of this facility to ensure the highest quality of care is afforded our residents.	05/19/2012

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	allegations of abuse reviewed affecting 1 of 3 residents (Resident #101) was reported immediately to the Administrator, investigated thoroughly, steps were taken to protect residents from the alleged perpetrator, and the allegation was reported to the Department of Health and other required entities. Finding includes: 1. During staff interviews regarding the facility's abuse protocol, CNA #20, on 04/18/12 at 2:30 P.M., indicated she had witnessed and reported an allegation of possible physical abuse between Resident #101 and CNA #21. During the daily exit conference, conducted on 04/18/12 at 3:30 P.M., the investigation for the allegation of abuse report for CNA #21 and Resident #101 was requested. On 04/19/12 at 9:30 A.M., the Administrator indicated he did not have any allegations of abuse in the past year reported which specifically involved Resident #101 and CNA #21. The Administrator requested additional information and indicated he would contact CNA #20 by telephone in an attempt to elicit more information.		Consistent with this practice, the following has been completed:*The corrective action taken for the residents found to have been affected by the deficient practice was:*The corrective action taken for those residents having the potential to be affected by the same deficient practice is:An abuse audit will be conducted and cognitively intact residents interviewed regarding staff treatment by Social Service Director or designee(s) on or before 5-19-12. All staff were interviewed by IDT completed 5-8-12, regarding any other outstanding allegations of abuse, with no additional concerns identified.*The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Staff will be educated on the facility abuse policy to include direct reporting to the facility executive director and supervisor immediately by the Staff Development Coordinator or designee(s) on or before 5-19-12 . *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates compliance timely investigation and reporting of allegations and assessment of staff understanding of the abuse policy and reporting procedures. The indicator will be completed by the Executive Director or her	

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	Interview with the Administrator, on 04/19/12 at 1:30 P.M., indicated the Staff Development Director, RN #22 had spoken with CNA #20 and she indicated she had reported her concern along with other interpersonal complaints regarding the work of CNA #21 to the unit manager, RN #3. The Administrator indicated he was trying to get CNA #20 to come in to the facility to give a statement so he could initiate the investigative process. He also indicated CNA #21 was to be suspended while the investigation ensued. Interview with RN #22, on 04/19/12 at 1:40 P.M. indicated CNA #20 had stated on the telephone she had reported to RN #3, at an undetermined time, a concern regarding getting soap in the eyes and scrubbing Resident #101's face roughly during a shower given to Resident #101 by CNA #20 and #21. She also indicated she had given a whole list of other non-abuse type concerns regarding CNA #21's work at the time of the report. Interview with RN #3, the Unit Manager, on 04/19/12 at 1:45 P.M., indicated she recalled a conversation with CNA #20 regarding concerns with CNA #21 but did not recall any concerns being voiced regarding the rough treatment of Resident #101 or any other resident.		designee weekly for the first month and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits. An investigation was initiated, by facility administration on 4-19-12, regarding the allegation of abuse reported during the survey. A head to toe assessment for resident #110 was conducted on 4-19-12, with no unusual findings. The family and physician were notified on 4-19-12 of allegation with no new orders received. The staff members involved in the allegation were suspended pending investigation and the allegation was reported to the ISDH.	

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	Because the allegation was not report to the Administrator timely, the investigation was never initiated and the allegation remained uninvestigated. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 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 record review and interviews, the facility failed to ensure 1 of 3 allegations of abuse reviewed affecting 1 of 3 residents (Resident #101) the facility failed to ensure they implement their Abuse protocol policy to ensure 1 of 3 allegations of abuse reviewed was reported immediately to the Administrator, investigated thoroughly, steps were taken to protect residents from the alleged perpetrator, and the allegation was reported to the Department of Health and other required entities. Finding includes: 1. During staff interviews regarding the facility's abuse protocol, CNA #20, on 04/18/12 at 2:30 P.M., indicated she had witnessed and reported an allegation of possible physical abuse between Resident #101 and CNA #21. During the daily exit conference, conducted on 04/18/12 at 3:30 P.M., the investigation for the allegation of abuse report for CNA #21 and Resident #101	F0226	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:*The corrective action taken for the residents found to have been affected by the deficient practice was:The facility based policy regarding abuse was validated to ensure that the most recent copy of the abuse policy indicating direct and immediate reporting of allegations of abuse to the facility executive director and employee's supervisor was available and accessible at all times.* The corrective action taken for those residents having the potential to be affected by the same deficient practice is:An abuse audit will be conducted and cognitively intact residents interviewed regarding staff treatment by Social Service Director or designee(s) on or before 5-19-12. All staff were interviewed by IDT completed 5-8-12, regarding any other outstanding allegations of abuse, with no additional concerns identified.A review of the personnel file and abuse acknowledgement of all current	05/19/2012

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	was requested. On 04/19/12 at 9:30 A.M., the Administrator indicated he did not have any allegations of abuse in the past year reported which specifically involved Resident #101 and CNA #21. The Administrator requested additional information and indicated he would contact CNA #20 by telephone in an attempt to elicit more information. Interview with the Administrator, on 04/19/12 at 1:30 P.M., indicated the Staff Development Director, RN #22 had spoken with CNA #20 and she indicated she had reported her concern along with other interpersonal complaints regarding the work of CNA #21 to the unit manager, RN #3. The Administrator indicated he was trying to get CNA #20 to come in to the facility to give a statement so he could initiate the investigative process. He also indicated CNA #21 was to be suspended while the investigation ensued. Interview with RN #22, on 04/19/12 at 1:40 P.M. indicated CNA #20 had stated on the telephone she had reported to RN #3, at an undetermined time, a concern regarding getting soap in the eyes and scrubbing Resident #101's face roughly during a shower given to Resident #101 by CNA #20 and #21. She also indicated		employees will be reviewed to ensure the most recent copy of the abuse policy indicating direct and immediate reporting of allegations of abuse to the facility executive director and supervisor is signed by all employees by the Staff Development Coordinator or designee(s) on or before 5-19-12.*The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Staff will be re-educated on the facility abuse policy to include direct reporting to the facility executive director and supervisor immediately by the Staff Development Coordinator on or before 5-19-12. The executive director has ensured that the most recent abuse policy indicating direct and immediate reporting of allegations of abuse to the facility executive director is maintained in the facility abuse binder.*To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance timely investigation and reporting of allegations, staff understanding of the abuse policy and reporting procedures and availability of the current abuse policy. The indicator will be completed by the Executive Director or designee weekly for 30 days, and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the*	

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	she had given a whole list of other non-abuse type concerns regarding CNA #21's work at the time of the report. Interview with RN #3, the Unit Manager, on 04/19/12 at 1:45 P.M., indicated she recalled a conversation with CNA #20 regarding concerns with CNA #21 but did not recall any concerns being voiced regarding the rough treatment of Resident #101 or any other resident. Interview with the Administrator, on 04/19/12 at 1:30 P.M., indicated the staff development nurse, RN #22 had spoken with CNA #20 and she indicated she had reported her concern along with other interpersonal complaints regarding the work of CNA #21 to the unit manager, RN #3. The Administrator indicated he was trying to get CNA #20 to come in to the facility to give a statement so he could initiate the investigative process. He also indicated CNA #21 was to be suspended while the investigation ensued. Interview with the Staff Development Director, RN #22, on 04/19/12 at 1:40 P.M. indicated CNA #20 had been hired in the recent few months and had been inserviced regarding the facility's policy to report any suspected allegation of abuse to their supervisor and to the		*monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.* An investigation was initiated, by facility administration on 4-19-12, regarding the allegation of abuse reported during survey. A head to toe assessment for resident 110 was conducted on 4-19-12 with no unusual findings. The family and physician were notified of allegation on 4-19-12 with no new orders received. The staff members involved in the allegation were suspended pending investigation and the allegation was reported to the ISDH.	

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	Administrator immediately. Review of an acknowledgement form, titled "(facility's name) Staff Treatment of Residents" indicated CNA #20 had signed, on 02/23/12, the form which included the following instructions: "...As an associate of (facility's name), you have a responsibility to assure that no resident is the victim of physical, mental, verbal, or sexual abuse, corporal punishment, involuntary seclusion, or misappropriation of resident property. As an associate, you are required to report immediately to the Executive Director if you have witnessed or are aware of a resident being abused, mistreated, or neglected...." Review of the facility's policy and procedure, titled, "Protection of Residents: Reducing the Threat of Abuse and Neglect, revised 02/2009, included the following: ...3. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin will be promptly reported to the Administrator and/or Director of Nursing,...5. The person(s) observing an incident of resident abuse or suspected resident abuse will immediately report such incidents to their immediate supervisor and/or the charge nurse. The supervisor and/or charge nurse will illicit			

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	the following information when the incident is report: a. The name of the resident involved in the incident. b. The date and time the incident occurred. c. Where the incident took place. d. The name(s) of the person(s) committing or involved with the incident, if known. e. The name(s) of any witnesses to the incident. f. The type of abuse and/or neglect that was committed. g. Any additional information that may be pertinent to the incident. 6. The charge nurse will complete and sign the Incident Report and notify the physician and the resident's responsible party of the occurrence...8. When an incident of resident abuse is suspected, the incident must be report to the supervisor regardless of the time lapse since the incident occurred. The supervisor notifies the Director of Nursing and the Executive Director (Administrator) of the alleged incident...12. Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to their state survey agency...Failure to do so will mean that the facility in not in compliance with the federal regulations...Abuse and/or Neglect Investigation...1. When an incident or suspected incident of resident abuse and/or neglect is reported, the Administrator will appoint a representative to investigate the			

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	occurrence...4.. If it is determined that alleged abuse and/or neglect has occurred, the Administrator, Director of Nursing, or his/her designee will promptly notify officials in accordance with state laws and corporate practices...6. If the accused individual is an employee, they will be placed on suspension pending the results of the investigation while the incident is being investigated..." Interview with the Administrator, on 04/19/12 at 3:00 P.M. indicated the 2009 Abuse policy and procedure was not the current policy in place. He could not locate a copy of the current policy but indicated, as shown in the training document for CNA #20, the 2009 policy had been revised and changed to indicate staff should report immediately to the Executive Director (Administrator) any allegation of abuse. He indicated other policy changes focused on reporting suspected crimes against resident regulations specific to the Elder Justice Act. Because the allegation was not reported immediately to the Administrator, the facility's policy and procedure regarding "Protection of Residents: Reducing the Threat of Abuse and Neglect" was not followed in a timely fashion.			

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	3.1-28(a)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a behavior management program was consistently implemented for 1 of 10 residents reviewed for behaviors in a sample of 21. (Resident #8) Finding includes: 1. Resident #8's clinical record was reviewed on 4/16/12 at 2:15 P.M.. The record indicated the resident was most recently readmitted to the facility on 8/10/10 and had diagnoses including, but not limited to, anxiety, insomnia and mental disorder not otherwise specified. The physician's orders medications dated 4/2/12, included, but were not limited to, Prozac 20 milligrams (mg) daily and Seroquel 50 mg at bedtime. Review of a progress note from a nurse practitioner (NP) from a psychiatric medical group dated 4/2/12 indicated a medication change resulting in starting Seroquel 50 mg at bedtime. The NP noted the resident had "insomnia-threatening	F0250	*The corrective action taken for the residents found to have been affected by the deficient practice was:*The interdisciplinary team reviewed the clinical record for resident #8 to include the behavior plan, associated interventions and behavior tracking log for appropriateness based on the cumulative documentation. A new behavior tracking record was implemented effective 5.1.12 with additional interventions. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*The clinical record for each resident was reviewed for the last 30 days to identify any behaviors that may not have been reflected on the behavior tracking log by IDT and completed on 5-3-12. The Social Service Director or designee will review the results of the audit and the appropriateness of the interventions based on the cumulative documentation. New behavior tracking logs will be available to the staff with updated interventions on or before 5-19-12. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Staff will be	05/19/2012

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	nurse last night, wanted meds but had received them-wandering, following nurse, not easily redirectable-sleeping soundly at noon-irritable when awakened-staff note moodiness during day...son recently moved to" (another state) "an increase in behaviors since then". Review of the resident's behavior monitoring records since 1/12 indicated 3 behavior incidents total on 1/10/12, 1/23/12 and 2/16/12. The behavior monitoring record form includes the actual behavior, duration of the incident, precipitating factor code (cause of behavior) unsuccessful approaches and successful approaches. An interview with the social service director (SSD) on 4/18/12 at 9:40 A.M., indicated more behaviors had occurred but were not put on behavior monitoring sheets. The SSD indicated nurses often chart behavior incidents on the nurse's notes only and do not utilize the facility process for monitoring behaviors. The SSD indicated she is to use the behavior monitoring records to gather information including the number and type of behaviors, successful and unsuccessful approaches and this information is to be used for medication changes.		educated by the Staff Development Coordinator or designee(s) on or before 5-19-12 regarding the behavior program to include the use of the behavior tracking log and required documentation. *To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance with the use of the behavior tracking log through review of behaviors that may be indicated in the clinical record and facility 24 hour report. The indicator will be completed by the Social Services Director or her designee weekly for the first month, and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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	3.1-34(a)			

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F0279 SS=E	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. 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. 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).			
	Based on observation, interview and record review the facility failed to initiate a care plan concerning abnormal involuntary movements for 2 of 21 residents reviewed for care plans in a sample of 21. In addition, the facility failed to initiate a care plan concerning medication refusals for 2 of 10 residents reviewed for behaviors in a sample of 21. (Resident #77, Resident #35, Resident #8 and Resident #68) Findings include: 1. a. Resident #77's record was reviewed	F0279	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* A care plan has been established for resident #77 on 4-23-12 and resident #35 on 4-18-12, completed per licensed nursing staff, based on the AIMS assessment and associated changes from prior assessment to include the presence of involuntary movements. A care plan has been developed for	05/19/2012

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	4-16-2012 at 2:15 p.m. Resident #77's diagnoses included but were not limited to psychosis, dementia with behavioral disturbances and chronic pain. On 4-16-2012 at 11:30 a.m., Resident #77 was observed in the resident lounge area sitting in an easy chair. Resident #77 was observed to have repeated lip puckering. On 4-18-2012 at 9:19 a.m., Resident #77 was observed sitting in an easy chair in the resident lounge area. Resident #77 was observed to have repeated lip puckering and foot tapping. An Abnormal Involuntary Movement Scale (AIMS) dated 6/2/2011 indicated Resident #77 had no abnormal involuntary movements. An AIMS dated 1/23/2012 indicated Resident #77 had new onset of involuntary movements in the lip and foot areas; scoring a 1 in each area. The legend at the top of the form indicated a score of 1 was minimal or normal. Under the section Interpretation of the AIMS score indicated no single score exceeding 1 indicated the resident may be at low risk for movement disorders. The form did not indicate an interpretation for a score of 1 in more than 1 area.		resident #68 on 4-18-12 and resident #8 on 4-25-12 related to medication refusal per licensed nursing staff. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*The care plans for resident's receiving antipsychotic medications will be reviewed by Behavior Committee on or before 5-19-12 to ensure that the results of the AIMS assessments were reflected in the individualized plan of care as necessary. The care plans for resident's who refuse care, including medication refusal, will be reviewed by DON or designee(s) on or before 5-19-12, to ensure that refusal of care was reflected in the individualized plan of care as necessary.*The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Licensed nursing staff will be educated by the Staff Development Coordinator on or before 5.19.12 accurately reflecting individualized resident need on the plan of care to include AIMS results and care refusal.*To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance with accurately reflecting individualized resident needs on the plan of care. The indicator will be completed by the*	

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	A review of care plans dated 4-12 indicated the new onset of involuntary movements was not included. In an interview on 4-17-2012 at 10:05 a.m. Unit Manager #3 indicated a care plan should have been initiated for the involuntary movements. 1. b. Resident # 35's record was reviewed 4-17-2012 at 2:00 p.m. Resident #35's diagnoses included Alzheimer's dementia, delusions, and dementia with behavioral disturbances. On 4-17-2012 at 8:45 a.m., Resident #35 was observed walking in the hall. Resident #35 was observed to have irregular purposeless movements with her arms. On 4-17-2012 between 2:50 and 2:55 p.m., Resident #35 was observed resting in bed. Resident #35 was observed to have repeated lateral foot movement. An Abnormal Involuntary Movement Scale (AIMS) dated 1/31/2012 indicated Resident #35 had no abnormal involuntary movements. An AIMS dated 4/16/2012 indicated Resident #35 had new onset of involuntary movements in the upper and		*Director of Nursing or her designee weekly for the first month, and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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	lower extremity areas; scoring a 1 in each area. The legend at the top of the form indicated a score of 1 was minimal or normal. Under the section Interpretation of the AIMS score indicated no single score exceeding 1 indicated the resident may be at low risk for movement disorders. The form did not indicate an interpretation for a score of 1 in each of the sections of a specific areas. A review of care plans dated 2-28-12 indicated there was no care plan for the new onset of involuntary movements. In an interview on 4-17-2012 at 10:05 a.m. Unit Manager #3 indicated a care plan should have been initiated for the new onset of involuntary movements. A policy titled Resident Care plan dated 12/08 indicated the care plan should be a brief individualized portrait of the resident and an individualized guide to the nursing care needed. The policy further indicated the care plan should include problems and approaches to be used. 2. Resident #68's clinical record was reviewed on 4/18/12 at 9:30 A.M.. The			

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	record indicated the resident had numerous medication refusals in March and April. The Medication Administration Record (MAR) for March 2012 and April 2012 indicated the resident did not receive physician's ordered medications of: Miralax 17 grams in 8 ounces water at 9:00 P.M. on: 3/13; 3/14; 3/16; 3/17; 3/18; 3/20-3/31; 4/1; 4/2; 4/3-4/11; 4/14; 4/18. Levothyroxine 50 micrograms (mcg) at 6:00 A.M. on: 3/24; 4/10; 4/16. Carvedilol 3.125 milligrams (mg) at 6:00 P.M. on: 3/23; 4/6; 4/7; 4/9; 4/10; 4/11; 4/13; 4/14; 4/15; 4/17. Carvedilol 3.125 milligrams (mg) at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Docusate Sodium 100 mg at 6:00 P.M. on: 3/23; 3/24; 4/6-4/11; 4/13-4/17. Docusate Sodium 100 mg at 9:00 A.M. on: 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Lipitor 80 mg at 9:00 P.M. on: 3/23; 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/15; 4/16; 4/17. Lopid 600 mg at 6:00 P.M. on: 3/23; 4/6; 4/7; 4/9; 4/10; 4/11; 4/13-4/17. Lopid 600 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Lactulose solution 30 milliliters (ml) at 9:00 A.M. on: 4/2; 4/3; 4/5; 4/6; 4/7; 4/10; 4/15; 4/16; 4/17.			

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	Nexium 20 mg at 9:00 A.M. on: 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Plavix 75 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Aspirin 81 mg at 9:00 A.M. on: 4/5; 4/6; 4/7; 4/10; 4/11; 4/12; 4/14-4/17. Review of the resident's health care plans indicated there was no health care plan addressing medication refusals. An interview with the Social Service Director on 4/18/12 at 9:55 A.M. indicated there was no health care plan for medication refusals. 3. Resident #8's clinical record was reviewed on 4/16/12 at 2:15 P.M.. The record indicated the resident had numerous medication refusals in March and April which were not reported to the physician. The Medication Administration Record (MAR) for March 2012 and April 2012 indicated the resident did not receive physician's ordered medications of: Metoprolol 50 mg at 9:00 A.M. on: 3/11; 3/17; 3/18; 4/1; 4/2; 4/4. Namenda 10 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2 l 4/4. Namenda 10 mg at 6:00 P.M. on: 4/4. Omeprazole 20 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4.			

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	Omeprazole 20 mg at 6:00 P.M. on: 4/4. Spiriva inhaler 18 mcg, 1 cap at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/4. Docusate Sodium 100 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4. Lisinopril 10 mg at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/2; 4/4. Mylanta 30 milliliters (ml) at 9:00 A.M. on: 3/17; 3/18; 3/22; 3/23; 4/1 4/4. Mylanta 30 milliliters (ml) at 6:00 P.M. on: 4/1; 4/4; 4/5. Systane eye drops, 1 drop into each eye at 9:00 A.M. on: 3/17; 3/18; 4/1; 4/4. Systane eye drops, 1 drop into each eye at 1:00 P.M. on: 3/17; 3/18; 4/1. Systane eye drops, 1 drop into each eye at 6:00 P.M. on: 3/17; 4/4; 4/5. Travatan eye drops, 1 drop into each eye at 9:00 P.M. on: 3/17/12; 4/1-4/4. Trazadone 50 mg at 9:00 P.M. on: 3/17/12. Gabapentin 600 mg at 9:00 A.M. on 3/17/12; 4/1; 4/2; 4/4. Review of the resident's health care plans indicated there was no health care plan addressing medication refusals. An interview with the Social Service Director on 4/18/12 at 9:55 A.M. indicated there was no health care plan for medication refusals. 3.1-35(a)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observations, record reviews and interviews the facility failed to ensure physician orders and care plans were followed 4 of 21 residents reviewed for physician orders and care plans in a sample of 21. (Residents #26, #82, #57 and #45) Findings include: 1. The clinical record of Resident #26 was reviewed on 4/17/2012 at 1:45 p.m. Resident #26's Physician orders dated 4/2/12 included an order for a pre-albumin blood test. An abnormal pre albumin blood results of 14.1 (Low) was obtained. On the lab result form was a handwritten note of "Dietary consult." The Resident's record contained a 'diet order and communication' slip dated 4/2/12 which indicated "Registered Dietician (RD) consult needed pre-albumin 14.1 L (Low)" The last Nutritional progress note in the Resident's clinical record was dated 3/26/12 and indicated "30 day review for 3/20."	F0282	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* Resident #26 – A dietary consult was completed on 4-18-12, for resident #26, to address the low pre-albumin level. As a result of the consult, the dietician recommended to repeat a prealbumin in one month. New orders received per physician. Resident #57 – The transfer status for resident #57 was reviewed and the use of a Hoyer lift continues to be indicated. Screen completed by Rehab Services Manager on 5-8-12. Resident #57 was evaluated for any signs or symptoms of injury related to the two-person transfer with no symptoms of pain or injury. The CNA's involved in the transfer were counseled due to disregard of Hoyer lift protocol in place at time of survey for resident #57. Resident #45 – The wound on resident #45 was treated and dressed by a licensed staff member per existing physician	05/19/2012

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	The Resident's care plan dated 2/27/12 indicated "I am at nutritional risk R/T (related to) mechanical soft diet DX (diagnosis) of MR, and low albumin." It was noted under care plan titled "Approaches ... Notify MD/RD of significant wt/condition change." The Resident's MDS [Minimum Data Set] assessment dated 3/1/12 indicated the care area assessment #12 Nutritional status was triggered, the care panning decision was triggered, and the location and date of the CAA documentation was in the "Dietary note." During interview on 4/17/12 at 5:15 p.m., Registered Dietician #15 stated, "I'm doing my routine rounds. If other things are required another Dietician will come throughout the week ... We [the Dieticians] make several visits every week to this facility." During interview on 4/18/12 at 10:30 a.m., the Dietary Manager indicated the process for relaying the information of a "diet order & communication" slip. The process was noted by the Dietary Manager as follows: "... when the slip is received, the name of the Resident, the date the slip is received by this department and a comment for the consult is noted and		order. Resident #82 – The delay in prescribed treatment, regarding Voltaren, was communicated to the physician with new treatment orders received on 3-28-12. Affected areas have since healed.*The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*All laboratory data for the past 30 days will be reviewed for abnormal levels to ensure that no other physician notifications, orders, or request for RD consult have been omitted by DON or designee(s) on or before 5-19-12. The transfer status, for all residents, will be reviewed by the Rehab Services Manager or designee(s) on or before 5-19-12, to ensure current transfer status is accurate.Wound treatment orders, will be reviewed during Monday through Friday change of condition meeting for implementation, correct transcription, and medication availability by DON or designee(s) on or before 5-19-12.*The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Licensed nurses will be inserviced by the Staff Development Coordinator on or before 5-19-12 on dietary communication flow process, completing treatments according to physician order, transcription of orders and process for communicating concerns	

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	written by myself on this sheet of paper..." The paper the Dietary Manager referred to was titled "Nutrition Referral List." On 4/18/12 at 10:30 a.m., a Nutritional referral list was provided by the Dietary Manager. Resident #26's name was listed with the date "4/2" with the comment "consult." During interview on 4/18/12 at 10:31 a.m., the Dietary Manager indicated it should not have taken from 4/2/12 to 4/18/12 to obtain the Dietary consult for Resident #26. 2. Resident #45's record was reviewed 4-18-12 at 10:22 a.m. Resident #45's diagnoses included but were not limited to diabetes, depression and cerebrovascular accident (stroke). A physician's order dated 4-12 indicated to cleanse the area on Resident #45's right buttock, and apply allevyn thin every other day.		regarding medication availability.Care staff will be inserviced by the Staff Development Coordinator on or before 5-19-12 on the following individualized plans of care established for each resident, including transfers. *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates compliance with transfers according to the plan of care, Dietary consult communication, transcription of orders, and completing treatments according to physician order. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 6 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits	

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	During an observation in 4-19-2012 at 9:37 a.m. Resident #45 was observed without a dressing over the wound on her right buttock. The right buttock area was observed with a whitish pink substance over the area. In an interview on 4-19-2012 at 9:37 a.m. LPN #1 indicated she did not know why there was no dressing or how long the dressing had not been on the area. LPN #1 additionally indicated the substance covering the right buttock area appeared to be calmoseptine. LPN#1 further indicated the dressing should have been replaced as soon as it was noted to have been dislodged. 3. During the initial tour of the facility, conducted on 04/16/12 between 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #57 was confused, required extensive staff assistance for activities of daily living, had pressure ulcers on her right and left buttocks, required mechanical lift assistance for transferring needs, and was incontinent of her bowels and bladder. Resident #57 was observed on 04/18/12 at 9:08 A.M., in her wheelchair in her room watching television. On 04/18/12 at 9:13 A.M., Resident #57 was noted to be in bed and CNA #2 and QMA #25 were			

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	preparing to provide incontinence care for the resident. The mechanical lift was not observed to have been taken into the resident's room. Interview with QMA #25 indicated the two staff had performed a two person transfer because the resident "gets mad" when transferred with the mechanical lift. QMA #25 indicated Resident #57 does not assist or bear any weight with her legs during transfers. The clinical record for Resident #57 was reviewed on 04/18/12 at 9:42 A.M. The most recent Minimum Data Set (MDS) assessment, completed on 02/27/12 indicated Resident #57 required extensive staff assistance of two for transferring needs and a mechanical lift was indicated on the assessment. The current health care plan regarding transfers, initiated on 01/24/2007 and current through 06/20/12, indicated the resident required hoyer (mechanical) lift transfer with two staff assistance for safe transfers. Resident #57 was observed on 04/18/12 at 11:45 A.M., transferred with a mechanical lift and staff assistance by QMA #25 and CNA #26. The resident did not make any negative comments or seem upset by the transferring process. #4. The clinical record of Resident #82 was reviewed on 4/16/12 at 2:15 p.m.			

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	The record indicated Resident #82's diagnoses included, but were not limited to, diabetes and chronic pain. The Nurse's Notes dated 3/14/12 at 8:00 p.m. indicated the resident had increased redness of the buttocks and Vaseline/aquaphor was applied to the buttocks and there was no excoriation noted on the buttocks. The Physician's Order dated 3/20/12 indicated Voltaren gel (used for yeast infection) apply 4 grams to affected area 4 times a day. The Physician was faxed on 3/23/12 at 6:30 a.m. and indicated the resident had scratched her right buttock and an order for EPC cream was received to apply the EPC cream every shift and as needed until healed. The Treatment Administration Record (TAR) dated 3/20/12 indicated there was no documentation the Voltaren gel had been transcribed on the 3/20/12 TAR. The Nurse's Notes dated 3/25/12 at 12:00 p.m. indicated the resident's chart was reviewed and the Physician's Order dated 3/20/12 for the Voltaren gel did not get transcribed by the nurse. The resident's Physician was notified and indicated he			

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	wanted to continue the order for the Voltaren gel 4 grams to apply to the affected area 4 times a day. On 4/19/12 at 9:00 a.m. Unit Manager RN # 3 was interviewed in regard to the Physician's order for Voltaren gel not transcribed for 5 days after the treatment was ordered. Unit Manager RN #3 indicated on 3/20/12 LPN #18 should had transcribed the Physician's Order for Voltaren gel for Resident #82. 3.1-35(g)(2)			

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F0309 SS=D	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. Based on interviews, observation, and record review, the facility failed to notify the Food Service Director in a timely manner in regard to the development of a pressure ulcer. The area on the buttocks had been a yeast infection and on 3/29/12 developed into a pressure area. This deficiency affected 1 of 7 who were reviewed for a pressure ulcer in a sample of 21 residents(Resident #82). Findings include: The clinical record of Resident #82 was reviewed on 4/16/12 at 2:15 p.m. The record indicated Resident #82's diagnoses included, but were not limited to, diabetes and chronic pain. The Quarterly Minimum Data Set (MDS) assessment dated 2/15/12 indicated the resident was independent in ambulation and was occasionally incontinent of bladder. The Braden Scale For Predicting Pressure	F0309	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* The registered dietician consult was completed for resident # 82 on 4-18-12 with recommendation from dietician for Vitamin C 500mg daily for 30 days. Physician orders were obtained for Vitamin C as recommended. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:* All residents with pressure ulcers and/or that are identified at high risk will be reviewed by DON or designee(s) on or before 5-19-12 to ensure that the Registered Dietician is made aware and intervene as professionally necessary. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:* All new skin conditions will be discussed at Monday	05/19/2012

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	Sore Risk dated 2/13/12 indicated a score of 20 indicated the resident was at risk for a pressure ulcer. The Physician's Order dated 2/17/12 indicated apply Vaseline/aquaphor to affected areas as needed. The Nurse's Notes dated 3/14/12 at 8:00 p.m. indicated the resident had increased redness of the buttocks and Vaseline/aquaphor was applied to the buttocks and there was no excoriation noted on the buttocks. The Physician's Order dated 3/20/12 indicated Voltaren gel (used for yeast infection) apply 4 grams to affected area 4 times a day. The Physician was faxed on 3/23/12 at 6:30 a.m. and indicated the resident had scratched her right buttock and an order for EPC cream was received to apply the EPC cream every shift and as needed until healed. The Treatment Administration Record (TAR) dated 3/20/12 indicated there was no documentation the Voltaren gel had been transcribed on the 3/20/12 TAR. The Nurse's Notes dated 3/25/12 at 12:00 p.m. indicated the resident's chart was		through Friday change of condition meeting and requisitions for dietary consultation completed at that time. All other changes in skin status will be discussed at the weekly skin/nutrition at risk meeting with those not progressing favorably referred to the registered dietician for further evaluation and review. All licensed nurses will be inserviced to notify dietary per corporate approved communication form when a resident has a pressure ulcer or at high risk by the Staff Development Coordinator on or before 5-19-12. *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates compliance with timely RD intervention for newly developed and existing pressure ulcers. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits	

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	reviewed and the Physician's Order dated 3/20/12 for the Voltaren gel did not get transcribed by the nurse. The resident's Physician was notified and indicated he wanted to continue the order for the Voltaren gel 4 grams to apply to the affected area 4 times a day. A document proved by the Director Nursing Service (DNS) on 4/18/12 at 10:30 a.m. indicated on 3/27/12 a cushion was applied to the resident's seating area. The Nurse's Notes dated 3/27/12 at 4:00 p.m. and indicated the Pharmacy was notified in regard to the Voltaren gel had not been received by the facility and the Pharmacist indicated the medication was not available. The resident's Physician was notified by phone and a message was left with the Physician's nurse. At 6:30 p.m. the nurse faxed the Physician in regard to the Voltaren gel was not available from the pharmacy. The Physician's Orders dated 3/28/12 and indicated to discontinue the Voltaren gel and start clotrimazole/betamethasone cream twice a day until the area is healed. The Nurse's Notes dated 3/29/12 at 5:30 p.m. and indicated "...Redness between buttocks (with) superficial depth nickel-sized '(?)' open area on inner right			

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	buttock. Red base (with) (no) drainage seen. Clotrimazole based cream applied...Res (resident) states 'That cream helped last night!'...." The Nurse's Notes dated 3/30/12 at 8:00 p.m. indicated the resident's buttocks had a decrease in inflammation and the skin was pink and blanchable. The Non-Pressure Skin Condition Record dated 3/30/12 and 4/9/12 and indicated the resident had a yeast infection to her right buttock measured at 0.7 centimeters (cm) in length and 0.3 cm in width. On 4/9/12 the open area measured 1.5 cm in length and 0.5 cm in width. There was no documentation on the Pressure Status Record until 4/13/12 and indicated the area on the right buttocks had become a stage 2 pressure ulcer measured at 1.5 cm in length and 1 cm in width. The Physician's Order dated 4/10/12 indicated to apply Allevyn dressing to the open area on the right and left buttocks. Change the Allevyn dressing every 3 days and as needed. The Pressure Ulcer Status Record dated 4/13/12 indicated a stage 2 pressure ulcer had developed on the left buttock and measured at 1 cm in length and 0.5 cm in			

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	width. The Dietary Notes were reviewed for March and April 2012 and there was no documentation to indicate the Food Service Director was aware of the pressure ulcers to the resident's buttocks. On 4/18/12 at 1:45 p.m. with Unit Manager RN #3 an observation of Resident #82 the RN #3 removed the Allevyn dressings and pressure area on the right buttock measured at 0.3 centimeters (cm) in length and 0.5 cm in width. The pressure area wound bed was red with a small amount of slough noted and the surrounded tissue of the pressure area was pink. The pressure area on the left buttock had a white center and surrounding tissue was pink and measured at 0.3 cm in length and 0.4 cm in width. On 4/18/12 at 2:30 p.m. an interview with the Food Service Director in regard to the resident's pressure ulcer. The Food Service Director indicated she had not been made aware of the resident's pressure ulcer until 4/16/12 when she received the Weekly Pressure Ulcer Tracking Report. On 4/19/12 at 9:00 a.m. an interview with Unit Manager RN #3 in regard to the			

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	resident's pressure ulcer. Unit Manager RN #3 indicated the Wound Nurse was responsible for notification of Dietary Services of the development of a pressure ulcer. Unit Manager RN #3 indicated the Wound Nurse every Monday submits the Weekly Pressure Ulcer Tracking Report to Dietary Services. On 4/19/12 at 9:00 a.m. Unit Manager RN # 3 was interviewed in regard to the Physician's order for Voltaren gel not transcribed for 5 days after the treatment was ordered. Unit Manager RN #3 indicated on 3/20/12 LPN #18 should had transcribed the Physician's Order for Voltaren gel for Resident #82. 3.1-37(a)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, record review, and interview, the facility failed to ensure 4 of 7 residents reviewed for pressure ulcers in a sample of 21 receiving preventative care and did not develop pressure ulcers and/or received appropriate treatment and services to promote healing. (Residents #14, 57, 84, and 45) Finding includes: 1. During the initial tour of the facility, conducted on 04/16/12 from 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #14 was not alert, required total staff assistance, was fed with a tube feed, had a tracheotomy, had a history of some psychiatric issues, and had a stage 4 pressure area. The clinical record for Resident #14 was reviewed on 04/17/12 at 8:25 A.M. Resident #14 was admitted to the facility	F0314	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* 14 – The skin treatment regime to include preventative measures for resident #14 was evaluated by the IDT on 5-1-12 with no changes as the current regime is yielding positive program57 –The skin treatment regime to include preventative measures for resident #57 was reviewed by the IDT on 5-1-12 and a pressure reducing cushion was added to the individualized plan of care. In addition, a pressure relieving mattress was added to the bed.84 – The antibiotic was changed on 4-17-12 during the course of the survey to ensure appropriate sensitivity to the organisms indicated on the laboratory result.45 – A dressing was	05/19/2012

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	on 07/21/11 with diagnoses, including but not limited to progressive neurological impairment, bipolar disorder, depression, and history of acute respiratory failure. The nursing admission assessment, completed on 07/21/11 indicated the resident's skin was warm and intact. There were no pressure ulcers present when the resident was admitted to the facility. The initial Braden's assessment, also completed on 07/21/11 indicated the resident was assessed to be a high risk for skin breakdown. An interim care plan, initiated on 07/22/11 indicated the resident was at risk for skin breakdown. The interventions included: "educate resident/family on maintaining skin integrity, elevating the heels off bed surface and "float" heels - no pressure heels, reposition every 2 hours, lift/pull sheet." There were no interventions to utilize a pressure reducing mattress or preventative treatments for her bony prominence other than her heels. A nursing note, dated 08/04/11 at 12:00 P.M. indicated a stage 2 pressure ulcer was noted on the resident's left ear and coccyx. The physician was notified and an air mattress and recliner were provided to the resident and treatment orders were		applied to the residents wound during the course of the survey and continued according to the treatment ordered by the physician. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:* The Braden scale assessment will be updated for all residents by DON or designee(s) on or before 5-19-12. Residents identified at risk for pressure ulcer development will be reviewed for appropriate preventative interventions by the IDT on or before 5-19-12 with updates to the individualized plan of care. The treatment regime for each resident with a pressure ulcer will be reviewed by the IDT on or before 5-19-12 for presence, appropriateness, and to evaluate progress towards treatment goals/healing. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:* The facility implement a new skin protocol to include weekly review of assessment of wound risk, pressure ulcer status/wound progression, interventions in place to promote healing and and prevention for those residents with a skin issue or who may be at risk for pressure ulcer development. In addition, care staff have been inserviced by 5.19.12 related to the interventions available and implementation of the plan of	

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	obtained for resident's pressure ulcers. On 08/25/11 the resident was admitted to an acute care center and upon readmission to the facility, the pressure ulcer had deteriorated and was a stage 4 pressure ulcer. The resident was readmitted to the facility on 08/28/11. Observation of the resident's pressure ulcer, on 04/17/12 at 2:30 P.M. indicated a triangular shaped, silver dollar sized healing stage 4 pressure ulcer with tunneling on the top side of the wound. The wound bed was noted to be light pinkish gray with a small area of yellow slough in the center of the wound. Interview with RN #17, on 04/17/12 at 2:30 P.M., indicated the wound was healing and looking better. 2. During the initial tour of the facility, conducted on 04/16/12 between 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #57 was confused, required extensive staff assistance for activities of daily living, had pressure ulcers on her right and left buttocks, required mechanical lift assistance for transferring needs, and was incontinent of her bowels and bladder. The clinical record for Resident #57 was reviewed on 04/18/12 at 9:42 A.M.		care and treatment regime for residents at risk or who have pressure ulcers. *To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance with the skin protocol to include interventions and implementation of the plan of care. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 6 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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	Resident #57 was admitted to the facility on 01/06/07 with diagnoses, including but not limited to gout, constipation, mononeuritis, stomach function disease, and hypertension. Review of the 12/03/11 annual Minimum Data Set (MDS) assessment, indicated the resident required extensive to total staff assistance for transferring, wheelchair locomotion, dressing, hygiene and bathing needs. The resident was always incontinent of her bowels and bladder and had impaired range of motion of her lower extremities. The resident did not have any pressure ulcers. However, by the 02/27/12 quarterly MDS review assessment the resident's physical condition had not changed except she now had 2 stage 2 pressure ulcers and 1 stage 1 pressure ulcer. Review of nursing notes, dated 02/11/12 at 1:45 P.M. indicated a stage 2 pressure ulcer was noted to the resident's right buttocks and a stage 2 pressure ulcer was noted to the resident's left buttocks. The physician was notified and treatment orders were obtained. An order was also obtained to lay the resident down after meals. Nursing note, dated 02/20/12 indicated the wounds were healed, the treatment orders discontinued, and order			

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	were given to utilize a protectant cream to her buttocks twice a day. Nursing notes, dated 04/10/12 at 1:40 P.M. indicated the resident had open areas on her buttocks. The areas were initially assessed to be 4.5 centimeter by 1.3 centimeter on the right buttocks, .6 centimeter by .4 centimeter on the left upper buttocks, and 9 centimeter by 2.2 centimeter on the left lower buttocks. The physician was again notified and a treatment was obtained. The resident was also documented as having complained of "soreness" in her buttocks. Review of a health care plan related to the resident's potential to develop impaired skin integrity, initiated on 01/24/07, indicated the following interventions: "monitor skin with care, interventions, and with bi-weekly showers, report any abnormal findings with skin integrity to MD/NP, pressure reduction mattress to bed, pericare per nursing after each incontinence episodes, Braden's assessment to be done quarterly, notify MD as needed." It did not appear the care plan had been updated since 01/24/07. An acute care plan related to the pressure ulcer development, dated 04/10/12 indicated the following: "turn and reposition every 2 hours, pressure reduction mattress, lay down after meals,			

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	treatment per MD, monitor weekly." There were no interventions to prevent pressure on the resident's coccyx and buttocks while she was up in her wheelchair and no interventions to discourage the use of cloth incontinence pads which increase pressure when placed underneath residents. Observation of the resident's open area, on 04/18/12 at 9:15 A.M. indicated 2 small pressure areas on the resident's coccyx, one larger tear drop shaped stage 2 pressure ulcer on the resident's left buttocks, and 2 small pencil eraser sized open areas on the resident's lower right buttocks. The centers of the open areas were yellow in color, no exudate was noted. The skin surrounding the open areas was slightly reddened. The resident was noted to be lying in her bed on a cloth chux, and had been wearing a disposable brief. The resident's wheelchair was noted to have an uncovered foam type wheelchair cushion. CNA #2 indicated the cushion was not the resident's and she did not know where the cushion had came from or how long it had been there. She though perhaps the resident's family had brought the cushion into the facility for the resident.			

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	After the resident was given care, CNA #2 indicated therapy had instructed her to place a small inflatable wheelchair cushion in the resident's wheelchair and cover it with a folded cloth incontinence pad. Interview with the Director of Nursing, on 04/19/12 at 11:45 A.M. indicated the resident had a "T-gel" mattress, a pressure relieving mattress placed on her bed on 04/11/12. She indicated the facility was going to have a new pressure ulcer prevention program implemented which would better document appropriate interventions. 3. Resident #45's record was reviewed 4-18-12 at 10:22 a.m. Resident #45's diagnoses included but were not limited to diabetes, depression and cerebrovascular accident. A physician's order dated 4-12 indicated to cleanse the area on Resident #45's right buttock, and apply allevyn thin every other day. During an observation in 4-19-2012 at 9:37 a.m. Resident #45 was observed to have no dressing over the wound on her right buttock. The right buttock area was			

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	observed to have a whitish pink substance over the area. In an interview on 4-19-2012 at 9:37 a.m. LPN #1 indicated she did not know why there was no dressing or how long the dressing had not been on the area. LPN #1 additionally indicated the substance covering the right buttock area appeared to be calmoseptine. LPN#1 further indicated the dressing should have been replaced as soon as it was noted to have been dislodged. 4. Resident #84's clinical record was reviewed on 4/17/12 at 9:35 A.M.. The record indicated on 2/28/12 a wound was noted to the resident's left outer ankle. On 4/3/12 a physician's order was received for a wound culture for a stage III pressure ulcer to outer left ankle related to increased dark thick drainage. On 4/3/12 the specimen was obtained and results received on 4/6/12. The organisms identified were Enterococcus species and Staphylococcus aureus. The drug sensitivity indicated the staphylococcus aureus was sensitive to trimeth/sulfa (brand same Bactrim DS). The drug sensitivity for Enterococcus species			

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	indicated trimeth/sulfa was not tested. On 4/7/12 a physician's order was received for Bactrim DS, one tabled by mouth twice daily for left ankle wound infection. An interview with LPN # 24 on 4/17/12 at 1:40 P.M. indicated she had contacted the physician regarding the wound culture and sensitivity from 4/6/12 and see if he wanted to change treatment and he wanted to continue to watch the wound if it was okay to not change the Bactrim treatment as the sensitivity results did not indicate the Enterococcus species organism was resistant to Bactrim. On 4/17/12 at 1:40 P.M. and observation of LPN # 24, was made of the resident receiving wound treatment to the left outer ankle wound. The wound was approximately 0.4 in diameter, depth unknown and had a brown, green thick purulent drainage. An interview with LPN # 24 on 4/17/12 at 1:50 P.M. indicated she was going to contact the physician to inform him of the wound drainage and see if he wanted to change treatment. An interview with LPN # 24 on 4/17/12 at 2:05 P.M. indicated a physician's order			

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	was received to add Augmentin 875 mg twice daily x 7 days. The wound culture and sensitivity report from 4/6/12 indicated Enterococcus species was sensitive to Augmentin. 3.1-40(a)(2)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, record review, and interviews, the facility failed to ensure incontinence care was provided to prevent urinary tract infections for 1 of 10 residents reviewed for incontinence needs in a sample of 21. (Resident #50) In addition, the facility failed to ensure a thorough bladder assessment was completed when a catheter was removed and for symptoms of a urinary tract infection for 2 of 10 residents reviewed for incontinence in a sample of 21. (Residents #8 and 45) Findings include: 1. During the initial tour of the facility, conducted on 04/16/12 between 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #50 was totally dependent of staff for all care needs, totally incontinent of his bladder and was checked and	F0315	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* A new bowel and bladder assessment was completed for resident's #50, #8 and #45 to ensure that toileting needs and voiding patterns were identified. All assessments completed on or before 5-8-12 by licensed nurses. Resident #8's physician was notified of lab results from 4-01-12 (probable nonclean catch) that were not present on chart and no documented physician response. New orders were obtained on 4-17-12 to obtain a UA and Dr. aware of results. Orders received on 4-19-12 to repeat UA with C & S if indicated per in and out catheter and Dr. aware of results with no new orders. *The corrective action*	05/19/2012

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	changed as needed every two hours. The clinical record for Resident #50 was reviewed on 04/18/12 at 10:45 A.M. The most recent Minimum Data Set (MDS) assessment for Resident #50, completed on 02/10/12 indicated the resident was always incontinent of his bowels and bladder and required total staff assistance of two for toileting needs. The bladder incontinence assessment, completed on 09/17/11 with the resident's most recent full MDS assessment indicated the resident exhibited functional incontinence, required extensive staff assistance of 2 for toileting needs, had impaired cognition, prostate enlargement, altered fluid intake and impaired mobility which potentially affected his continence. The assessment indicated the resident could not follow directions or recognize the urge sensation. The assessment recommended the resident be placed on and "check and change program." The current health care plans for Resident #50, current through 05/22/12, indicated the following interventions: "peri care for incontinent episodes as needed, assist me to toilet as needed, I am on a prompted void program." Resident #50 was observed on 04/18/12 from 8:50 A.M., when he was pushed to		*taken for those residents having the potential to be affected by the same deficient practice is:*The bowel and bladder assessments for all residents will be reviewed for initiation, accuracy, and necessary updates with results reflected in the individualized plan of care by DON or designee(s) on or before 5-19-12. All residents with catheters discontinued, will be reviewed by DON or designee(s) on or before 5-19-12, to ensure a 3-day voiding pattern assessment initiated upon removal. All residents with lab orders for the last 30 days will be reviewed by DON or designee(s) on or before 5-19-12 to ensure all results have been obtained, lab reports present on the chart, and physician notified as needed. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Nursing staff will be inserviced on following the plan of care as it relates to individualized toileting programs by the Staff Development Coordinator or designee(s) on or before 5-19-12. Licensed nurses will be inserviced on the completion of the bowel and bladder assessment and a 3 day void diary upon removal of a urinary catheter by the Staff Development Coordinator or designee(s) on or before 5-19-12. Inservice education will be completed by 5.19.12. All licensed nurses will be inserviced	

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	the hall by the nurse's station in a reclining geri chair to 11:35 A.M. when the activity director pushed him to the dining room. He was not checked for incontinence nor was he prompted to void during the almost 3 hour time from. On 04/18/12 at 1:20 P.M. he was observed lying in his bed in his room. Resident #50 was observed on 04/19/12 at 8:20 A.M., in the main dining room in a gerichair being assisted to eat breakfast. At 8:35 A.M., he was pushed from the dining room to the hallway by the central nursing station. At 9:15 A.M., he was pushed to his room, left in his gerichair. He was not prompted to void, nor was he checked for incontinence. He remained in his gerichair in his room, with the back of the chair facing the hallway until 9:50 A.M., when the nurse gave him some medications, moved his gerichair in front of his television in his room, and turned on the television. He remained in his room in the gerichair until 11:45 A.M., when the social service director pushed his to the dining room. The resident was not checked for incontinence nor was he prompted to void in the over 3 hour time frame. 2. Resident #45's record was reviewed 4-18-12 at 10:22 a.m. Resident #45's		regarding the use of a lab reconciliation tracking process to ensure that results are received in a timely manner and appropriate follow through occurs based on the lab results by the Staff Development Coordinator or designee(s) on or before 5-19-12. *To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates the bowel and bladder assessment process, the delivery of routine toileting care in accordance with the plan of care, and evaluates the laboratory process to include timely receipt of laboratory results and appropriate follow through. The indicator will be completed by the Director of Nursing or her designee weekly for the first month, and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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	diagnoses included but were not limited to diabetes, depression and cerebrovascular accident (stroke). A physician's order dated 4-17-2012 indicated Resident #45 was to have her Foley catheter removed. During an observation on 4-18-2012 at 10:00 a.m., Resident #45 was observed to have had her Foley catheter removed. A review of Resident #45's record did not reveal assessment of Resident #45's urinary status since the Foley catheter had been removed. In an interview on 4-19-12 at 9:12 a.m. CNA #2 indicated there was no voiding pattern being performed for Resident #45 and the staff was utilizing check and change program. In an interview on 4-19-2012 at 9:12 a.m. LPN #1 indicated there was no patterning being completed for Resident #45 and the staff had been instructed to use check and change program to manage Resident #45's incontinence. An undated policy titled Foley Catheter provided by Unit Manager #3 on 4-19-12 at 10:26 a.m. did not include actions to take after the catheter had been removed			

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	to regain continence. A request for a more thorough policy regarding assessment after Foley catheter removal as of 4-19-2012 at 3:30 p.m. had no additional information was provided. 3. Resident #8's clinical record was reviewed on 4/16/12 at 2:15 P.M.. The record indicated in the nurse's notes on 3/30/12 at 4:00 P.M., the resident complained of frequent urination and expressed pain upon palpation of her bladder. A physician's order was received for a urinalysis (UA) with a culture and sensitivity (C&S) if required for a possible urinary tract infection (UTI). Review of the nurse's notes from 3/30/12 after the initial reporting of bladder pain and increased urinary frequency at 4:00 P.M. through 4/3/12 at 12:49 A.M. indicated no further assessment of bladder pain or increased urinary frequency or other symptoms of a possible UTI. On 4/1/12 an UA was collected at 11:15 A.M. and results were verified on 4/2/12 according to lab documentation. The UA result indicated the resident had mixed flora and was a probably non clean-catch specimen. The lab results for the UA from			

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	4/1/12 were not available at the facility. An interview with LPN # 23 on 4/16/12 at 3:00 P.M. indicated she obtained a copy of the lab result on 4/16/12 and indicated the specimen was contaminated and stated she would contact the physician to see if the UA was to be redone. An interview with RN # 3 on 4/17/12 at 9:25 A.M. indicated the physician ordered a new UA done for the contaminated specimen completed on 4/1/12. 3.1-41(a)(1)			

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on interview and record review, the facility failed to assure a resident had respiratory assessments completed consistently before and after a respiratory treatment was administered. This deficiency affected 1 of 1 residents reviewed for respiratory treatments in a sample of 21 (Resident #110). Findings include: The closed clinical record of Resident #110 was reviewed on 4/19/12 at 9:15 a.m. The closed record indicated Resident #110 diagnoses included, but were not limited to, chronic obstruction pulmonary disease (COPD) and congestive heart failure. The Physician's Order Sheet dated 1/2012 indicated an order dated 12/23/11 for ipratropium- albuterol 0.5 milligrams (mg) -3 mg/3 milliliters (ml) the resident	F0328	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* Resident # 110 no longer resides at the facility. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:* All other residents receiving nebulizer treatments were audited to ensure that an assessment had been completed per facility policy by DON or designee(s) on or before 5-19-12. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:* Licensed nurses will be inserviced by 5.19.12 on the use of the respiratory assessment flow sheet to include pre and post lung sounds, sputum assessment, and associated documentation for	05/19/2012

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	is to inhale 3 ml by nebulizer 3 times a day for the diagnosis of COPD. The January 2012 Respiratory Flow Sheet indicated assess the lung sounds, and resident's sputum before and after the ipratropium- albuterol nebulizer was administered at 9:00 a.m., 1:00 p.m., and 6:00 p.m. The Respiratory Flow Sheet dated from 1/4-1/13/12 at 9:00 a.m. and 6:00 p.m. indicated there was no documentation the lung sounds and sputum had been assessed before and after the ipratropium- albuterol nebulizer was administered. The Nurse's Notes dated 1/4-1/13/12 were reviewed and there was no documentation the lung sounds and the resident's sputum had been assessed for 9:00 a.m. and 6:00 p.m. The undated Respiratory Care Services Policy and Procedure for Hand Held Nebulizer-Aerosolized Medication Administration received from the Director Nursing Services and reviewed on 4/19/12 at 2:15 p.m. indicated "...7. Assemble equipment...8. Obtain respiratory quality...cough effort/production...16. The aerosol should be nebulized until all of the medication is gone...18. Complete final...auscultation,...cough		residents receiving respiratory treatments to include nebulizer treatments. *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates compliance with assessing and recording pre and post lung sounds and sputum assessment for residents receiving respiratory treatments. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits	

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	effort/production...." On 4/19/12 at 2:45 p.m. an interview with the Nurse Consultant in regard to the lung sound and resident's sputum prior to and after the ipratropium- albuterol nebulizer treatment. The Nurse Consultant indicated the nurses should had assessed the Residents lung sounds and sputum prior to and after the ipratropium-albuterol nebulizer treatment was administered. 3.1-47(a)(6)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interview, the facility failed to attempt alternative measure prior to initiating antianxiety medication for 1 of 10 residents reviewed for psychoactive medications in a sample of 21. (Resident #14) Findings include: 1. During the initial tour of the facility, conducted on 04/16/12 from 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident	F0329	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* The medication regime for resident #14 was reviewed with the physician on 5-8-12 . The pain assessment was updated and the interdisciplinary team reviewed the results. A gradual dose reduction was initiated in concert with ongoing pain	05/19/2012

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	#14 was not alert, required total staff assistance, was fed with a tube feed, had a tracheotomy, had a history of some psychiatric issues, and had a stage 4 pressure area. Resident #14 was observed on 04/16/12 at 2:00 P.M., lying in her bed, her eyes were closed, the tube feeding was infusing, humidified oxygen was connected to her tracheotomy, rolled splints were in both of her hands, she had her eyes closed and was not moving. Resident #14 was observed on 04/17/12 at 1:15 P.M., during tracheotomy care. The resident's eyes were open, at one point she appeared to attempt to respond to the nurse, her arms and upper trunk were noted to be stiff and flailing about in the bed. RN #17 had to reposition the resident several times as the resident preferred to list herself against the right side of the bed and wall. The clinical record for Resident #14 was reviewed on 04/17/12 at 8:25 A.M. Resident #14 was admitted to the facility on 07/21/11 with diagnoses, including but not limited to, progressive neurological impairment, aphasia, atrophy, depression, bladder spasms, acute respiratory failure, and bipolar disorder. The resident was admitted to an acute care facility on		assessment. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*A review of all residents who receive anti-anxiety medication will be reviewed by the Behavior Committee on or before 5-19-12. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Licensed nursing staff will be inserviced on non-pharmalogical interventions available and the use of the interdiscplianry team for advice and counsel prior to requesting an anti-anxiety from the physician by Staff Development Director or designee(s) on or before 5-19-12.*To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance with the use of non-pharmacological interventions prior to the implementation of routine use of anti-anxiety has been established. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 6 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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	02/22/12 due to respiratory issues and infection and was readmitted to the facility on 02/25/12. Review of the physician orders, on admission, on 02/25/12 indicated the resident received an antidepressant medication and had orders for pain medication if needed. Nursing progress notes, from 03/01/12 - 03/08/12 indicated there were no documented episodes of any type of behavior issues or anxiety issues. The medication administration record for March 2012 did not indicate any doses of pain medication as having been given. Nursing notes, dated 03/08/12 at 11:00 A.M. indicated the resident was slightly restless and was moving her arms. The note indicated the resident was repositioned frequently, given tracheotomy care, and oral care. There were no further notes of restlessness until 03/10/12 at 4:00 A.M., when the resident was documented as having "spastic movements notes..." The note indicated tracheotomy and respiratory care were given including suctioning and the resident's pressure ulcer treatment was completed. A subsequent nursing note, dated			

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	03/10/12 at 12:50 P.M. indicated the resident was having "continuous spastic movement and was making eye contact." A note, dated 03/10/12 at 2:30 P.M., indicated the resident's son was visiting and was concerned with the resident's "restless, spastic movements" with the resident not sleeping well. The physician was notified and a low dose of the antianxiety medication, xanax was requested. A physician's order was received on 03/12/12 for the antianxiety medication, xanax .25 mg to be given twice a day. Nursing notes, dated 03/10/12 - 03/30/12 indicated the resident displayed restless movements and spasticity on 12 occasions and was given 6 doses of pain medication but the outcome was not charted. On 03/30/12 nursing notes indicated the resident had increased restlessness and the physician was contacted and increased the xanax to three times a day. He also increased the pain medication to every 4 hours as needed. On 04/18/12 at 1:30 P.M., Resident #14 was noted to be lying in her bed with her eyes partially opened. The resident's head was resting against the far right padded bedrail but the resident did not appear to			

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	be restless and was not moving about in her bed. Interview with RN #12, on 04/18/12 at 1:30 P.M., indicated she had given the resident some pain medication earlier and it seemed to make the resident less restless. She indicated she did not work on the central unit very often but had noted the resident's movements were much less after having received pain medication. There was no indications attempts at pain control, aggressive reposition, and/or checking for other physical symptoms which could have caused the resident's restlessness were addressed before antianxiety medication was administered. In addition, pain control was again not consistently attempted before an increase in antianxiety medication was administered. 3.1-48(a)(4)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to assure a resident had a	F0441	It is the practice of this facility to ensure the highest quality of care	05/19/2012

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	first step Mantoux test read. This deficiency affected 1 of 21 residents reviewed for Mantoux testing in a sample of 21.(Resident #30). Findings include: The clinical record of Resident # 30 was reviewed on 4/17/12 at 1:15 p.m. The record indicated Resident #30's diagnoses included, but were not limited to, diabetes and congestive heart failure. The resident was admitted to the facility on 3/14/12. The Resident TB (tuberculosis) Screening and Immunization Record indicated on 3/12/12 the resident had a Mantoux test at the hospital. There were no results of the Mantoux test documented on the Immunization Record. There was no documentation on the March 2012 Medication Administration Record (MAR) the Mantoux test had been read. The policy for Admission of Residents and Follow-Up revised on 6/23/08 was received from the Director Nursing Service (DNS) and reviewed on 4/18/12 at 2:45 p.m. and indicated "1. All first time residents will be screened for infection with tubercle bacilli on		is afforded our residents. Consistent with this practice, the following has been done:*The corrective action taken for the residents found to have been affected by the deficient practice was:*For resident #30, a first step Mantoux was initiated on 4-17-12 with results read on 4-20-12 with no reaction noted.*The corrective action taken for those residents having the potential to be affected by the same deficient practice is:*A review of all resident's Mantoux were completed to ensure timely administration and evaluation with special attention to newly admitted residents by DON or designee(s) on or before 5-19-12. *The measures put into place and systemic change made to ensure the deficient practice does not recur is:*Licensed nursing staff will be inserviced relative to appropriately initiating and/or transcribing Mantoux administration and read dates on the Medication Administration Record by the Staff Development Coordinator or designee(s) on or before 5-19-12. *To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement audit tool has been established which evaluates compliance with initiating, transcribing and/or reading Mantoux results. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly*	

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	admission. See the form 'Resident TB Screening & Immunization Record.' 2. Screening for infection will consist of a PPD (purified protein derivative) (Mantoux) skin test." On 4/18/12 at 2:45 p.m. the DNS was interviewed in regard to the Mantoux test was not read and the DNS indicated the Mantoux should had been read on 3/15/12 by the nurse. The DNS further indicated the nurse should had transcribed the Mantoux test onto the March MAR. On 4/19/12 at 8:45 a.m. LPN #6 was interviewed in regard the resident's Mantoux test was not read. LPN #6 indicated the nurse who had admitted the resident should had documented on The Immunization Record and on the March MAR the date the Mantoux should had been read. 3.1-18(e)		*thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits.*	

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F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interviews, the facility failed to ensure laboratory test results were promptly obtained and the physician notified of need for additional treatment and/or orders for 3 of 21 residents reviewed for laboratory tests in a sample of 21. (Resident #57, 8, and 84) Findings include: 1. The clinical record for Resident #57 was reviewed on 04/18/12 at 9:42 A.M. Nursing notes, dated 03/14/12 at 7:00 A.M., indicated the resident had exhibited an increase in confusion. The nurse completed an assessment and noted the resident's urine was strong and foul smelling. The note indicated the resident had a standing order for an in/out catheterization urinalysis if a urinary tract infection was suspected. The test was obtained on 04/18/12 at 11:45 A.M. A physician order was given, on 03/15/12 for the antibiotic, Levaquin 250 mg to be given once a day for 7 days for a urinary tract infection. On 03/19/12, 4 days after the Levaquin was initiated, a physician's order was given to discontinue the Levaquin antibiotic and start the	F0505	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was:* Resident #57 – Resident was assessed and shows no signs and symptoms of further infection post antibiotic treatment (3-26-12) based on the delayed test results. Resident #84 – A new antibiotic was ordered during the course of the survey that provided coverage for the organism indicated on the laboratory result. Resident #8 – A new specimen was collected during the course of the survey, results obtained and no new orders received by the physician. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is:* A review of laboratory orders for the last 30 days will be conducted to ensure that all results have been obtained and antibiotics ordered are consistent with organisms identified by DON or designee(s) on or before 5-19-12. The physician will be notified of any concerns related to any unresolved orders with new orders received as necessary. *The*	05/19/2012

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	antibiotic, Rocephin 500 mg Intramuscularly once a day for 7 days. Review of the laboratory test results for the culture and sensitivity and interview with hospital laboratory personnel indicated the culture and sensitivity test was completed on 03/17/12 at 7:44 A.M. However, the facility did not receive the test results until 03/19/12 at 3:03 P.M. The culture and sensitivity results indicated the isolated organism was resistant to the antibiotic Levaquin. Nursing notes, dated 03/20/12 indicated the antibiotic, Rocephin was not initiated until 03/20/12 in the evening. Thus, an effective treatment was not initiated for almost 3 days after the test results were completed and staff were unaware of the need to change treatment for 2 days after the test was completed. 2. Resident #84's clinical record was reviewed on 4/17/12 at 9:35 A.M.. The record indicated on 2/28/12 a wound was noted to the resident's left outer ankle. On 4/3/12 a physician's order was		*measures put into place and systemic change made to ensure the deficient practice does not recur is:*All licensed nurses will be inserviced regarding the use of a lab reconciliation tracking process to ensure that results are received in a timely manner and appropriate follow through occurs based on the laboratory results by Staff Development Coordinator or designee(s) on or before 5-19-12. *To ensure the deficient practice does not recur, the monitoring system established is:* A Performance Improvement audit tool has been established which evaluates the laboratory process to include timely receipt of laboratory results and appropriate follow through based on the results. The indicator will be completed by the Director of Nursing or her designee weekly for the first month and monthly thereafter for 3 months. The results of the audit tool will be reviewed at the monthly performance improvement meeting and the facility will achieve at least 95% compliance threshold prior to discontinuing audits	

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	received for a wound culture for a stage III pressure ulcer to outer left ankle related to increased dark thick drainage. On 4/3/12 the specimen was obtained and results received on 4/6/12. The organisms identified were Enterococcus species and Staphylococcus aureus. The drug sensitivity indicated the staphylococcus aureus was sensitive to trimeth/sulfa (brand same Bactrim DS). The drug sensitivity for Enterococcus species indicated trimeth/sulfa was not tested. On 4/7/12 a physician's order was received for Bactrim DS, one tabled by mouth twice daily for left ankle wound infection. An interview with LPN # 24 on 4/17/12 at 1:40 P.M. indicated she had contacted the physician regarding the wound culture and sensitivity from 4/6/12 and see if he wanted to change treatment and he wanted to continue to watch the wound if it was okay to not change the Bactrim treatment as the sensitivity results did not indicate the Enterococcus species organism was resistant to Bactrim. On 4/17/12 at 1:40 P.M. and observation of LPN # 24, was made of the resident receiving wound treatment to the left outer ankle wound. The wound was approximately 0.4 in diameter, depth			

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	unknown and had a brown, green thick purulent drainage. An interview with LPN # 24 on 4/17/12 at 1:50 P.M. indicated she was going to contact the physician to inform him of the wound drainage and see if he wanted to change treatment. An interview with LPN # 24 on 4/17/12 at 2:05 P.M. indicated a physician's order was received to add Augmentin 875 mg twice daily x 7 days. The wound culture and sensitivity report from 4/6/12 indicated Enterococcus species was sensitive to Augmentin. 3. Resident #8's clinical record was reviewed on 4/16/12 at 2:15 P.M.. The record indicated in the nurse's notes on 3/30/12 at 4:00 P.M., the resident complained of frequent urination and expressed pain upon palpation of her bladder. A physician's order was received for a urinalysis (UA) with a culture and sensitivity (C&S) if required for a possible urinary tract infection (UTI). Review of the nurse's notes from 3/30/12 after the initial reporting of bladder pain and increased urinary frequency at 4:00 P.M. through 4/3/12 at 12:49 A.M. indicated no further assessment of bladder			

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	pain or increased urinary frequency or other symptoms of a possible UTI. On 4/1/12 an UA was collected at 11:15 A.M. and results were verified on 4/2/12 according to lab documentation. The UA result indicated the resident had mixed flora and was a probably non clean-catch specimen. The lab results for the UA from 4/1/12 were not available at the facility. An interview with LPN # 23 on 4/16/12 at 3:00 P.M. indicated she obtained a copy of the lab result on 4/16/12 and indicated the specimen was contaminated and stated she would contact the physician to see if the UA was to be redone. An interview with RN # 3 on 4/17/12 at 9:25 A.M. indicated the physician ordered a new UA done for the contaminated specimen completed on 4/1/12. 3.1-49(f)(2)			