

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2014
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00142667 and IN00142650.</p> <p>Complaint IN00142667 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00142650 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 27, 28, 29, 30, & 31, 2014.</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Marcy Smith, RN-TC Christie Davidson, RN Diana Zgonc, RN (January 28, 29, 30, & 31, 2013)</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 03</p>	F000000	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged of the conclusion set forth the in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.</p>	

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

TITLE

(X6) DATE

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

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	<p>Medicaid: 39 Other: 02 Total: 44</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 05, 2014; by Kimberly Perigo, RN.</p>						

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F000156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide the appropriate documentation of liability and appeal notice(s) for residents discharged from medicare services for 3 of 4 residents reviewed for liability notices. (Resident #38, Resident #40, Resident #50)</p> <p>Findings include:</p> <p>During an interview on 1/29/14 at 12:32 p.m., Business Office Manager (BOM) #1 was requested to provide appropriate documentation of liability and appeal notice(s) for Resident #40 and Resident #50; whom were discharged from medicare services without expiring the 100 days of service. BOM #1 indicated the Social Services Designee (SSD) prepared the documentation.</p> <p>1. On 1/31/14 at 9:54 a.m., the SSD provided a facility document titled, "Friendship Healthcare Notice of Medicare Non-Coverage," for Resident #38 to demonstrate a facility sample. The document, indicated, "...OT [Occupational therapy]/PT [Physical Therapy]</p>	F000156	<p>Resident # 38 and Resident # 50 both discontinued Medicare A coverage when they began hospice services. Resident # 38 and #50 are both deceased, so delivery of notice of discontinued coverage is not appropriate at this point for those residents. Resident # 40 still resides at this facility. He was provided with notification of discontinued Medicare A coverage by March 2, 2014. All residents who discontinue Medicare A coverage prior to using 100 days of available coverage have the potential to be affected. Department heads have morning meeting each business day. During this meeting, one item on the agenda will be to review any residents who will be having a change in payer source coming up. Residents who are to discontinue Medicare A services will be issued the appropriate notice at least three days prior to discontinuing Medicare A services. The DON will be responsible for preparing and delivering this notice to the resident or responsible party. An audit will be conducted by the MDS Coordinator once monthly as a method to monitor. During this audit, the records of any residents who discontinue Medicare A services will be reviewed to make sure that documentation that they were</p>	03/02/2014			

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	<p>services will end January 12, 14 [January 12, 2014]...Your Medicare Advantage (MA) plan and /or provider have determined that Medicare probably will not pay for your current therapy services after the effective date indicated above...Please sign below to indicate that you have received this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]...." The document was signed by Resident #38's power of attorney, dated 1/13/14. The document also was signed by the facility's SSD, dated 1/13/14.</p> <p>During an interview on 1/31/14 at 10:50 a.m., the SSD indicated Resident #38's medicare services ended on 1/14/14, and the date above was recorded incorrectly. The SSD indicated Resident #38 was admitted to hospice on 1/14/14.</p> <p>2. A facility document for Resident #40, titled, "Occupational Therapy [OT] Evaluation," indicated, "...D/C [discharge] from skilled OT services due to maximal potential. Res [resident] to continue [sign for with]</p>		<p>notified of discontinuing Medicare A services is present. These monthly audits will be continued for twelve months. Results of the audit will be presented to the QA meeting no less than quarterly for one year. Completion Date March 2, 2014</p>				

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	<p>nrsrg [nursing] services...Date: 9/15/13...."</p> <p>During an interview on 1/31/14 at 10:50 a.m., Business Office Manager #2 indicated the facility did not have documentation regarding Resident #40's discharge from medicare coverage.</p> <p>3. During an interview on 1/31/14 at 10:50 a.m., Employee #2 indicated she was waiting on Resident #50's documentation.</p> <p>As of the exit conference on 1/31/14 at 4:00 p.m., the facility lacked documentation of liability and appeal notice(s) for Resident #40 and Resident #50.</p> <p>Advance Beneficiary Notice of Noncoverage (ABN) Second Edition dated April 2011 indicate, "Form Instructions - Notice of Medicare Provider Non-Coverage ... A Medicare provider must give a completed copy of this notice to beneficiaries receiving services ... not later than 2 days before the termination of services."</p> <p>3.1-4(f)(3)</p>						

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F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse from another resident for 1 of 1 residents reviewed for abuse in a sample of 1 who met the criteria for abuse. (Resident #54)</p> <p>Findings include:</p> <p>During a Stage 1 interview on 1/28/14 at 2:48 p.m., Resident #54 described an incident involving another resident residing in the facility, Resident #62. The incident</p>	F000223	<p>1. During day two of ISDH Survey it was brought resident 62. to our attention the reported incident between resident # 54 and resident # 62. The 2567 identified one resident with 2 different identifying numbers. Resident # 62 and resident # 64 are the same residents. Throughout his Plan of Correction we will refer to resident #62 as that is the correct resident. The Incident occurred on January 26, 2014 the facility abuse policy was followed and incident had been reported per policy and was in process of being reviewed. The residents had been separated</p>	03/02/2014	

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	<p>had occurred over the past weekend. Resident #54 indicated he gave Resident #64 a "minute phone." Resident #54 indicated Resident #62 accused him of "getting the phone turned off" and indicated he (#62) would "slap the s--" out of Resident #54. Resident #54 indicated there were other residents that overheard the alleged verbal threat, made by Resident #62. Resident #54 indicated, "I have witnesses that he (#62) said he (#62) would pull me in the room and beat me up off camera." Resident #54 indicated he reported the altercation to LPN #4. Resident #54 indicated both residents were instructed to stay away from each other.</p> <p>Resident #54 indicated Resident #62 resided, on the opposite unit, in the facility.</p> <p>During an interview on 1/29/14 at 5:15 p.m., Resident #62 indicated he purchased a cellular phone from Resident #54 for \$30.00. Resident #62 indicated after two days the phone was turned off. Resident #62 indicated he was upset, because he paid \$30.00 for the phone and he thought it would have service for at least a couple of months. Resident</p>		<p>and put on resident observation every 15 minutes. The Survey commenced during the investigation and investigation was completed appropriately. There were no other incidents between Resident # 54 and Resident # 62. The Administrator interviewed Resident #62 regarding discharge. His wish was to return to Kansas with his Mother and friends. Administration contacted a friend of Resident 62 regarding discharge and received an address of the receiving party. An Airline ticket was purchased for resident to return to Wichita Kansas address. Resident # 62 was discharged . The Mother was also notified. Additional observation during survey Resident #54 did not report to staff that Resident 62 threatened to pull him into another room and beat him up. Resident was observed smiling, joking and engaging with others. No signs of intimidation and no verbal complaints. Resident # 62 was put on 1:1 viewing until time of discharge. Resident # 62 did not make any threats to any other resident. Residents and staff will be re educated on abuse. Residents and staff will be re educated on reporting of abuse. All will be informed there is ZERO tolerance for any type of abuse. Social Services and Nursing will be responsible for education of staff and residents. All</p>				

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	<p>#62 indicated he asked a facility staff member (he could not recall the staff member's name or title) within ear shot of Resident #54 what he/she would do if they bought a phone and it was turned off after two days. Resident #62 indicated he asked Resident #61 within ear shot of Resident #54, while all three residents were in the smoking area outside, what she would do if she purchased a phone and it was turned off. Resident #62 indicated, at that time, Resident #54 spoke up and asked to be spoken to directly if there was a problem. Resident #62 indicated he verbalized to Resident #54, "I should smack the f--- out of you!"</p> <p>The record review of Resident #54 was reviewed on 01/31/2014 at 12:45 p.m.</p> <p>Diagnoses included, but were not limited to, depression, hypertension, and seizure disorder.</p> <p>The most recent quarterly Minimum Data Set [MDS] assessment for Resident #54, dated 10/14/13, indicated Resident #54 was a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS); which indicated Resident #54 was</p>		<p>grievances, concerns and incident reports will be reviewed in every morning meeting and Action Plans put into place. Action Plans will be submitted to QA. Date of Completion March 02,2014. Addendum:In Morning Meeting each business day, situations related to abuse is on the agenda to review, as are reportable events. This is to ensure that facility management as a group reviews any possible abusive situations and puts interventions in place to prevent abuse going forward. Abuse will be added to the QA Meeting agenda for the QA team to monitor the effectiveness of our abuse prevention program. Recommendations for improvement will be made at that time. The monitoring by the QA Committee will continue on an ongoing basis.</p>		

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	<p>cognitively intact. The MDS indicated Resident #54 was independent with locomotion on the unit and utilized a wheelchair for mobility.</p> <p>A facility "Incident Report Form" dated 1/26/14, indicated an incident involving Resident #54 and Resident #62 allegedly occurred on 1/26/14 at 4:00 p.m. The reportable indicated, "...Brief Description of Incident: Verbal altercation between [name of Resident #54] and [name of Resident #62]--foul language and verbal abuse used. No physical contact made...Immediate Action Taken: Residents were immediately separated...Crisis observation was initiated with both residents checked every 15 minutes. Both residents are alert and oriented, and both agree to stay away from each other."</p> <p>An undated, untimed, type-written statement signed by the Social Service Designee (SSD) indicated Resident #54's statement. The statement indicated, "It started at the pantry, [name of Resident #62] asked [name of CNA #7], 'How would you feel if you bought a phone from someone et [and] they turned around [sign for and] sold it 3 days later?'...While outside [name of</p>						

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	<p>Resident #62] again asked [name of Resident #61], 'How would you feel if someone sold you a phone et sold it 3 days later?' [name of Resident #54] then asked [name of Resident #62] if he was directly [sic] it towards him, [name of Resident #62] then said, 'I feel like slapping the s--- out of you right now!' [name of Resident #62] then said, 'I feel like pulling You away from the camera & slapping you!'...."</p> <p>An undated, untimed, type-written statement signed by the SSD indicated Resident #62's statement. The statement indicated, "...[name of Resident #62] said he told [name of Resident #54], 'I feel like slapping you right now.'...[name of Resident #62] had been very upset [sign for with] [name of Resident #54] but stated that he would never hit someone in [name of Resident #54's] condition...."</p> <p>An unsigned, type written resident interview dated 1/26/14 for Resident #61 regarding an incident between Resident #54 and Resident #62 indicated, "...Then [name of Resident #62] said I will B---- slap you...."</p> <p>A behavioral health progress note</p>						

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	<p>for Resident #54 dated 1/29/14 indicated, "...who was reportedly told by another resident that he 'should be slapped' on 1/26/14. Pt [patient] has been seen on two other occasions for incidents involving false allegations...pt said he is not worried and concerned about safety...."</p> <p>A behavioral health progress note for Resident #62 dated 1/29/14 indicated, "...seen on this day per staff request. Patient reportedly got into a verbal altercation and made a statement that he would 'slap' another resident on 1/26/14. Staff immediately intervened, patients were separated and this patient was placed on 15 minute checks...Patient immediately admitted stating that he stated, 'I should slap the s--- of out [sic] you.' Patient stated, 'I wasn't joking but I wasn't serious either.' Patient stated, 'I would never actually hit someone, and I definitely would not hit someone in a wheelchair.'...."</p> <p>During an interview on 1/30/14 at 10:07 a.m., in regard to the incident between Resident #54 and Resident #62, the DoN indicated, LPN #4 reported the allegation to the Assistant Administrator on 1/26/14</p>						

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	<p>at 5:00 p.m. " I believe a resident told her." The DoN indicated the staff were directed to separate the residents and initiate 15 minute checks. The DoN indicated the residents had agreed to stay away from each other.</p> <p>During an interview on 1/30/14 at 10:07 a.m., in regard to the incident between Resident #54 and Resident #62, the Assistant Administrator indicated the investigation was initiated Monday morning. The Assistant Administrator indicated the Administrator and the facility nurse consultant initiated the investigation, and he filed the report to The Indiana State Department of Health [ISDH]. He indicated he had not submitted the follow-up report, yet, as the investigation was not complete.</p> <p>During an interview on 1/31/14 at 10:45 a.m., the DoN indicated the facility incorporated both policies regarding abuse prohibition that were presented during the survey.</p> <p>A facility policy provided by the facility nurse consultant on 1/27/14 at 2:25 p.m., titled, "Abuse Prohibition Policy/Procedure," indicated, "...It is the policy of</p>				

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	<p>Friendship Healthcare to keep its residents free from abuse...In the event of an incident the following procedure will be followed....The incident must be reported to the Administrator <u>immediately</u> ... The Administrator or designee will report the incident to the Indiana State Department of Health immediately upon investigation of the incident...Investigation of incidents of alleged abuse will be carried out by the Administrator beginning immediately following notification of event...See also policy titled 'Abuse Prohibition Policy Summary' for information regarding screening, training, prevention, identification, investigation, protection, reporting and response."</p> <p>A facility policy provided by the facility nurse consultant on 1/30/14 at 10:30 a.m., titled, "Abuse Prohibition Policy Summary," indicated, "...It is the policy of Friendship Healthcare Center to prevent abuse to residents, and investigate and report suspected abuse as needed...All staff is responsible for identifying and reporting to the Charge Nurse any evidence of abuse...The Charge Nurse will begin the investigation process and notify the DON of the</p>						

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	<p>issue...The DON will investigate all...incidents of abuse or suspected abuse...The DON and/or Administrator will report any incidents of abuse or suspected abuse to...the ISDH [Indiana State Department of Health]...."</p> <p>3.1-27(b)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	Resident #6 was moved	03/02/2014			

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	<p>review, the facility failed to report to the State survey and certification agency an allegation of resident to resident verbal abuse for 1 of 4 facility reportable incidents reviewed. (Resident #6)</p> <p>Findings include:</p> <p>The record for Resident #6 was reviewed on 1/30/14 at 8:47 a.m.</p> <p>Diagnoses included, but were not limited to, depression, bipolar, diabetes, seizures, colostomy, urostomy, and decubitis.</p> <p>The most recent discharge Minimum Data Set (MDS) assessment, dated 12/9/13, indicated Resident #6 was independent with reasonable decisions. The MDS indicated Resident #6 was totally dependent on staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing.</p> <p>A nurse's note, dated 1/12/14 at 6:00 p.m., indicated, "Res [resident] stated she did not feel safe [sign for with] roommate. Stated roommate has made physical threats toward her. Reported to writer [sign for at] app [approximately] 5 pm. MDS [Minimum Data Set] coordinator</p>		<p>immediately to another room. Resident #6 roommate was interviewed and denies making the statement. Interview with Resident #6 offered confusion about the allegation and claims her Mom was upset with roommate and indicated her Mother wanted her to make the room change. No other residents were at risk. SSD was educated regarding reporting of incidents or allegations. The Management Team was also re educated on immediately reporting of incidents or allegations immediately to ADM.AADM.DON or QA Nurse. Any allegations must be reported to ISDH in a timely manner. A checkoff list has been implemented for reporting allegations of abuse to ensure that every step is taken to follow the facility's abuse policy. All staff will be inserviced on abuse quarterly X 4 and then annually thereafter. Additionally, new employees will be instructed on abuse as part of new employee orientation. During morning meeting, abuse related items are on the agenda to make sure that every reportable event is reported to the ISDH in a timely manner. Date of Completion March 2, 2014 Addendum:1. The systemic change we have put into place is that we have implemented a check off tool for reporting allegations of abuse to ensure that every step is taken, and every reportable event is</p>		

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	<p>notified. Res moved...."</p> <p>A Social Services Designee (SSD) progress note for Resident #6, dated 1/15/14, indicated, "Writer spoke to this resident today re: [regarding] the alleged abuse from another resident...I asked her why she moved rooms but she didn't know...Before I left her room she said, 'She did threaten to hit me, that's why I'm not communicating [sign for with] her.' I reminded the resident of her answers before et [and] she put her hand on her forehead et shook her head. I asked the resident again which answers were the correct ones et she didn't respond...."</p> <p>During an interview on 1/30/14 at 4:30 p.m., the SSD indicated the allegation regarding Resident #6 was reported by Resident #6's family member to LPN #4. The SSD indicated this particular family member had been problematic at the facility. The SSD indicated the report was initially reported to the DoN by LPN #4, and Resident #6 was moved immediately. The SSD indicated she interviewed Resident #6's roommate and the roommate denied threatening Resident #6. The SSD indicated the allegation</p>		<p>reported to ISDH in a timely manner. 2. Facility staff was inserviced to notify the Administrator immediately in the event of an allegation of abuse. If the Administrator is not able to be reached immediately, the Assistant Administrator is to be notified. If the Assistant Administrator is not able to be reached, the Director of Nursing will be notified. Staff does not need to notify all of the individuals listed in the POC. Facility policy has been updated to reflect this. 3. Reportables will be added to the QA Meeting agenda for the QA team to monitor the effectiveness of our incident reporting system. Recommendations for improvement will be made at that time. The monitoring by the QA Committee will continue on an ongoing basis.</p>				

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	<p>was unsubstantiated.</p> <p>During an interview on 1/31/14 at 9:11 a.m., regarding abuse prohibition policies, the DoN indicated, "If observe issue, or allegation, get patient away, write statement, suspend, do investigation, notify administrator and follow up."</p> <p>During an interview on 1/31/14 at 9:25 a.m., the DoN indicated a family member of Resident #6 reported to LPN #4 that Resident #6 felt threatened. The DoN indicated Resident #6 was transferred to another room. The DoN indicated the allegation was not reported to the state agency. "I'm sure we did."</p> <p>During an interview on 1/31/14 at 10:45 a.m., the DoN indicated the facility incorporated both policies regarding abuse prohibition that were presented during the survey.</p> <p>During an interview on 1/31/14 at 1:42 p.m., the Administrator indicated, families are educated on admission how to report allegations of abuse. The Administrator indicated employees are in-serviced on how, to whom and when to report allegations of abuse. The</p>						

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	<p>Administrator indicated the daily morning meetings include any reports of abuse and a decision is made based on the statement and based on the resident. The Administrator indicated, "if reportable, then report."</p> <p>During an interview on 1/31/14 at 2:00 p.m., the Administrator and Assistant Administrator/MDS coordinator indicated the facility lacked documentation the allegation involving Resident #6 was reported to the state agency and the facility lacked documentation the facility conducted a thorough investigation regarding the allegation involving Resident #6.</p> <p>A facility policy provided by the facility nurse consultant on 1/27/14 at 2:25 p.m., titled, "Abuse Prohibition Policy/Procedure," indicated, "...It is the policy of Friendship Healthcare to keep its residents free from abuse...In the event of an incident the following procedure will be followed....The incident must be reported to the Administrator <u>immediately</u>... The Administrator or designee will report the incident to the Indiana State Department of Health immediately upon investigation of the</p>			
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	<p>incident...Investigation of incidents of alleged abuse will be carried out by the Administrator beginning immediately following notification of event...See also policy titled 'Abuse Prohibition Policy Summary' for information regarding screening, training, prevention, identification, investigation, protection, reporting and response."</p> <p>A facility policy provided by the facility nurse consultant on 1/30/14 at 10:30 a.m., titled, "Abuse Prohibition Policy Summary," indicated, "...It is the policy of Friendship Healthcare Center to prevent abuse to residents, and investigate and report suspected abuse as needed...All staff is responsible for identifying and reporting to the Charge Nurse any evidence of abuse...The Charge Nurse will begin the investigation process and notify the DON of the issue...The DON will investigate all...incidents of abuse or suspected abuse...The DON and/or Administrator will report any incidents of abuse or suspected abuse to...the ISDH [Indiana State Department of Health]...."</p> <p>3.1-28(c) 3.1-28(d)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their policies regarding abuse prohibition related to reporting allegations of abuse and related to thorough investigations of allegations of abuse for 1 of 4 facility reportable incidents reviewed. (Resident #6)</p> <p>Findings include:</p> <p>The record for Resident #6 was reviewed on 1/30/14 at 8:47 a.m.</p> <p>Diagnoses included, but were not limited to, depression, bipolar, diabetes, seizures, colostomy, urostomy, and decubitis.</p>	F000226	<p>Resident #6 was moved immediately to another room. Resident #6 roommate was interviewed and denies making the statement. Interview with Resident #6 offered confusion about the allegation and claims her Mom was upset with roommate and indicated her Mother wanted her to make the room change. No other residents were at risk. SSD was educated regarding reporting of incidents or allegations. The Management Team was also re educated on immediately reporting of incidents or allegations immediately to ADM.AADM.DON or QA Nurse. Any allegations must be reported to ISDH in a timely manner. A checkoff list has been implemented for reporting allegations of abuse to ensure that every step is taken to follow the facility's abuse policy. All staff</p>	03/02/2014

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	<p>The most recent discharge Minimum Data Set (MDS) assessment, dated 12/9/13, indicated Resident #6 was independent with reasonable decisions. The MDS indicated Resident #6 was totally dependent on staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing.</p> <p>A nurse's note, dated 1/12/14 at 6:00 p.m., indicated, "Res [resident] stated she did not feel safe [sign for with] roommate. Stated roommate has made physical threats toward her. Reported to writer [sign for at] app [approximately] 5 pm. MDS [Minimum Data Set] coordinator notified. Res moved...."</p> <p>A Social Services Designee (SSD) progress note for Resident #6, dated 1/15/14, indicated, "Writer spoke to this resident today re: [regarding] the alleged abuse from another resident...I asked her why she moved rooms but she didn't know...Before I left her room she said, 'She did threaten to hit me, that's why I'm not communicating [sign for with] her.' I reminded the resident of her answers before et [and] she put her hand on her forehead et shook her head. I asked the resident again which</p>		<p>will be inserviced on abuse quarterly X 4 and then annually thereafter. Additionally, new employees will be instructed on abuse as part of new employee orientation. During morning meeting, abuse related items are on the agenda to make sure that every reportable event is reported to the ISDH in a timely manner. Date of Completion March 2, 2014Addendum:1. The systemic change we have put into place is that we have implemented a check off tool for reporting allegations of abuse to ensure that every step is taken, and every reportable event is reported to ISDH in a timely manner. 2. Facility staff was inserviced to notify the Administrator immediately in the event of an allegation of abuse. If the Administrator is not able to be reached immediately, the Assistant Administrator is to be notified. If the Assistant Administrator is not able to be reached, the Director of Nursing will be notified. Staff does not need to notify all of the individuals listed in the POC. Facility policy has been updated to reflect this. 3. Reportables will be added to the QA Meeting agenda for the QA team to monitor the effectiveness of our incident reporting system. Recommendations for improvement will be made at that time. The monitoring by the QA Committee will continue on an</p>				

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	<p>answers were the correct ones et she didn't respond...."</p> <p>During an interview on 1/30/14 at 4:30 p.m., the SSD indicated the allegation regarding Resident #6 was reported by Resident #6's family member to LPN #4. The SSD indicated this particular family member had been problematic at the facility. The SSD indicated the report was initially reported to the DoN by LPN #4 and Resident #6 was moved immediately. The SSD indicated she interviewed Resident #6's roommate and the roommate denied threatening Resident #6. The SSD indicated the allegation was unsubstantiated.</p> <p>During an interview on 1/31/14 at 9:11 a.m., regarding abuse prohibition policies, the DoN indicated, "If observe issue, or allegation, get patient away, write statement, suspend, do investigation, notify administrator and follow up."</p> <p>During an interview on 1/31/14 at 9:25 a.m., the DoN indicated a family member of Resident #6 reported to LPN #4 that Resident #6 felt threatened. The DoN indicated Resident #6 was transferred to</p>		ongoing basis.				

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	<p>another room. The DoN indicated the allegation was not reported to the state agency. "I'm sure we did."</p> <p>During an interview on 1/31/14 at 10:45 a.m., the DoN indicated the facility incorporated both policies regarding abuse prohibition that were presented during the survey.</p> <p>During an interview on 1/31/14 at 1:42 p.m., the Administrator indicated, families are educated on admission how to report allegations of abuse. The Administrator indicated employees are in-serviced on how, to whom, and when to report allegations of abuse. The Administrator indicated the daily morning meetings include any reports of abuse, and a decision is made based on the statement and based on the resident. The Administrator indicated, "If reportable, then report."</p> <p>During an interview on 1/31/14 at 2:00 p.m., the Administrator and Assistant Administrator/MDS coordinator indicated the facility lacked documentation the allegation involving Resident #6 was reported to the state agency, and the facility lacked documentation the facility conducted a thorough investigation</p>			

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	<p>regarding the allegation involving Resident #6.</p> <p>A facility policy provided by the facility nurse consultant on 1/27/14 at 2:25 p.m., titled, "Abuse Prohibition Policy/Procedure," indicated, "...It is the policy of Friendship Healthcare to keep its residents free from abuse...In the event of an incident the following procedure will be followed....The incident must be reported to the Administrator <u>immediately</u> ... The Administrator or designee will report the incident to the Indiana State Department of Health immediately upon investigation of the incident...Investigation of incidents of alleged abuse will be carried out by the Administrator beginning immediately following notification of event...See also policy titled 'Abuse Prohibition Policy Summary' for information regarding screening, training, prevention, identification, investigation, protection, reporting and response."</p> <p>A facility policy provided by the facility nurse consultant on 1/30/14 at 10:30 a.m., titled, "Abuse Prohibition Policy Summary," indicated, "...It is the policy of Friendship Healthcare Center to</p>				

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	<p>prevent abuse to residents, and investigate and report suspected abuse as needed...All staff is responsible for identifying and reporting to the Charge Nurse any evidence of abuse...The Charge Nurse will begin the investigation process and notify the DON of the issue...The DON will investigate all...incidents of abuse or suspected abuse...The DON and/or Administrator will report any incidents of abuse or suspected abuse to...the ISDH [Indiana State Department of Health]...."</p> <p>3.1-28(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan related to a resident's refusal to turn and reposition every 2 hours for 1 of 25 care plans reviewed in a Stage 2 sample of 30. (Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 1/30/14 at 8:47 a.m.</p> <p>Diagnoses included, but were not</p>	F000279	Resident # 6 has a care plan that addresses her refusal to be repositioned appropriately to address her skin integrity issues. This care plan, dated 1/15/16, was located in the North Wound Book. A copy of this care plan should have been included in the North Care Plan Book as well. A copy has been placed there for increased accessibility. All residents with skin issues requiring specific care plans have the potential to be affected. The Wound Books for both units have been reviewed to ensure that copies of all skin related care plans are in the Care Plan Books	03/02/2014	

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	<p>limited to, depression, bipolar, diabetes, seizures, colostomy, urostomy, and decubitis.</p> <p>The most recent discharge Minimum Data Set (MDS) assessment, dated 12/9/13, indicated Resident #6 was independent with reasonable decisions. The MDS indicated Resident #6 was totally dependent on staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing.</p> <p>A wound clinic progress note dated 1/8/14 indicated, "...multiple pressure ulcers...Plan...Right, Lateral Ischial...Turn every 2 hours...Coccyx...Turn every 2 hours...Left Ischial...Turn every 2 hours..."</p> <p>A nurse's note dated 1/13/14 at 7:50 a.m., indicated "Resident cont [continues] to be non compliant with tg [turning] in bed refuses to lay on either side will only allow slight position changes...."</p> <p>A nurses's note dated 1/14/14 at 1:00 p.m., indicated, "Resident refused to be turned...."</p> <p>During an interview on 1/30/14 at 9:18 a.m., CNA #5 indicated</p>		<p>as well as the Wound Books. The licensed nurse who placed the care plan for Resident # 6 in the Wound Book was inserviced on 2/17/2014 on placing care plans in the care plan books. Additionally, all licensed nurses will be instructed that all care plans should be placed in the care plan books by March 2, 2014. During each care plan meeting, the most recent weekly skin condition report will be reviewed to make sure that if the resident being care planned that day has skin issues, then a care plan is in place in the care plan book. The facility's care planning process will be discussed in QA meeting quarterly X 4 as a method to monitor the effectiveness of this correction. Completion Date March 2, 2014</p>		

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	<p>Resident #6 gets up every day before lunch. CNA #5 indicated Resident #6 "likes to lay on her bottom." CNA #5 indicated Resident #6 refuses to turn and likes to lay on her right side. "Sometimes I have got her to turn a bit."</p> <p>During an interview on 1/31/14 at 9:14 a.m., the DoN indicated Resident #6 was resistant when the nursing staff attempted to reposition her. A care plan for resistance to repositioning was requested.</p> <p>During an interview on 1/31/14 at 10:45 a.m., the DoN indicated a care plan had not been developed for Resident #6 related to refusing and/or resisting to be turned and repositioned every 2 hours as recommended as part of her complete care plan.</p> <p>During an interview on 1/31/14 at 11:45 a.m., RN #6 indicated when attempting to turn and reposition Resident #6 throughout the night, she refused and "sometimes she prefers her right side because her legs are contracted due to multiple sclerosis, and when she turns it puts her in an awkward position."</p> <p>As of the exit conference on 1/31/14</p>			

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	<p>at 4:00 p.m., the facility lacked documentation of a care plan for resisting/refusing to be turned and repositioned every 2 hours for Resident #6.</p> <p>3.1-35(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a care plan was updated for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication (Resident #55) and a care plan was updated for a resident who lost her lower dentures for 1 of 3 residents reviewed for dental care in a sample of 3 who met the criteria for review of dental care. (Resident #22)</p> <p>Findings include:</p> <p>1. The clinical record of Resident</p>	F000280	Resident #55 has had medication reviewed and were revised. Resident #22 has been seen by a Dentist and assessed for a new lower denture. Resident #55 care plan has been reviewed, and updated. All residents with psychotropic medications and have dentures have potential to be affected. These residents will be assessed for appropriate medications and dosage. Oral assessments will be performed to assure all residents with dentures are present and in working order. All care plans will be reviewed, revised and updated for psych medications and dentures. The Care Plan Team will be re educated on updating care plans	03/02/2014			

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	<p>#55 was reviewed on 1/29/14 at 4:00 p.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, dementia, memory loss, and insomnia.</p> <p>A recapitulated physician's order for January, 2013, indicated she was to receive Seroquel 100 milligrams 3 times per day. Seroquel is an antipsychotic medication.</p> <p>A recapitulated physician's order for January, 2014 indicated Resident #55 was to receive Seroquel 100 milligrams 3 times per day for agitation.</p> <p>During an interview, on 1/30/14 at 2:00 p.m., the Nurse Consultant indicated Resident #55 had been receiving Seroquel 100 milligrams three times per day since January, 2013.</p> <p>A care plan for Resident #55, dated 3/25/13, indicated a problem of, "Risk for side effects from antipsychotic medication use (takes.....Seroquel). The goal was, "Will not have any side effects from medication." Interventions included observing for side effects of</p>		<p>appropriately. Date of completion March 2, 2014. Addendum:At each care plan meeting, residents will be reviewed using a head to toe care plan tool that includes dental care and appliances, gradual dose reductions, and AIMS testing among items to review for each resident. The care plan team will report to the Quality Assurance Committee regarding the effectiveness of this method to ensure compliance. This will continue indefinitely.</p>				

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	<p>Seroquel and monitoring behaviors..."to assure lowest therapeutic dose given." There was no documentation in the resident's record, which indicated this care plan had been reviewed or updated since March, 2013.</p> <p>No documentation was provided that indicated Resident #55's care plan for antipsychotic medication had been reviewed or updated since March, 2013.</p> <p>2. The clinical record of Resident #22 was reviewed on 1/30/14 at 1:15 p.m.</p> <p>Diagnoses for Resident #22 included, but were not limited to, schizophrenia, gastroesophageal reflux disease, diabetes mellitus, and high blood pressure.</p> <p>A Minimum Data Set assessment, dated 11/25/13, indicated Resident #22's cognitive status was not impaired.</p> <p>A care plan for Resident #22, dated 5/18/13 and updated through 2/15/14, indicated she had dentures. Interventions included, "Assess resident's dentures for proper fitting...Remove and clean dentures</p>						

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	<p>[at bed time and as needed], Inform nurse of missing or broken dentures..."</p> <p>During an interview with Resident #22 on 1/28/14 at 4:48 p.m., she indicated she had lost her lower dentures at the facility and had difficulty chewing food. She indicated she was not sure when she had lost her dentures. She indicated, "Sometimes I swallow my food almost whole, because I can't chew it." At that time, the resident was observed to have upper dentures in place, but no lower dentures.</p> <p>An Oral Evaluation/Treatment record, dated 10/14/13, signed by the facility dentist, indicated, "Lost lower denture. When was denture made?" No documentation was found in Resident #22's record which indicated the facility had addressed the dentist's concern. No other documentation was found in the record, which indicated the facility was aware the resident was missing her lower dentures.</p> <p>During an interview with CNA (Certified Nursing Assistant) #21 on 1/30/14 at 12:55 p.m., she indicated she had worked at the facility for 5</p>			

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F000282 SS=D	<p>months and had never seen Resident #22 wearing dentures.</p> <p>During an interview with the Social Service Director (SSD) on 1/30/14, she indicated she had not followed up on the concern the dentist had written on his evaluation of 10/14/13. On 1/31/14, the SSD indicated she would try to find out when Resident #22 had bought her current dentures, and the dentist was scheduled to see the resident on 2/10/14.</p> <p>Resident #22's care plan was not updated to indicate she had lost her lower dentures.</p> <p>3.1-35(e)</p> <p>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 record review and interview, the facility failed to ensure a medication was given according to physician's orders (Resident #55)</p>	F000282	Resident #55 medications were reviewed and clarified as needed. All residents have the capacity to be effected. The M.A.R. s(Medication, Administration,	03/02/2014

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	<p>and care plans were followed for a resident on antipsychotic medications (Resident #55) and a resident needing oral/dental care. (Resident #22)</p> <p>Findings include:</p> <p>1.a. The clinical record of Resident #55 was reviewed on 1/29/14 at 4:00 p.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, dementia, memory loss, insomnia, and agitation.</p> <p>Recapitulated physician's order for December, 2013, indicated Resident #55 could receive trazodone 25 milligrams (mg) every evening as needed for insomnia. Trazodone is an antidepressant medication. A common side effect is drowsiness.</p> <p>A physician's order dated 12/20/13, indicated Resident #55 was ordered to receive trazodone 50 mg daily at bedtime, for insomnia.</p> <p>Review of the Resident #55's Medication Administration Record (MAR) for December, 2013, indicated she received trazodone 50 mg every evening from 12/21/13 -</p>		<p>Record) and the physicians orders will be reviewed by 2 nurses to ensure accuracy. The AIMS tests will be reviewed and revised no less then every 6 months. The Nursing Staff will be educated on checking the MARs and physicians orders. The Nurses will also be educated on the AIMS when to complete. Resident #22 See F 280.Addendum:At each care plan meeting, residents will be reviewed using a head to toe care plan tool that includes dental care and appliances, gradual dose reductions, and AIMS testing among items to review for each resident. The care plan team will report to the Quality Assurance Committee regarding the effectiveness of this method to ensure compliance. This will continue indefinitely.</p>		

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	<p>12/31/13.</p> <p>Recapitulated physician's orders for January, 2014, for Resident #55, indicated she was supposed to receive trazodone 25 mg every evening as needed for insomnia. The January 2014 orders lacked documentation for trazodone 50 mg daily at bedtime, for insomnia.</p> <p>Review of the resident's MAR for January, 2014, indicated she received trazodone 25 mg as needed, 4 times during the month of January, 2014. The MAR lacked documentation of trazodone 50 mg daily at bedtime.</p> <p>During an interview with Licensed Practical Nurse (LPN) #4 on 1/30/14 at 10:00 a.m., she indicated the trazodone order from 12/20/14 for Resident #55 had not been carried over to the January, 2014 recapitulated physician's orders, nor to the January, 2014, MAR. She indicated, "We missed it." During an interview with the Nurse Consultant on 1/30/14 at 2:00 p.m., she indicated the trazodone order from 12/20/13 had not been carried over to the January physician's orders or MAR.</p>				

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	<p>On 1/30/14 at 10:15 a.m., LPN #4 added the correct trazodone order to the January, 2014 MAR.</p> <p>b. 1. A recapitulated physician's order for January, 2014 indicated Resident #55 was to receive Seroquel 100 milligrams 3 times per day for agitation. A recapitulated physician's order for January, 2013, indicated she was to receive Seroquel 100 milligrams 3 times per day. Seroquel is an antipsychotic medication.</p> <p>A care plan for Resident #55, dated 3/25/13, indicated a problem of, "Risk for side effects from antipsychotic medication use (takes.....Seroquel). The goal was, "Will not have any side effects from medication." Interventions included observing for side effects of Seroquel and monitoring behaviors..."to assure lowest therapeutic dose given." There was no documentation in the resident's record, which indicated this care plan had been reviewed or updated since March, 2013.</p> <p>During an interview the Nurse Consultant on 1/30/14 at 2:00 p.m., she indicated Resident #55 had been receiving Seroquel 100</p>						

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	<p>milligrams three times per day since January, 2013.</p> <p>An AIMS (Abnormal Involuntary Movement Scale) assessment for Resident #55 was performed on 5/7/13. No other documentation was found in the resident's record, which indicated she had been monitored or assessed for side effects of Seroquel since January, 2013. On 1/30/14 at 2:00 p.m., the Nurse Consultant indicated no other assessments had been done.</p> <p>An undated facility policy, titled, "Abnormal Involuntary Movement Scale (AIMS) for Tardive Dyskinesia ,(abnormal involuntary movements) received from the Director of Nursing on 1/31/14 at 8:50 a.m., indicated, "I. Purpose: To formally assess patients for whom psychotropic medications have been prescribed to identify symptoms that may indicate the presence of Tardive Dyskinesia. II. The AIMS examination will be administered to all patients for whom psychotropic medications are prescribed. The examination will be administered either at the time of the patient's admission...or when medications are initially prescribed. In addition, for patients taking psychotropic</p>						

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	<p>medication, AIMS examination procedures will be repeated at intervals of no less than every six (6) months.</p> <p>2. The clinical record of Resident #22 was reviewed on 1/30/14 at 1:15 p.m.</p> <p>Diagnoses for Resident #22 included, but were not limited to, schizophrenia, gastroesophageal reflux disease, diabetes mellitus, and high blood pressure.</p> <p>A Minimum Data Set assessment, dated 11/25/13, indicated Resident #22's cognitive status was not impaired.</p> <p>A care plan for Resident #22, dated 5/18/13 and updated through 2/15/14, indicated she had dentures. Interventions included, "Assess resident's dentures for proper fitting...Remove and clean dentures [at bed time and as needed], Inform nurse of missing or broken dentures..."</p> <p>During an interview with Resident #22 on 1/28/14 at 4:48 p.m., she indicated she had lost her lower dentures at the facility and had difficulty chewing food. She</p>				

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	<p>indicated she was not sure when she had lost her dentures. She indicated, "Sometimes I swallow my food almost whole, because I can't chew it." At that time, the resident was observed to have upper dentures in place, but no lower dentures.</p> <p>An Oral Evaluation/Treatment record, dated 10/14/13, signed by the facility dentist, indicated, "Lost lower denture. When was denture made?" No documentation was found in Resident #22's record which indicated the facility had addressed the dentist's concern. No other documentation was found in the record, which indicated the facility was aware the resident was missing her lower dentures.</p> <p>During an interview with CNA (Certified Nursing Assistant) #21 on 1/30/14 at 12:55 p.m., she indicated she had worked at the facility for 5 months and had never seen Resident #22 wearing dentures.</p> <p>During an interview with the Social Service Director (SSD) on 1/30/14, she indicated she had not followed up on the concern the dentist had written on his evaluation of 10/14/13. On 1/31/14, the SSD indicated she</p>				

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F000323 SS=D	<p>would try to find out when Resident #22 had bought her current dentures, and the dentist was scheduled to see the resident on 2/10/14.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure resident safety from access to chemicals stored in a "Soiled Utility" room for 2 of 2 residents randomly observed and reviewed for safety of 20 mobile residents on the north unit. (Resident #24, Resident #42)</p> <p>Findings include:</p> <p>A. During the initial tour of the north unit of the facility on 1/27/14 at 11:15 a.m., an observation indicated</p>	F000323	The DON alerted the Administrator of surveyors' concerns regarding the Soiled Utility Room door. The Facility would like to add defensively that no incident has ever occurred as a result of the placement of the key beside the door, where it has been for many years. However, the Administrator and Assistant Administrator quickly problem solved the issue and had a keyless entry lock installed on the door, thus eliminating the need for a key. This correction would prevent a confused resident from attempting to use a key to open the door. All confused residents	03/02/2014	

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	<p>a door marked, "Soiled Utility." A key was observed hanging from a string on the hand rail next to door. The door was locked. The key on the string was within reach of the doorknob and keyhole and accessed the soiled utility room. In the soiled utility room under an unlocked sink, were two bottles of bleach. Three specimen containers were observed on the counter top with unidentifiable, green-brown colored specimens inside the containers. Sealed biohazard containers were located in the "Soiled Utility" room. No residents were observed in the area at the time of the observation.</p> <p>During an interview on 1/27/14 at 11:25 a.m., the DON was queried regarding any ambulatory or mobile residents on the north unit and the mobile/ambulatory residents' cognition status.</p> <p>On 1/27/14 at 1:30 p.m., the DoN provided a type-written prepared list of residents titled, "Ambulatory or W/C [wheelchair] North Unit." The DoN denoted Resident #42 as "confused."</p> <p>During an interview on 1/27/14 at 1:50 p.m., the DoN was requested to provide a copy of the Material Safety</p>		<p>in the facility are identified as having the potential to be affected. The keyless entry lock was installed to prevent an occurrence. The Maintenance Supervisor will inspect function of doors securing potentially hazardous materials on a monthly basis, as evidenced by documentation on the monthly preventive maintenance log. The Maintenance Supervisor will review with the QA Committee each month the results of the monthly maintenance checks on hazardous materials as a method to monitor. It is the sincere desire to prevent any exposure to hazardous materials. Date of Completion March 2, 2014.</p>				

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	<p>Data Sheet (MSDS) for the bleach that was stored under the sink in the "Soiled Utility" room.</p> <p>A. 1. The record for Resident #24 was reviewed on 1/30/14 at 1:50 p.m.</p> <p>Diagnoses included, but were not limited to, paranoid schizophrenia, hypertension, neurogenic bladder, and paraplegia.</p> <p>The most recent quarterly Minimum Data Set [MDS] assessment for Resident #24, dated 12/2/13, indicated Resident #24 was unable to complete the Brief Interview for Mental Status [BIMS]. The MDS indicated Resident #24 was moderately impaired, decisions poor, and required cues and supervision. The MDS indicated Resident #24 was independent with locomotion on the unit using a wheelchair.</p> <p>A care plan for Resident #24, dated 6/11/13, with an updated goal date of 3/5/14, indicated, "Risk of increasing confusion and disordered thoughts secondary to schizophrenia...Keep environment free of hazards...."</p>						

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	<p>A. 2. The record for Resident #42 was reviewed on 1/31/14 at 12:45 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, depression, and non organic psychosis.</p> <p>The most recent quarterly MDS assessment for Resident #42, dated 12/30/13, indicated a BIMS of 10 out of a possible 15, which indicated he could not report the correct year or day of the week. The MDS indicated Resident #42 required supervision and oversight for mobility on the unit and did not utilize assistive devices for mobility.</p> <p>A care plan for Resident #42, dated 10/8/13, with an updated goal date of 4/2/14, indicated, "Potential for increasing confusion secondary to dementia...Verbal reminders which assist resident in orientation...."</p> <p>The MSDS for bleach was provided by the DoN on 1/27/14 at 2:25 p.m. The MSDS for bleach indicated, "...Health Hazard Information...Respiratory tract irritant...<u>IF SWALLOWED:</u> Call poison control center or doctor immediately for treatment advice...<u>SKIN CONTACT:</u></p>						

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	<p>Contact with liquid can cause chemical burns...<u>EYE CONTACT:</u> Hold eye open and rinse slowly and gently with water for 15-20 minutes...Call a poison control center or doctor for treatment advice...."</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=E	<p>483.25(I) 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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>1. Based on record review and interview, the facility failed to ensure a gradual dose reduction was considered or attempted for a resident taking an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #55)</p> <p>2. Based on record review and interview, the facility failed to ensure pharmacy recommendations for antipsychotic medication</p>	F000329	Resident # 55 had a Gradual Dose Reduction (GDR) of her Seroquel on 2/10/2014. Resident # 18 and Resident # 42 both have had Abnormal Involuntary Movement Scale (AIMS) tests done. All residents on psychoactive medications have potential to be affected. All residents with psychoactive medications have been reviewed to ensure that any appropriate GDRs have been attempted and AIMS tests are current. The Consultant Pharmacist will review all residents and make	03/02/2014			

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	<p>assessments were followed for 2 of 5 residents reviewed for unnecessary medications. (Residents #18 and #42)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #55 was reviewed on 1/29/14 at 4:00 p.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, dementia, memory loss, insomnia, and agitation.</p> <p>A recapitulated physician's order for January, 2013, indicated she was to receive Seroquel 100 milligrams 3 times per day. Seroquel is an antipsychotic medication</p> <p>A recapitulated physician's order for January, 2014 indicated Resident #55 was to receive Seroquel 100 milligrams 3 times per day for agitation. medication.</p> <p>During an interview with the Nurse Consultant on 1/30/14 at 2:00 p.m., she indicated Resident #55 had been receiving Seroquel 100 milligrams 3 times per day since January, 2013.</p>		<p>recommendations for GDRs as appropriate per facility policy, pharmacy policy, and state regulations. AIMS tests will be completed at least every six months by nursing. The Consultant Pharmacist will report to the QA Committee no less than quarterly as a method to monitor the process of following up on pharmacy recommendations. Completion date March 2, 2014 Addendum: Nursing staff will be inservised on Friday February 28, 2014 regarding AIMS testing and gradual dose reductions.</p>	

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	<p>A current care plan for Resident #55, dated 3/25/13 (date initiated), indicated a problem of, "Risk for side effects from antipsychotic medication use (takes.....Seroquel). The goal was, "Will not have any side effects from medication." Interventions included observing for side effects of Seroquel and monitoring behaviors ... to assure lowest therapeutic dose given." .</p> <p>No documentation was found in Resident #55's record, which indicated a gradual dose reduction (GDR) had been considered or attempted during 2013 through 1/30/14.</p> <p>During an interview with the Nurse Consultant on 1/30/14 at 2:00 p.m., she indicated a GDR on Resident #55's Seroquel had not been attempted during the year 2013, through 1/30/14.</p> <p>A facility policy, titled Medication Monitoring and Management, dated December, 2009, received from the Director of Nursing on 1/28/14 at 9:30 a.m., indicated, "c...During the first year in which a resident is admitted on a psychopharmacological</p>			

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	<p>medication...or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated...b. The continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function..."</p> <p>2. a. The clinical record for Resident #18 was reviewed on 1/30/14 at 11:05 A.M.</p> <p>Diagnoses for Resident #18 included, but were not limited to, schizophrenia, schizoaffective disorder, metabolic encephalopathy, diabetes, hypertension, congestive heart failure, chronic obstructive pulmonary disease, and chronic respiratory failure.</p> <p>Review of the resident's current physician's orders indicated a need for the administration of the following psychotropic medications: divalproex 500 milligrams (mg) twice daily (BID) and Seroquel 100 mg</p>						

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	<p>every morning and 300 mg every bedtime for the treatment of schizophrenia.</p> <p>A "Consultant Pharmacist's Medication Regimen Review," dated 12/20/13, indicated a recommendation from the pharmacist for an AIMS (abnormal involuntary movement scale) assessment for monitoring side effects related to psychotropic medication use should be completed soon because, one could not be found in the resident's record.</p> <p>The record lacked documentation of the AIMS assessment for monitoring side effects related to the administration of psychotropic medications.</p> <p>2. b. The clinical record for Resident #42 was reviewed on 1/30/14 at 10:36 A.M.</p> <p>Diagnoses for Resident # 42 included, but were not limited to, non-organic psychosis, dementia and depression.</p> <p>Review of the resident's current physician's orders indicated a need for the administration of the psychotropic medication Zyprexa 10</p>				

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	<p>mg at bedtime.</p> <p>A "Consultant Pharmacist's Medication Regimen Review" dated 12/20/13, indicated a recommendation from the pharmacist, an AIMS assessment for monitoring side effects related to psychotropic medication use should be completed because one could not be found in the resident's record.</p> <p>The record lacked documentation of the AIMS assessment for monitoring side effects related to the administration of psychotropic medications.</p> <p>During an interview with the Quality Assurance (QA) nurse on 1/30/14 at 12:50 P.M., she indicated the AIMS were not completed as requested by the pharmacist for Resident #18 or Resident #42 and could not be found.</p> <p>An undated facility policy, titled, "Abnormal Involuntary Movement Scale (AIMS) for Tardive Dyskinesia,(abnormal involuntary movements) received from the Director of Nursing on 1/31/14 at 8:50 a.m., indicated, "I. Purpose: To formally assess patients for whom psychotropic medications have been</p>			

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	<p>prescribed to identify symptoms that may indicate the presence of Tardive Dyskinesia. II. The AIMS examination will be administered to all patients for whom psychotropic medications are prescribed. The examination will be administered either at the time of the patient's admission...or when medications are initially prescribed. In addition, for patients taking psychotropic medication, AIMS examination procedures will be repeated at intervals of no less than every six (6) months.</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p>			

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F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received follow up services after a dental evaluation for 1 of 3 residents who met the criteria for review of dental services in a sample of 30. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record of Resident #22 was reviewed on 1/30/14 at 1:15 p.m.</p> <p>Diagnoses for Resident #22 included, but were not limited to, schizophrenia, gastroesophageal reflux disease, diabetes mellitus, and high blood pressure.</p> <p>A Minimum Data Set assessment, dated 11/25/13, indicated Resident</p>	F000412	<p>Resident # 22 was seen by a dentist on 2/10/2014. The DDS is proceeding with making a lower denture for Resident # 22. All residents with dentures are identified as having the potential to be affected. All residents with dentures will be scheduled to be seen by DDS for assessment and evaluation of dentures. The SSD and DON will both review dental consults after each dentist visit to make sure that any issues requiring follow up are addressed. Additionally, licensed nurses have been instructed that they are required to alert the DON and SSD of need for any dental care. Appointments to see the dentist will be made as soon as possible after an issue is identified. QA Meeting is held monthly and will include oral care issues on the agenda for the QA team to monitor compliance. Completion Date March 2, 2014</p>	03/02/2014			

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	<p>#22's cognitive status was not impaired.</p> <p>A care plan for Resident #22, dated 5/18/13 and updated through 2/15/14, indicated she had dentures. Interventions included, "Assess resident's dentures for proper fitting...Remove and clean dentures [at bed time and as needed], Inform nurse of missing or broken dentures..."</p> <p>During an interview with Resident #22 on 1/28/14 at 4:48 p.m., she indicated she had lost her lower dentures at the facility and had difficulty chewing food. She indicated she was not sure when she had lost her dentures. She indicated, "Sometimes I swallow my food almost whole, because I can't chew it." At that time, the resident was observed to have upper dentures in place, but no lower dentures.</p> <p>An Oral Evaluation/Treatment record, dated 10/14/13, signed by the facility dentist, indicated, "Lost lower dentures. When was denture made?" No documentation was found in Resident #22's record, which indicated the facility had addressed the dentist's concern. No</p>						

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	<p>other documentation was found in the record, which indicated the facility was aware the resident was missing her lower dentures.</p> <p>During an interview with CNA (Certified Nursing Assistant) #21 on 1/30/14 at 12:55 p.m., she indicated she had worked at the facility for 5 months and had never seen Resident #22 wearing her lower dentures.</p> <p>During an interview with the Social Service Director (SSD) on 1/30/14, she indicated she had not followed up on the concern the dentist had written on his evaluation of 10/14/13. On 1/31/14, the SSD indicated she would try to find out when Resident #22 had bought her current dentures, and the dentist was scheduled to see the resident on 2/10/14.</p> <p>3.1-24(a)(3)</p>				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure insulin pens were stored</p>	F000431	The insulin pens contained in Resident # 40's bag were immediately removed and	03/02/2014			

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	<p>and labeled according to facility policy for 3 of 4 residents with insulin pens. (Resident #40, Resident #65, Resident #16)</p> <p>B. Based on interview and record review, the facility failed to ensure the narcotic reconciliation record on both the north and south unit were maintained according to facility policy for 2 of 2 medication carts reviewed.</p> <p>Findings include:</p> <p>A. 1. On 1/29/14 at 2:42 p.m., the medication storage review was conducted with LPN #3 for the medication cart on the north unit of the facility.</p> <p>LPN #3 removed a plastic bag marked with a pre-printed pharmacy resident label for Resident #40 from the medication cart. The bag contained 3 NovoLog insulin pens marked with names, LPN #3 was not familiar with. One pen was marked with a different resident name, not Resident #40 and dated as opened on 11/4/13. The other two insulin pens were marked with another resident name, not Resident #40. LPN #3 indicated he believed those two residents had been discharged</p>		<p>disposed of per policy. A replacement pen was taken from Resident #40's supply in the medication room, and the pharmacy was notified of need to re-order to ensure that the medication was available to administer per physician's orders. Resident #65 was discharged to home. Resident # 16's Novolog pen without fill date, open date or name was immediately disposed of per policy and a replacement pen, appropriately labeled, was taken from Resident # 16's supply in the medication room. All residents with orders for insulin have the potential to be affected. An inventory of both North and South unit medication carts was performed to ensure names and pharmacy labels are in place and legible, and that all pens and vials are marked with the date opened. Any improperly labeled items were disposed of per facility policy and medication was re-stocked from the medication room or re-ordered from the pharmacy as appropriate to ensure that the physician prescribed medication is available for each resident. All licensed nurses were inserviced on 2/14/2014 regarding the facility's policy on the labeling of all medications and marking dates opened. Along with this, there will be placed in the medication book a list of expiration dates once insulins are opened or unrefrigerated. This will also be</p>				

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	<p>from the facility.</p> <p>During the medication cart review, a Lantus insulin pen for Resident #65 was observed opened with no documented open date.</p> <p>During the medication care review, a HumaLog insulin pen for Resident #65 was observed opened with no documented open date.</p> <p>During an interview on 1/29/14 at 2:42 p.m., regarding the facility policy related to open dates for insulin pens, LPN #3 indicated, "I count on the last person to write on it." Regarding the facility policy for insulin pen expiration once opened, LPN #3 indicated, "Longer than 30 days. I don't know."</p> <p>A. 2. On 1/30/14 at 11:35 a.m., the medication storage review was conducted with LPN #4 on the medication cart on the south unit of the facility.</p> <p>LPN #4 removed a plastic bag marked with a pre-printed pharmacy resident label for Resident #16. The bag contained 2 NovoLog insulin pens. One opened NovoLog insulin pen inside the bag was not labeled with a resident name, pharmacy</p>		<p>part of our licensed nursing staff orientation to ensure that we prevent a recurrence of this problem. Licensed nurses will be inserviced annually regarding medication storage and labeling. Each Monday morning, an audit will be performed on each medication cart to ensure that all containers opened are properly labeled with open dates and that the facility policy is being followed. The DON will be responsible to designate a licensed nurse each Monday morning to perform the audit and deliver it to the DON. The DON will report to the QA Committee the results of these audits as a method to monitor compliance. All licensed nurses were inserviced on 2/14/2014 on the procedures and documentation for counting narcotics between shifts. The signature log indicating that two licensed nurses performed the count together at shift change will be audited once weekly by the Director of Nursing or designee. If any required signatures are missing, disciplinary action will be followed for the nurses responsible. These weekly audits will continue until 100% compliance is achieved for three consecutive weeks. When that is achieved, the audits will reduce in frequency to monthly, and will continue on an ongoing basis. The DON will report to the QA Committee the results of the</p>		

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	<p>distribution date, nor open date.</p> <p>A facility policy provided by the DoN on 1/31/14 at 10:40 a.m., titled "Preparation and General Guidelines..." indicated, "...Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use and disposal...The date opened and the initials of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose...Once opened, insulins may be used for 28 days...."</p> <p>A facility policy provided by the DoN on 1/31/14 at 10:40 a.m., titled, "Medication Storage in the Facility," indicated, "...Outdated...medications...are immediately removed from stock, disposed of according to procedures for medication disposal...."</p> <p>A pharmacy recommendation sheet provided by the DoN on 1/31/14 at 10:40 a.m., indicated, "...Humalog (Vial & Pen)...Discard 28 days after initial use of removing from refrigeration...Lantus (Vial & Pen)...Discard 28 days after initial</p>		weekly audits. Completion date March 2, 2014				

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	<p>use or removing from refrigeration...Novolog(Vial & Pen)...Discard 28 days after initial use or removing from refrigeration...."</p> <p>B. 1. On 1/29/14 at 2:42 p.m., the medication storage review was conducted with LPN #3 for the medication cart on the north unit of the facility. The document titled, "Controlled Drug Audit," lacked documentation of two nurses' signatures for each shift as required to ensure the on coming nurse reconciled the narcotics with the off going nurse.</p> <p>On 1/29/14 at 3:59 p.m., the DoN was requested to provide documentation of the reconciliation sheets for the north and south unit medication carts for narcotics for the month of January.</p> <p>For the month of January 2014 for the north unit medication cart, the "Controlled Drug Audit," indicated only one nurse signature was documented for...</p> <p>January 2-night shift "on" January 3-evening shift "on", night shift "off" January 4-evening shift "off" January 10-evening shift "on", night</p>						

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	<p>shift "off" January 12-day shift "off", night shift "on" January 13-day shift "off" January 15-day shift "off", night shift "on" January 18-evening shift "off" January 21-day shift "off", evening shift "on" January 22-evening shift "on", night shift "off" January 24, night shift "off" January 25, day shift "off"</p> <p>B. 2. On 1/30/14 at 11:35 a.m., the medication storage review was conducted with LPN #4 for the medication cart on the south unit of the facility. The document titled, "Controlled Drug Audit," lacked documentation of two nurses' signatures for each shift as required to ensure the on coming nurse reconciled the narcotics with the off going nurse.</p> <p>On 1/29/14 at 3:59 p.m., the DoN was requested to provide documentation of the reconciliation sheets for the north and south unit medication carts for narcotics for the month of January.</p> <p>For the month of January 2014 for the south unit medication cart, the</p>						

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	<p>"Controlled Drug Audit," indicated only one nurse signature was documented for...</p> <p>January 1- day shift "on", evening shift "off", night shift "on" January 2-night shift "off" January 3-night shift "off" January 4-day shift "off" January 6-evening shift "on", night shift "off" January 9-night shift "off" January 10-night shift "off" January 12-evening shift "on", night shift "off" January 14-evening shift "on" January 22- day shift "off", evening shift "on", night shift "off"</p> <p>During an interview on 1/30/14 at 11:35 a.m., LPN #4 indicated the narcotic count sheet was completed every shift- "sign in and sign out." LPN #4 indicated the current nurse (off going) has the keys to the narcotic drawer, and the off going nurse gives the keys to the on coming nurse, and the nurses sign "the sheet in the front of book." LPN #4 indicated, "We normally sign with someone else."</p> <p>During an interview on 1/31/14 at 9:30 a.m., the DoN indicated she did not have an audit system to verify</p>						

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	<p>the nurses are reconciling on each shift according the the facility policy.</p> <p>The "Controlled Drug Audit" records for the north and south medication carts were provided by the DoN on 1/29/14 at 4:15 p.m. The "Controlled Drug Audit," indicated, "<u>...IMPORTANT</u> Control Drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty. Signatures by the nurse/medication aides verify that an actual count has been made and the count is the same as that indicated on the individual control drug record (32002). Note any discrepancy in the comment section and report discrepancy to the Director of Nurses...."</p> <p>3.1-25(j) 3.1-25(k)</p>				

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F000514 SS=B	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure a resident's clinical record was accurately documented for 1 of 30 records reviewed for accurate documentation. (Resident #67, RN #6)</p> <p>Findings include:</p> <p>The clinical record of Resident #67 was reviewed on 1/31/14 at 11:00 a.m.</p> <p>Diagnoses for Resident #67 included, but were not limited to, dysphagia, placement of feeding tube, and bipolar disorder.</p>	F000514	Resident # 67 RHC Any resident with a g/tube has the potential to be affected. All residents with g/tube orders will be reviewed and revised. Nurses will be educated on proper procedure for checking for residual and documentation. Residents with order change regarding the G/tube will be discussed in Morning Meeting and results to QA. Completion Date March 2, 2014.Addendum:G-tube orders will be added to the QA Meeting agenda for the QA team to monitor for compliance. The monitoring by the QA Committee will continue on an ongoing basis.	03/02/2014

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	<p>Resident #67 was admitted to the facility on 1/27/14.</p> <p>A physician's order, dated 1/27/14, indicated Resident #67's feeding tube should be checked for placement and residual before each use, and if the residual was >100 cc's (cubic centimeters), the physician should be notified before anything else was put through the tube. An elevated residual might indicate the stomach was not digesting properly or the feeding tube had become displaced.</p> <p>A physician's order dated 1/27/14, indicated Resident #67's feeding tube was to be flushed with 120 cc's of water every 6 hours, at 12:00 a.m. and 6:00 a.m.</p> <p>A physician's order dated 1/27/14, indicated Resident #67 was to receive Tylenol Elixir 650 milligrams per feeding tube every 6 hours, at 12:00 a.m. and 6:00 a.m.</p> <p>Review of Resident #67's Medication Administration Record (MAR) for January, 2013, indicated her feeding tube had been checked for placement and residual at 12:00 midnight and 6:00 a.m. on 12/31/14 when RN #6 gave the resident her</p>						

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	<p>Tylenol and flushed her tube with 120 cc's water.</p> <p>During an interview with Licensed Practical Nurse (LPN) #24 on 1/31/14 at 11:15 a.m., she indicated when she got report from the night nurse RN #6 on 1/31/14 around 7:30 a.m., he indicated he had not given Resident #67 her Tylenol yet or flushed her feeding tube with water. He indicated he would do this before he left to go home. LPN #24 indicated around 7:45 a.m. on 1/31/14, RN #6 told her he had gone in to give the Tylenol and found the resident unresponsive.</p> <p>On 7/31/14 at around 7:45 a.m., the resident was found unresponsive, cardiopulmonary resuscitation was initiated and 911 emergency services were requested.</p> <p>During an interview with RN #6 on 1/31/14 at 11:40 a.m. he indicated he had documented with his initials as completed the scheduled 6:00 a.m. administration, the 6:00 a.m. water flush of the feeding tube, and the checking for residual and tube placement ahead of time. When he found Resident #67 unresponsive around 7:45 a.m., he did not complete the tasks and forgot to</p>						

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	circle that he hadn't done them at 6:00 a.m. 3.1-50(a)(2)			