

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/03/2013
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00128119, IN00128508, IN00128614, IN00128738, and IN00130059.</p> <p>Complaint IN00128119-unsubstantiated due to lack of evidence.</p> <p>Complaint IN00128508-substantiated, Federal/Sate deficiencies related to the allegations were cited at F325 and F371.</p> <p>Complaint IN00128614-substantiated, Federal/Sate deficiencies related to the allegation are cited at F250, F278, F279 and F411.</p> <p>Complaint IN00128738-substantiated, Federal/Sate deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00130059-substantiated, Federal/Sate deficiencies related to the allegation are cited at F280 and F315.</p> <p>Survey dates: June 24, 25, 26, 27, 28, 2013 and July 1 and 2, 2013</p>	F000000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the complaint survey which was conducted on July 3, 2013.Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law.Please accept this plan of correction as the provider's credible allegation of compliance effective August 2, 2013.Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</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>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Regina Sanders, RN, TC Shannon Pietraszewski, RN Caitlyn Doyle, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 38 SNF/NF: 19 Residential: 47 Total: 104</p> <p>Census Payor type: Medicare: 33 Medicaid: 10 Other: 61 Total: 104</p> <p>Residential sample: 7</p> <p>There deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 9, 2013, by Janelyn Kulik, RN,</p>				

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F000157 SS=D	<p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview, the facility failed to notify a physician of a resident with loose stools for 7 days in 1 of 3 residents reviewed for incontinence.</p>	F000157	<p>August 2, 2013 F-157 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident F</p>	08/02/2013			

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	<p>(Resident #F)</p> <p>Findings include:</p> <p>On 6/27/13 at 1:50 p.m., Resident #F's brief was observed to be saturated with stool (and urine) from front to back to the top of her brief. Resident #F's clothes were observed to be soiled as well. During this time, an interview with CNA #41, indicated the resident "tends to have loose stools". CNA #41 indicated the resident had loose stools before lunch. CNA #41 indicated the nurses have been made aware of the loose stools all week. CNA #41 indicated she was told it was due to a medication the resident was on. During the peri care, the resident informed the CNA she was having another bowel movement.</p> <p>On 6/28/13 at 12:00 p.m., Resident #F was observed in her wheelchair, in the lounge, asking for assistance with her "dress". Resident #F's clothing was observed soiled with stool. At 12:10 p.m. Resident #F's clinical record was reviewed during this time and there was no nursing documentation to indicate the resident had loose stools all week and if the physician had been notified. Resident #F's diagnoses included, but</p>		<p>physician notified and treated for loose stools. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents with loose stools have been assessed and physician notified for treatment. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced to assess and notify the physician when residents are having loose stools for treatment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review any residents having loose stools during clinical meeting M-F to ensure physician has been notified and orders obtained for treatment of loose stools. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>were not limited to, congestive heart failure, urosepsis, confusion, and history of urinary tract infections.</p> <p>A care plan for diarrhea was initiated on 5/18/13. The interventions indicated to assess/record for complications related to diarrhea or for increased episodes of diarrhea and report significant finding to the physician.</p> <p>Review of the Bowel and Bladder record indicated from 6/14/13 to 6/27/28, the resident had 7 loose stools. The June 2013 Medication Administration Record did not indicate anti-diarrhea medication had been given during this time.</p> <p>An interview with RN #42 on 6/28/13 at 1:00 p.m., indicated she was not made aware of the resident having loose stools until CNA #41 informed her. CNA #41 reported to RN #42 she had informed the nurses all week. RN #42 reviewed the 24 hour report sheets and indicated the incontinence had not been documented. RN #42 indicated she would give the Resident #F an anti-diarrhea medication and notify the physician.</p> <p>3.1-5(a)(2)</p>			

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F000225 SS=C	<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 record review and interview</p>	F000225	August 2, 2013 F-225	08/02/2013			

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	<p>the facility failed to ensure new employees did not have a history of abuse, neglect, and/or mistreatment of residents, related to 5 of 55 new employees hired by the facility had no reference checks completed prior to working at the facility. (Environmental #34, Environmental #35, Dietary #36, Minimum Data Set Nurse #37, and RN #38)</p> <p>Findings Include:</p> <p>Employee personal files were reviewed on 07/01/13 at 8 a.m. The files lacked documentation to indicate reference checks were attempted to be checked for the following new employees:</p> <p>Environmental #34, hired 06/18/13 Environmental #35, hired 06/25/13 Dietary #36, hired 06/18/13 Minimum Data Set Nurse #37, hired 06/25/13 RN #38, hired 06/18/13</p> <p>Review of the above employee's time record indicated the employees had worked with the residents' of the facility prior to the reference checks being checked.</p> <p>During an interview on 07/01/13 at 9:30 a.m., the Human</p>		<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Environmental #34, Environmental #35, Dietary #36, Minimum Data Set Nurse #37, and RN #38 will have reference checks completed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Audit completed of current employees to ensure reference checks completed at this time. Employees currently being hired will have reference checks completed during hiring process, prior to working at the facility. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: BOM/designee will review any new hires for appropriate completed reference checks for 6 months or until substantial compliance is achieved. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>Resource/Payroll Clerk stated the references were not completed due to, "a lack of time and not enough people to do them."</p> <p>This Federal Tag relates to complaint number IN00128738</p> <p>3.1-28(b)(1)(A) 3.1-28(b)(1)(B)</p>			

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F000226 SS=C	<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 record review and interview the facility failed to follow the abuse and neglect policy of the facility, related to screening of potential employees prior to new employees working at the facility for 5 of 55 new employees hired in the past four months. (Environmental #34, Environmental #35, Dietary #36, Minimum Data Set Nurse #37, and RN #38)</p> <p>Findings Include:</p> <p>A facility policy, titled, "Abuse and Neglect Procedural Guidelines", dated 11/2010, and received from the Executive Director as current, indicated, "...Screening: i. Screen all potential employees for a history of abuse, neglect or mistreatment of patients during the hiring process. It will consist of, but is not limited to the following:...3. Reference checks from previous/current employers...."</p> <p>Employee personal files were reviewed on 07/01/13 at 8 a.m. The</p>	F000226	<p>August 2, 2013 F-226 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Environmental #34, Environmental #35, Dietary #36, Minimum Data Set Nurse #37, and RN #38 will have reference checks completed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Audit completed of current employees to ensure reference checks completed at this time. Employees currently being hired will have reference checks completed during hiring process, prior to working at the facility. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: BOM/designee will review any new hires for appropriate completed reference checks for 6 months or until substantial compliance is achieved. Audits will be</p>	08/02/2013

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	<p>files lacked documentation to indicate reference checks were attempted to be checked for the following new employees:</p> <p>Environmental #34, hired 06/18/13 Environmental #35, hired 06/25/13 Dietary #36, hired 06/18/13 Minimum Data Set Nurse #37, hired 06/25/13 RN #38, hired 06/18/13</p> <p>Review of the above employee's time records indicated the employees had worked with the residents' of the facility prior to the reference checks being checked.</p> <p>During an interview on 07/01/13 at 9:30 a.m., the Human Resource/Payroll Clerk stated the references were not completed due to, "a lack of time and not enough people to do them."</p> <p>This Federal Tag relates to complaint number IN00128738</p> <p>3.1-28(a)</p>		<p>reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to provide medically-related social services to attain the highest practicable physical, mental, and psychosocial well being of residents, related to, dental exams and appointments were not followed up on for 2 of 4 residents who met the criteria for dental status in a total sample of 27. (Residents #B and #D)</p> <p>Findings include:</p> <p>1. During an interview on 06/24/13 at 2:31 p.m., Resident #B indicated she had missing upper teeth and a broken front tooth. She indicated she had been to the dentist about a month ago, but hadn't heard anything about what they were going to do since she had been to the dentist.</p> <p>During an observation of Resident #B on 06/24/13 at 2:35 p.m., the resident had upper teeth missing and a broken front tooth.</p>	F000250	<p>August 2, 2013 F-250 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident B received the dental services needed. Resident D and her family refused dental services offered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take:</p> <p>Current residents have been assessed for any dental concerns and appointment made with dentist if indicated.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Licensed nursing staff have been inserviced to assess residents oral cavity and notify family and social services for appointment with dentist if indicated. Social services has been inserviced to follow up with dentist for treatment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p>	08/02/2013			

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	<p>During a family interview on 06/25/13 at 5:29 p.m., the family member indicated the resident had a broken tooth and the facility had not done anything about it. The family member indicated Social Service did not know about the broken tooth and once informed they made an appointment with an outside Dentist.</p> <p>Resident #B's record was reviewed on 06/26/13 at 7:18 a.m. The resident's diagnoses included, but were not limited to, seizures and neuropathy.</p> <p>A Minimum Data Set Assessment Supportive Documentation Tool, dated 05/02/13, indicated the resident had no cognitive impairment.</p> <p>A dental exam, dated 12/18/12, indicated the resident had a broken front tooth and the resident was not concerned about the broken tooth and the Dentist would see the resident every three months.</p> <p>There was a lack of documentation in the resident's record to indicate the resident had been seen by a Dentist since 12/18/12.</p> <p>A Social Service note, dated 05/01/13 indicated the Social Service</p>		<p>DHS/designee will review residents for dental assessments during clinical meeting M-F. Residents with oral cavity issues will be referred to Social Services for follow up with dental appointments and notification of family. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>Department was contacting a dentist for the resident since the resident had forgotten her Dentist's name.</p> <p>During an interview on 06/26/13 at 9:57 a.m., the Assistant Social Service Director (ASSD) indicated the Dentist who comes to the facility only does light cleaning, so they had made an appointment for the resident with a Dentist outside of the facility to consult on the resident's broken tooth. She indicated she was unaware of the resident's broken tooth and as soon as she was informed of the broken tooth, an appointment was made. She indicated there was not a Dental Progress note in the record.</p> <p>A Dental Progress note, dated 05/06/13, faxed to the facility on 06/26/13 at 4:36 a.m. and received from the ASSD, indicated the resident had a broken front tooth with decay left of the broken tooth area. The progress note indicated the treatment plan was to extract the teeth for an upper denture placement after approval was obtained.</p> <p>There was a lack of further documentation to indicate a follow-up appointment had been made.</p>			

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	<p>During an interview on 6/26/13 at 11:45 a.m., the ASSD indicated she had just called the Dentist's office and was told the resident had refused a follow up appointment and the Dentist office did not tell the facility because the resident made her own decisions.</p> <p>During an interview on 6/26/13 at 1:53 p.m., Resident #B indicated she wanted her tooth fixed. She indicated she would go out to the Dentist to get it fixed.</p> <p>A typed memo, dated 06/26/13, received and signed by the ASSD on 06/26/13 at 3:55 p.m., indicated, "On Wednesday, 6-26-13, I spoke with (Dental office) and requested doctor's notes...They stated, "yes, we want to extract the broken tooth then fit the resident for dentures." They then said that upon discharge from the dentist office, we ask the patient if they would like to make their next appointment and if an appointment is not made that means that the patient did not want to make an appointment. However, if they change their mind, it is then the patient's responsibility to follow up for an appointment time...The office also stated that they did not send any paperwork with the patient when she left the office...They indicated that one of Avalon's staff</p>			

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	<p>(Environment #15), may have decided not to make the follow up appointment instead of the patient."</p> <p>A typed memo, dated 06/26/13, received from the ASSD on 06/26/13 at 3:55 p.m. and signed by Environment #15, indicated, "...I went to pick her up...(Resident Name) stated that she had what she needed, and wanted to talk to her family prior to making another appointment...stated that it was going to be too costly for the dental work and she didn't want to go back..."</p> <p>During an interview on 6/26/13 at 3:55 p.m., The ASSD indicated the facility Dentist had not seen the resident after December 2012. She indicated she called the Dentist and no reason was given. She indicated the Dentist faxed the facility a list of residents they were going to see and then the facility added the names of the resident's who need to be seen. She indicated the Social Service Department does not see the progress notes and no one looks at the progress notes to see if follow-up care is needed. She indicated no one in the facility monitored to ensure the residents were seen by the Dentist.</p> <p>2. Resident #D's clinical record was</p>			

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	<p>reviewed on 6/27/13 at 1:20 p.m. Resident #D's diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), coronary artery disease, stroke, and myocardial infarction (heart attack).</p> <p>Prior to Resident #D's admission to the facility, a bedside swallow evaluation dated 5/29/13, indicated the resident had partial dentition.</p> <p>A Nursing Admission Assessment dated 6/5/13, indicated the resident had "broken or loose fitting full or partial dentures" as well as having her own teeth.</p> <p>Review of the Admission Comprehensive MDS (Minimum Data Set) Assessment dated 6/12/13, indicated the SSA (Social Service Assistant) signed off on the meeting which indicated the resident had broken teeth.</p> <p>Review of the Resident First Care Plan Conference note dated 6/27/13, indicated the resident needed to see a dentist.</p> <p>An interview with Resident #D on 6/25/13 at 11:00 a.m., indicated she had missing and broken teeth. Resident #D was observed to have</p>			

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	<p>missing/broken lower teeth</p> <p>An interview with the (SSD) Social Service Director on 6/28/13 at 8:53 a.m., indicated she was not made aware of the broken/missing teeth until the family had brought it to her attention at the care plan meeting on 6/27/13. The SSD indicated the nursing staff had not made her aware of any abnormal oral conditions and her social service admission paperwork did not address oral conditions. The SSD indicated the Admissions Coordinator would address the Patient Choice and Right to Refuse form (outside services for dental, audiology, vision, and podiatry) prior to the admission into the facility.</p> <p>An interview with the SSD on 6/28/13 at 9:50 a.m., indicated a Patient Choice and Right to Refuse form (not dated) was found on her desk indicating the resident would like to receive outside services. She indicated the SSA did not inform her of the missing/broken teeth from the 6/12/13 MDS meeting. The SSD indicated the Admission Care Plan meetings were usually done within the first 5 days of admission, depending upon the family availability.</p>						

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	This Federal Tag relates to complaint number IN00128614. 3.1-34(a)				

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F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessments were accurate related to, dental status, oxygen, cognition, falls and medications for 3 of 27 residents reviewed for MDS</p>	F000278	<p>August 2, 2013 F-278 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident B had a significant correction to prior comprehensive assessment dated 5/5/13 with ARD (assessment reference</p>	08/02/2013	

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	<p>Assessments in a total sample of 27. (Residents #B ,#D and #37)</p> <p>Findings include:</p> <p>1. During an observation of Resident #B on 06/24/13 at 2:35 p.m., the resident had upper teeth missing and a broken front tooth.</p> <p>Resident #B's record was reviewed on 06/26/13 at 7:18 a.m. The resident's diagnoses included, but were not limited to, seizures and neuropathy.</p> <p>An Annual MDS Assessment, dated 05/05/13, indicated the resident rarely/never understood and the cognition pattern could not be completed and there were no oral/dental concerns of broken teeth or other dental problems.</p> <p>A Minimum Data Set Assessment Supportive Documentation Tool, dated 05/02/13, indicated the resident had no cognitive impairment.</p> <p>During an interview on 06/26/13 at 9:53 a.m., the Assistant Social Service Director indicated the cognition status of the resident was incorrect.</p>		<p>date) of 7/9/13. Resident D had a modification to the prior comprehensive assessment dated 6/12/13 on 7/19/13. Resident 37 had a modification to the prior comprehensive assessment dated 6/7/13 on 7/19/13. Resident 37 had a significant correction to the prior comprehensive assessment dated 6/19/13 with ARD (assessment reference date) of 7/10/13. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents have had minimum data set (MDS) assessment audited for accuracy for dental status, oxygen, cognition, falls and coumadin medication. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: MDS coordinator has been inserviced on accuracy of MDS for dental status, oxygen, cognition, falls and coumadin medication. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: MDS/designee will audit MDS's for accuracy of dental status, oxygen, cognition, falls and coumadin medication prior to submission</p>		

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	<p>During an interview on 6/26/13 10:03 am, the MDS Coordinator indicated the dental status on the MDS was not correct.</p> <p>2. Resident #D's clinical record was reviewed on 6/27/13 at 1:20 p.m. Resident #D's diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), coronary artery disease, stroke, and myocardial infarction (heart attack).</p> <p>The June 2013 MAR (Medication Administration Record) indicated the resident had received coumadin on 6/7/13, 6/8/13, 6/9/13, 6/10/13 and 6/11/13.</p> <p>The Respiratory/Inhalation/Breathing Treatment Record indicated the resident had received 5 liters of oxygen on 6/6/13, 6/7/13, 6/10/13, and 6/11/13. The June 2013 Physician Recaptulation orders indicated oxygen to be administered at 5 liters per nasal cannula continuously.</p> <p>Review of the Admission Comprehensive MDS (Minimum Data Set) Assessment dated 6/12/13, did not indicate the resident was receiving blood thinners during the last seven days or that she had</p>		<p>of MDS Mon thru Fri. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>received oxygen therapy in the last 14 days.</p> <p>Interview with the MDS Coordinator on 6/27/13 at 1:15 p.m., indicated he had only been with the company for four months and manages other buildings. The MDS Coordinator indicated there had been several staffing changes in the last few months and things were left in a "mess". The MDS Coordinator had indicated he completed an audit in May and he was aware of MDS (Minimum Data Set) Assessments to be incomplete, coded incorrectly, and/or not completed in a timely manner.</p> <p>3. Resident #37's clinical record was reviewed on 6/26/13 at 9:30 a.m. Resident #37's diagnoses included, but were not limited to muscle weakness, hypertension, TIAs (mini strokes), and dementia. The resident was admitted on 5/31/13.</p> <p>A Fall Circumstance Form dated 6/3/13 at 2:00 a.m., indicated the resident had a witnessed fall. The resident received a bruise and abrasion to her bilateral knees.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 6/7/13, did not</p>				

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	<p>indicate the resident had a fall with injury since admission/entry or reentry or Prior Assessment..</p> <p>A Fall Circumstance Form dated 6/9/13 at 12:45 a.m., indicated the resident had an unwitnessed fall. There were injuries to her right knee and right elbow.</p> <p>A nursing note on 6/10/13 at 3:00 a.m., indicated the resident had been awake and wanted to leave all shift. Attempted to get out of bed without assistance, does not use call light and does not understand the concept. The resident had to be continuously redirected by the nurse and aide without success.</p> <p>The Nursing Admission Assessment dated 6/12/13 at 5:00 p.m., indicated the resident was restless/fidgety and had trouble falling or staying asleep in the mood and behavior section</p> <p>A Fall Circumstance Form dated 6/16/13 at 6:30 p.m., indicated the resident had an unwitnessed fall.</p> <p>A Comprehensive MDS Assessment dated 6/19/13, did not indicate the resident had fallen in the last 2 to 6 months and only had one fall instead of two falls since prior assessment.</p>						

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	<p>The MDS assessment also did not indicate the resident had behaviors.</p> <p>A Clinical Documentations systems on Admission Nursing Assessment and Data Collection (undated), was provided by the DoN on 6/28/13 at 8:00 a.m. The policy indicated the comprehensive head to toe assessment should be initiated within 24 hours and completed within 72 hours of admission. The assessment should include identification of risk factors through assessment, observation, and review of pertinent documentation. A temporary plan of care should be developed based on the assessment results. The plan of care should be communicated to the relevant care givers to ensure interventions are put into action.</p> <p>Interview with the MDS Coordinator on 6/27/13 at 1:15 p.m., indicated he had only been with the company for four months and manages other buildings. The MDS Coordinator indicated there had been several staffing changes in the last few months and things were left in a "mess". The MDS Coordinator had indicated he completed an audit in May and he was aware of MDS (Minimum Data Set) Assessments to be incomplete, coded incorrectly,</p>			

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	<p>and/or not completed in a timely manner.</p> <p>This Federal Tag relates to complaint number IN00128614.</p> <p>3.1-31(d)(1) 3.1-31(e)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop residents' care plans, related to, dental, falls, and medication, for 3 of 27 residents reviewed for care plans in a total sample of 27. (Residents #37, #D and #H)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed on 06/27/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus,</p>	F000279	<p>August 2, 2013 F-279 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident H careplan for ritalin medication has been revised to reflect the residents current status. Resident D careplan has been revised to reflect resident dental status. Resident 37 careplan has been revised to reflect fall/safety, skin issue with falls, and behavior status. Identification of other residents having the potential to be</p>	08/02/2013	

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	<p>hypertension, narcolepsy, and renal failure. The resident was admitted into the facility on 04/10/13.</p> <p>The Physician's Recapitulation Orders, dated 06/13, indicated an order for Ritalin (stimulant) 2.5 milligrams daily for narcolepsy, originally ordered on 04/11/13.</p> <p>There was a lack of documentation to indicate a care plan had been developed for the resident's Ritalin usage and narcolepsy.</p> <p>During an interview on 06/27/13 at 2:45 p.m., LPN #39 indicated there was not a care plan for the Ritalin usage and the narcolepsy.</p>		<p>affected by the same alleged deficient practice and corrective actions take: An audit of current residents careplans for ritalin medication, dental status, falls, skin issue with a fall and behavior has been completed and updated as indicated to reflect residents current status.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Licensed nursing staff, MDS coordinator, and Social Service have been inserviced on updating careplans for ritalin use, dental status, falls/safety and skin issues with falls and behaviors to reflect residents current status How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: MDS coordinator/designee, Social Service/designee and DHS/designee will audit careplans to ensure accuracy of residents current status for ritalin use, dental status issues, falls/safety, skin issues with falls and behaviors 3 times per week for 2 months, then 2 times per week for 2 months then weekly for 2 months. Audits will be reviewed during Quality Assurance meeting monthly x 6</p>		

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	<p>2. Resident #D's clinical record was reviewed on 6/27/13 at 1:20 p.m. Resident #D's diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), coronary artery disease, stroke, and myocardial infarction (heart attack). Resident #D was admitted on 5/31/13.</p> <p>Prior to Resident #D's admission to the facility, a bedside swallow evaluation dated 5/29/13, indicated the resident had partial dentition.</p> <p>A Nursing Admission Assessment dated 6/5/13, indicated the resident had broken or loose fitting full or partial dentures as well as having her own teeth in the Nutrition section. The Nutrition POC (Plan of Care) section did not have interventions initiated.</p> <p>Review of the Admission Comprehensive MDS (Minimum Data Set) Assessment dated 6/12/13, indicated the SSA (Social Service Assistant) signed off on the meeting which indicated the resident had broken teeth.</p> <p>Review of the Resident First Care</p>		<p>months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>Plan Conference notes dated 6/27/13, indicated the resident needed to see a dentist.</p> <p>An interview with Residnet #D on 6/25/13 at 11:00 a.m., indicated she had missing and broken teeth.</p> <p>Interview with the MDS Coordinator on 6/27/13 at 1:15 p.m., indicated he had only been with the company for four months and manages other buildings. The MDS Coordinator indicated there had been several staffing changes in the last few months and things were left in a "mess". The MDS Coordinator had indicated he completed an audit in May and he was aware of care plans not being updated and/or missing.</p> <p>An interview with the SSD (Social Service Director) on 6/28/13 at 9:50 a.m., indicated the SSA did not inform her of the missing/broken teeth from the 6/12/13 MDS meeting. The SSD indicated the Admission Care Plan meetings were usually done within the first 5 days of admission, depending upon the family availability.</p> <p>3. Resident #37's clinical record was reviewed on 6/26/13 at 9:30 a.m. Resident #37's diagnoses included, but were not limited to stroke, bilateral</p>						

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	<p>hip replacements and dementia. The resident was admitted on 5/31/13.</p> <p>The May 2013 MAR (Medication Administration Record) indicated a bed and chair alarm were put into place on 5/31/13.</p> <p>A nursing note dated 6/2/13, indicated the resident tried to stand and ambulate. The resident was brought to the nurses station in her wheel chair. The resident continued to try to stand and ambulate without assistance. The resident was unable to be redirected. She was requiring 1:1 care all shift.</p> <p>There was no fall/safety care plan indicating the resident's history of falls and safety measures that were put into place upon admission.</p> <p>A Fall Circumstance form dated 6/3/13 at 2:00 a.m., indicated the resident had a witnessed fall. The resident received a bruise and abrasion to her bilateral knees. The activity at the time of the fall indicated transferring self and ambulating. The fall risk assessment section indicated the resident refuses to comply with safety measures such as call light use, alarms, appliances.</p>			

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	<p>The Prevention update section indicated bedside mat, low bed, defined parameter mattress, bed and or chair alarm, therapy evaluation, nonskid footwear, frequently used items within reach, room close to nurses station (6/3/13) and call bell. IDT (Interdisciplinary Team) review on 6/3/13, indicated a new intervention for the resident to be moved closer to the nurses station.</p> <p>There were no fall, skin or behavior care plans initiated after the falls or after the care plan conference.</p> <p>A Fall Circumstance form dated 6/9/13 at 12:45 a.m., indicated the resident had an unwitnessed fall. There were injuries to her right knee and right elbow. The resident indicated she was transferring self to the toilet. The resident did not use the call light and did not use the wheelchair. The fall risk assessment section indicated the resident refused to comply with safety measures such as call light use, alarms, appliances.</p> <p>The Prevention update section indicated neurochecks for 48 hours (no frequency indicated), "need" parameter mattress, bed and/or chair alarm, bed in low position, ensure wheel chair brakes are locked,</p>				

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	<p>therapy evaluation, room close to the nurses station, call bell, and glasses in place. The IDT review on 6/10/13, indicated a perimeter mattress to be provided.</p> <p>There were no fall, skin or behavior care plans initiated after the falls or after the care plan conference.</p> <p>On 6/10/13 at 11:45 a.m., a nursing note indicated the resident admitted to a hospital after an episode of syncope.</p> <p>Resident #37 was readmitted on 6/12/13. An Assessment Review and Consideration [undated], indicated the resident was a fall risk related mobility impairment. No care plan was initiated.</p> <p>A Nursing Admission Assessment dated 6/12/13 at 5:00 p.m., indicated the resident was restless/fidgety and had trouble falling or staying asleep in the mood and behavior section. The note indicated there was no history of behaviors. The safety section indicated the resident was to have 1/2 side rails only, provide assistance for transfers and ambulation as needed, toilet resident per toileting schedule, ensure call light is within reach, redirect resident, provide side rails for</p>				

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	<p>bed mobility, and instruct resident on use of the call light.</p> <p>A Fall Circumstance form dated 6/16/13 at 6:30 p.m., indicated the resident had an unwitnessed fall. The resident indicated she was reaching for an item on the floor, the wheel chair wasn't locking and she slid out of wheel chair when it moved. The equipment inspection indicated the wheel chair was not locked. The fall risk assessment section indicated the resident had cognitive or memory impairment that effects safety and judgment and refuses to comply with safety measures such as call light use, alarms, appliances.</p> <p>The Prevention update section indicated neuro checks every four hours for 72 hours, frequently used items within reach, and oriented to the environment. An IDT (Interdisciplinary team) reviewed the form on 6/17/13, indicated to place mats on the floor.</p> <p>A Fall Circumstance form dated 6/24/13 at 5:10 p.m., indicated Resident #37 had an unwitnessed fall. The comments indicated the resident stated she lost her balance. The fall risk assessment section indicated the resident had cognitive</p>			

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	<p>impairment that effected the resident's safety and judgment, had a fall in the past three months, requires use of an assist device but forgets to use the device. The prevention update section indicated to encouraged the resident to ask for assistance and use a walker to meals. The IDT review dated 6/25/13, indicated the root cause was a balance issue and the intervention update was appropriate but added furniture to be rearranged in room.</p> <p>There were no Nursing Assessment and Data Collection located in the chart after 2/11/13. The DHS (Director of Health Services) or the Nursing Consultant was not able to provide documentation after the 2/11/13 date with the exception to 6/26/13.</p> <p>There were no fall or behavior care plans initiated after the fall.</p> <p>A Clinical Documentations systems on Admission Nursing Assessment and Data Collection (undated), was provided by the DoN on 6/28/13 at 8:00 a.m. The policy indicated the comprehensive head to toe assessment should be initiated within 24 hours and completed within 72 hours of admission. The assessment</p>			

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	<p>should include identification of risk factors through assessment, observation, and review of pertinent documentation. A temporary plan of care should be developed based on the assessment results. The plan of care should be communicated to the relevant care givers to ensure interventions are put into action.</p> <p>A Resident First Meeting Guidelines [undated], was provided by the DHS (Director of Health Services) on 6/28/13 at 8:00 a.m. The policy indicated the resident's first meeting should be scheduled and held within 3 to 5 days of admission. The policy indicated to make sure issues related to falls, restraints, skin breakdown, psychotropic medications, and weight loss are discussed and effective interventions were implemented and documented.</p> <p>This Federal Tag relates to complaint number IN00128614.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>				

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F000280 SS=E	<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 record review and interview, the facility failed to update and revise care plans for residents, related to falls, incontinence, diets, and a feeding tube (g-tube) for 4 of 27 records reviewed for care plans in a total sample of 27. (Residents #25, #E, #G, and #H)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed on 06/27/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, narcolepsy, and renal failure. The resident was</p>	F000280	<p>August 2, 2013 F-280 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident H careplan for g-tube was discontinued. Resident H nutritional careplan was updated to reflect the low potassium diet. Resident 25 fall careplan has been updated to reflect changes in assistance with transfer/ambulation, nonskid footwear. Physical therapy as indicated and neurochecks to be completed as indicated. The abrasion is healed to the lower</p>	08/02/2013			

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	<p>admitted into the facility on 04/10/13.</p> <p>A) The Medication Administration Record, dated 05/13, indicated the resident's g-tube was discontinued on 05/22/13.</p> <p>A physician's order, dated 05/22/13, indicated the resident's g-tube was discontinued.</p> <p>A care plan, dated 05/13/13, indicated the resident had a feeding tube, which received flushes only.</p> <p>B) Resident #H's physician's orders, dated 05/20/13, indicated an order for a low potassium diet.</p> <p>There was a lack of documentation on the resident's nutritional care plan, dated 06/06/13, to indicate the resident was on a low potassium diet.</p> <p>During an interview on 6/27/13 at 2:45 p.m., LPN #39 indicated the resident's care plan had not been revised.</p>		<p>back. Resident E urinary incontinence careplan has been updated to reflect the call light within reach at all times and hourly checks. Resident G has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: An audit of current residents careplans for falls, urinary incontinence, diets and g-tube has been completed and updated as indicated to reflect residents current status. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff and MDS coordinator have been inserviced on updating careplans related to falls, urinary incontinence, diets and g-tubes to reflect residents current status How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: MDS coordinator/designee, and DHS/designee will audit careplans to ensure accuracy of residents current status for falls, incontinence, diets and g-tubes 3 times per week for 2 months, then 2 times per week for 2 months then weekly for 2</p>		

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	<p>2. On 6/28/13 at 11:15 a.m., Resident #25's clinical record was reviewed. Resident #25's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A care plan dated 5/14/13, indicated the resident was at risk for fall/injury as evidenced by history and potential for falls. Interventions included reporting falls to the physician/responsible party, monitor and report negative side affects of medications to the physician, half rails for enablers, call light within reach, adequate glare free lighting, area free of clutter, walker/can and appropriate footwear.</p> <p>A care plan dated 5/14/13, indicated the resident had ADL (Activities of Daily Living) self-care deficit as evidenced by bed mobility, transfer, walking, locomotion, dressing, eating, toilet use, personal hygiene and bathing. Interventions included assess/record self-care status changes, report significant changes in ADL status to the physician an responsible party, assist with personal</p>		<p>months. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>hygiene as needed, stand-by assistance and contact guarding.</p> <p>A care plan dated 5/14/13, indicated the resident had the potential for alteration in skin integrity related to mild renal insufficiency and dementia. Interventions included assess/record changes in skin status, report pertinent changes in skin status to the physician, monitor lab and report lab results, and pressure reducing mattress.</p> <p>A Fall Circumstance Assessment and Intervention dated 5/31/13 at 9:45 a.m., indicated Resident #25 had an unwitnessed fall in the bathroom. The resident received an injury of an abrasion to the left lower back. The activity at the time of the fall was toileting. The Fall Risk assessment indicated the resident had cognitive impairment that effects safety and judgment, difficulty understanding and following directions, had a fall in the past three months, required assistance to transfer and to ambulate safely. The prevention update indicated neurochecks, nonskid footwear, and education on call light use for help.</p> <p>The IDT (Interdisciplinary Team) review dated 6/3/13, indicated the</p>				

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	<p>resident had a balance issue and no interventions were indicated.</p> <p>Physician order dated 6/3/13, indicated to monitor abrasion to the lower back until healed.</p> <p>The skin and fall care plans had not been updated to indicated the abrasion to the lower back, changes in assistance with transfer/ambulation, nonskid footwear and neurochecks.</p> <p>A Fall Circumstance Assessment and Intervention dated 6/4/13 at 1:15 p.m., indicated Resident #25 had a witnessed fall located in the Time Square area, located in the center of the skilled units. The activity at the time of the fall was ambulating. The Fall Risk assessment indicated the resident had cognitive impairment which affected safety and judgment, had a fall in the past three months, required the use of an assistive device, and forgot to use device (walker). The Prevention Update indicated neurochecks and proper fitting shoes.</p> <p>A physician order dated 6/9/13, indicated physical therapy to evaluate and treat.</p>			

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	<p>The Fall care plan was not updated to indicate physical therapy or neurochecks.</p> <p>3. Interview with the Resident #E's caregiver on 6/24/13 at 2:50 p.m., indicated she had found the resident "soaked" in urine on 5/30/13. The call light was not near the resident. The staff had been instructed to check the resident hourly for incontinence and the call light to be within reach.</p> <p>Resident #E's clinical record was reviewed on 6/26/13 at 11:00 a.m. Resident E's diagnosis included, but were not limited to hypertension, atrial fibrillation, and urinary tract infections.</p> <p>A care plan for incontinence was revised on 5/10/13. The interventions indicated to "provide incontinence care after each episode, toilet before and after meals, upon rising in the A.M. and before bed at night...ensure call light is within reach and answer call light promptly."</p> <p>A Resident Concern form dated 5/30/13 (no time), indicated a family member informed social service regarding the call light was not within reach for the resident and the care giver (provided by the family) had come in and found the resident</p>						

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	<p>soaked with urine up to the hairline. The Resident Concern form indicated the call button was attached to the bed and fell between rail and mattress. The resolution indicated the Executive Director followed up with the family member with plan to put Resident #E on hourly checks for placement of call button and incontinence care.</p> <p>The incontinence care plan had not been updated regarding the call light and hourly checks regarding the incontinence.</p> <p>4. On 6/24/13 at 1:30 p.m., a family member of Resident #G's indicated a problem with Resident #G receiving the correct diet at least one meal a day. The family member had indicated the resident was a diabetic, his blood glucose levels had been out of control and the problem had been addressed several times with the Dietary Manager and had not been resolved. The family member indicated the family was having to take turns and stay with Residnt #G on a daily basis to make sure his diet was correct.</p> <p>Resident #G's clinical record was reviewed on 6/27/13 at 9:40 a.m. Resident #G's diagnoses included,</p>			

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	<p>but were not limited to, insulin dependent diabetes, chronic kidney disease, congestive heart failure, and stroke.</p> <p>Hospital Discharge Physician orders dated 5/29/13, indicated Resident #G was to have a diabetic diet.</p> <p>A Nutritional Assessment and Data Collection dated 5/29/13, indicated the food and nutrition history was skim milk only, difficulty following what was being said, and will provide wife with weekly menus due to the resident's wife was "noted" to fill out menus daily, and 3:3:4 Carbohydrate choices at meals.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 6/5/13, indicated the resident was moderately cognitively impaired and was on a therapeutic diet. The resident was a diabetic receiving insulin.</p> <p>A care plan dated 6/5/13, for Nutrition/Hydration was initiated. The care plan had not been updated to indicate the resident's difficulty to follow nutrition-related recommendations due to cognitive impairment, assistance with menu choices, and to honor family preferences on the menu and to</p>			

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	<p>provide the spouse with menus weekly.</p> <p>An interview with Resident #G's spouse on 6/26/13 at 5:15 p.m., indicated she had several conversations with the Dietary Manager on the meal service of appropriate and inappropriate food and the Dietary Manager indicated he had many talks with his staff. The spouse indicated when she questioned the staff, they would inform her they were not aware of the resident's restrictions.</p> <p>Observation of the resident's meal ticket during this time indicated the diet was carbohydrate controlled, without allergies, dislikes and preferences. The spouse indicated she had informed the Dietary Manager on dislikes and preferences. The spouse indicated she had to fill out the menu for the resident and had to be present at meal times to prevent the staff from serving wrong entrees' or desserts.</p> <p>Interview with LPN #43 on 6/27/13 at 10:05 a.m., indicated she did inform her CNAs' of the resident being a diabetic. LPN #43 indicated the resident would accept sugary foods when offered even though he was</p>			

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	<p>cognitively impaired.</p> <p>This Federal Tag relates to complaint number IN00130059.</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders and care plans, related to a laboratory test for 1 of 27 residents reviewed for following physician's orders and care plans in a total sample of 27. (Residents #38)</p> <p>Findings include:</p> <p>1. Resident #38's record was reviewed on 6/26/13 at 4:02 p.m. The resident's diagnoses included, but were not limited to, vascular dementia, lymphadema, hypothyroidism, and hypertension.</p> <p>Review of the Physician Recapitulation Orders dated 6/2013 indicated lab orders for BMP (electrolytes), CBC (complete blood count), TSH (thyroid stimulating hormone, a laboratory test to assess thyroid function), and T4 (thyroxine, a laboratory test to assess thyroid function) every six months in March and September on the 25th.</p> <p>Review of lab results indicated the</p>	F000282	<p>Date: 8.2.13 F-282 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 38 had a BMP (basic metabolic panel) drawn and physician notified of results. Careplan has been revised to reflect residents current status. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents have been audited to ensure labs were completed per physician order and careplans updated. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced on following physician orders for labs and updating careplans to reflect resident current status How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS (Director of health services) designee will audit lab orders and lab</p>	08/02/2013

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	<p>CBC, TSH, and T4 had been completed on 3/26/13. There was lack of documentation in the record to indicate the BMP had been completed for March 2013.</p> <p>Review of the lab tracking form for March 2013 indicated the CBC, TSH, and T4 were completed. There was lack of documentation to indicate the BMP had been completed.</p> <p>Interview with the DHS (Director of Health Services) on 6/27/13 at 2:46 p.m. indicated the CBC, TSH, and T4 were completed and the BMP was not completed. The DHS indicated the facility must have missed ordering the BMP on the lab requisition since the other labs (CBC, TSH, and T4) had been completed on 3/26/13 as ordered by the physician.</p> <p>3.1-35(g)(2)</p>		<p>careplans five times a week for 2 months, then three times a week for 2 months, then weekly for 2 months. Lab audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is achieved.</p>		

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to provide necessary nursing services related to following physician orders and care plans for a resident with loose stools and for residents with diabetes for 3 of 27 residents reviewed. (Resident #F, #H and #7)</p> <p>Findings include:</p> <p>1. On 6/27/13 at 12:45 p.m., Resident #F's was observed returning from lunch and was placed in the lounge. The resident was observed to be restless and speaking out for assistance. The hair dresser came a few minutes later and took the resident to the beauty shop.</p> <p>On 6/27/13 at 1:40 p.m., Resident #F was observed returning from the beauty shop and placed back into the lounge. The resident was observed to be mumbling and complained about her paints. At 1:42 p.m., LPN #40 was observed to check the</p>	F000309	<p>August 2, 2013 F-309 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident F physician notified and treated for loose stools with careplan update. Resident H and resident #7 physician was notified of blood glucose levels and sliding scale insulin orders. No negative outcome was noted to either resident. Resident H and #7 careplans were updated to reflect residents current status. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents with loose stools have been assessed and physician notified for treatment. Current residents with blood glucose levels and sliding scale insulin have been reviewed to ensure physician orders are followed. Measures put into place and systemic</p>	08/02/2013	

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	<p>resident's pants under the blanket and indicated out loud the resident was fine and took her to her room. The radio was turned on for the resident and the LPN was observed leaving the room and speaking with CNA #41.</p> <p>On 6/27/13 at 1:50 p.m., Resident #F was observed to be saturated from front to back to the top of her brief. Resident #F clothes were observed to be soiled with stool, as well. An interview with CNA #41 during this time, indicated the resident "tends to have loose stools". CNA #41 indicated the resident had loose stools before lunch. CNA #41 indicated the nurses have been made aware of the loose stools all week. CNA #41 indicated she was told the loose stools were due to a medication the resident was on. During the peri care, the resident informed the CNA she was having another bowel movement.</p> <p>On 6/28/13 at 12:00 p.m., Resident #F was observed in her wheelchair, in the lounge, asking for assistance with her "dress". Resident #F's clothing was observed to be soiled with stool. At 12:10 p.m., RN #42 was observed taking Resident #F to the dining room for lunch. An interview with RN #42</p>		<p>changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced to assess and notify the physician when residents are having loose stools for treatment and update careplan to reflect current resident status. Licensed nursing staff have been inserviced on following physician orders in regards to blood glucose levels and sliding scale insulin and update careplan to reflect current resident status. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review any residents having loose stools during clinical meeting M-F to ensure physician has been notified and orders obtained for treatment of loose stools and careplan updated. Audits will be reviewed in Quality Assurance meetings monthly x 6 months and then quarterly thereafter until 100% compliance is obtained. DHS/designee will review diabetic flow sheet to ensure blood glucose levels and sliding scale insulin are completed per physician orders along with careplan updated. Audits will be reviewed in Quality Assurance</p>				

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	<p>upon her return, indicated the resident would be checked for incontinence approximately every hour and her last check was about 10:30 to 11:00 a.m. RN #42 indicated she was not aware the resident was soiled prior to taking her to the dining room.</p> <p>On 6/28/13 at 12:15 p.m., Resident #F's clinical record was reviewed. Resident #F's diagnoses included, but were not limited to, congestive heart failure, urosepsis, confusion, and history of urinary tract infections.</p> <p>A care plan for diarrhea was initiated on 5/18/13. The interventions indicated to assess/record for complications related to diarrhea or for increased episodes of diarrhea and report significant finding to the physician.</p> <p>The last nursing documentation in the progress notes was 6/10/13. There were no Nursing Assessment and Data Collection notes between 5/17/13 to 6/25/13, to indicate the resident had loose stools and if the physician had been notified. The Nursing Assessment and Data Collection note for 6/26/13 did not indicate the resident had loose stools.</p>		<p>meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>Review of the Bowel and Bladder record indicated from 6/14/13 to 6/27/28, the resident had 7 loose stools. The June 2013 Medication Administration Record did not indicate anti-diarrhea medication had been given during this time.</p> <p>An interview with RN #42 on 6/28/13 at 1:00 p.m., indicated she was not made aware of the resident having loose stools until CNA #41 informed her. CNA #41 reported to RN #42 she had informed the nurses all week. RN #42 reviewed the 24 hour report sheets and indicated the loose stools were not documented. RN #42 indicated she would give the Resident #F an anti-diarrhea medication and notify the physician.</p> <p>2. Resident #H's record was reviewed on 06/27/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, narcolepsy, and renal failure.</p> <p>The resident's care plan, dated 05/13/13, indicated the resident had unstable glucose levels. The interventions included to monitor the resident's finger stick blood glucose levels.</p>			

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	<p>The Physician's Recapitulation Orders, dated 06/13, indicated an order, originally dated for 04/11/13 for sliding scale (insulin given per glucose reading) Accu-check) Novolog (insulin) before breakfast, before lunch, before supper, and at bedtime, with the following dosages: 151-200 accu-check=4 units 201-250 accu-check=8 units 251-300 accu-check=12 units 301-350 accu-check=16 units 351-400 accu-check=20 units over 400 accu-check=23 units and call the physician.</p> <p>The Medication Administration Record (MAR), dated 05/13, indicated the resident's accu-check on 05/24/13 before lunch was 209 and no insulin was given and the resident's blood sugar at bedtime was on 5/30 /13 was 400 and 23 units of Novolog was given.</p> <p>The MAR dated 06/13 indicated the following: 06/07/13 no accu-check completed before lunch. 06/24/13 before lunch the residents accu-check was 349 and no insulin coverage was given. 06/22/13 before supper accu-check was 246 and 16 units of Novolog insulin was administered.</p>			

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	<p>During an interview on 06/27/13 at 2:45 p.m., LPN #39 indicated the dosages for the insulin were not correct and the blood sugars were not obtained as ordered.</p> <p>3. Resident #7's record was reviewed on 06/26/13 at 11:23 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and fibromyalgia.</p> <p>The resident's care plan, dated 05/13, indicated the resident had unstable glucose levels. The interventions included sliding scale per orders and monitor finger stick blood glucose levels.</p> <p>The Physician's Recapitulation Orders, dated 06/13, indicated the following Novolog sliding scale orders to be given before breakfast, before lunch, and before supper: 150-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units</p> <p>The MAR, dated 06/13 indicated the following: 06/02/13 before supper accu-check was 337 and 20 units of Novolog</p>						

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	<p>given 06/03/13 before supper accu-check was 248 and 12 units of Novolog was given 06/14/13 no blood sugar obtained before supper 06/15/13 before breakfast accu-check was 168 and no insulin was given 06/21/13 before supper accu-check 214 and 4 units of Novolog insulin was given 06/24/13 before lunch accu-check 258 and no insulin was given</p> <p>During an interview on 06/26/13 at 10:45 a.m., LPN #39 indicated the insulin was not administered correctly and was unsure why the accu-check had not been completed on 06/14/13.</p> <p>3.1-37(a)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident did not have a decline in urinary continence for 1 of 3 residents reviewed. (Resident #F)</p> <p>Findings include:</p> <p>On 6/27/13 at 12:45 p.m., Resident #F's was observed returning from lunch and was placed in the lounge. The resident was observed to be restless and speaking out for assistance. The hair dresser came a few minutes later and took the resident to the beauty shop.</p> <p>On 6/27/13 at 1:40 p.m., Resident #F was observed returning from the beauty shop and placed back into the lounge. The resident was observed to be mumbling and complained about her paints. At 1:42 p.m., LPN #40 was observed to check the</p>	F000315	<p>Date: August 2, 2013 F315 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident F has been assessed for bladder incontinence and plan of care updated. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All current residents that are incontinent of bladder have been assessed to ensure interventions for incontinence is appropriate Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced on the elimination assessment circumstance form to assess resident bladder continence. A 72 hour bladder form initiated</p>	08/02/2013			

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	<p>resident's pants under the blanket and indicated out loud the resident was fine and took her to her room. The radio was turned on for the resident and the LPN was observed leaving the room and speaking with CNA #41.</p> <p>On 6/27/13 at 1:50 p.m., Resident #F's brief was observed to be saturated with urine (and stool) from front to back to the top of her brief. Resident #F's clothes were observed to be soiled well. During this time, an interview with CNA #41, indicated the resident had always been incontinent as long as she had been on the 100 Unit.</p> <p>On 6/28/13 at 12:00 p.m., Resident #F was observed in her wheelchair, in the lounge, asking for assistance with her "dress". Resident #F's clothing was observed to be soiled. At 12:10 p.m., RN #42 was observed taking Resident #F to the dining room for lunch. During this time, an interview with RN #42, indicated the resident would get checked for incontinence approximately every hour and her last check was about 10:30 to 11:00 a.m. RN #42 indicated she was not aware the resident was soiled.</p> <p>On 6/28/13 at 12:15 p.m., Resident</p>		<p>to determine a voiding pattern How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: All admissions/readmissions will have the elimination assessment and 72 hour voiding form reviewed during clinical meeting 5 days per week for 2 months, then 3 days per week for 2 months, then weekly times 2 months. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>	

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	<p>#F's clinical record was reviewed. Resident #F's diagnoses included, but were not limited to, congestive heart failure, urosepsis, confusion, and history of urinary tract infections.</p> <p>A Comprehensive Admission MDS (Minimum Data Set) Assessment dated 1/15/13, indicated the resident was occasionally incontinent (less than 7 incontinent episodes in a week). The MDS indicated the resident did not have a trial of the toileting program since admission and had received a diuretic (water pill) medication.</p> <p>A 14 day MDS Assessment dated 1/22/13, indicated the resident was not on a toileting program. The resident had continued to receive diuretics.</p> <p>A 30 day MDS Assessment dated 2/5/13, indicated the resident was not on a toileting program. The resident had continued to receive diuretics.</p> <p>A 60 day MDS Assessment dated 3/5/13, indicated the resident was not on a toileting program. The resident had continued to receive diuretics.</p> <p>A Quarterly MDS Assessment dated 4/4/2013, indicated the resident was</p>			

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	<p>frequently incontinent (greater than 7 incontinent episodes, but at least one continent episode, in a week). The MDS indicated the resident was not on a bladder program and had received a diuretic medication.</p> <p>A care plan for bladder incontinence was revised on 5/13/13. The interventions indicated the resident was to be toileted before and after meals, upon rising in the morning, and before bed at night and as needed.</p> <p>Review of the Bowel and Bladder record indicated from 6/14/13 to 6/28/13, the resident has had 35 incontinent episodes and 5 continent episodes of urine .</p> <p>An interview with the DHS on 6/27/13 at 1:30 p.m., indicated Resident #F most likely did not have a bladder assessment/training upon admission or any program since Resident #F's admission.</p> <p>This Federal Tag relates to complaint number IN00130059.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure interventions were revised and implemented to prevent further falls for 2 of 3 residents reviewed for falls (Residents #25 and #37) in a total sample of 27, failed to supervise residents in the dining room, which had the potential to affect 10 residents, and failed to ensure the residents' environment remained free of hazards, related to razors and medication stored in residents' bathrooms (Residents # B and #7, #35, #48) and cans of pan coating spray stored in an unlock cabinet in the resident's lounge.</p> <p>Findings include:</p> <p>1. On 6/28/13 at 11:15 a.m., Resident #25's clinical record was reviewed. Resident #25's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A care plan dated 5/14/13, indicated the resident was at risk for fall/injury</p>	F000323	<p>Date: August 2, 2013 F-323 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 25 and 37 have their careplan updated with interventions related to falls to reflect current status of resident. Residents that eat in the dining room are supervised by staff at each meal. No negative outcome noted. Resident 7 and 48 had razors removed from their bathroom and placed in sharps container during survey. Resident B and 35 had the Vit B12 removed from their bathroom during survey. Residents were not affected by the 4 cans of pan coating spray under the sink in residents lounge. The 4 cans of pan cooking spray is in locked cabinet in resident lounge. No negative outcome noted. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents that have</p>	08/02/2013			

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	<p>as evidenced by history and potential for falls. Interventions included reporting falls to the physician/responsible party, monitor and report negative side affects of medications to the physician, half rails for enablers, call light within reach, adequate glare free lighting, area free of clutter, walker/cane and appropriate footwear.</p> <p>A care plan dated 5/14/13, indicated the resident had ADL (Activities of Daily Living) self-care deficit as evidenced by bed mobility, transfer, walking, locomotion, dressing, eating, toilet use, personal hygiene and bathing. Interventions included assess/record self-care status changes, report significant changes in ADL status to the physician an responsible party, assist with personal hygiene as needed, stand-by assistance and contact guarding.</p> <p>A Fall Circumstance Assessment and Intervention dated 5/31/13 at 9:45 a.m., indicated Resident #25 had an unwitnessed fall in the bathroom. The resident received an injury of an abrasion to the left lower back. The activity at the time of the fall was toileting. The environment inspection section indicated inadequate lighting. Personal inspection section indicated</p>		<p>had falls or at risk for falls have been reviewed and their careplans updated with their interventions. Residents that eat their meals in the dining room are supervised by a staff member at each meal. Residents that use razors will have the razors disposed of after use in sharps container. Residents do not have any medications in their room. Residents are not self administering medications. Pan cooking spray is locked in cabinet in the resident lounge which residents do not have access. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced to update careplan with falls or if at risk for fall. Nursing staff, dining staff and meal managers have been inserviced for a staff member to be present in dining room during meals. Nursing staff have been inserviced to dispose of razor in sharps container after use as well as residents are not to have any medications in their room. Activites and housekeeping staff have been inserviced to have pan cooking spray locked in cabinet in resident lounge when not in use for activites. How the</p>		

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	<p>toileting needs. The fall risk assessment section indicated the resident had cognitive impairment that would affect safety and judgment, difficulty understanding and following directions, had a fall in the past three months, required assistance to transfer and to ambulate safely, unable to maintain balance while sitting, standing or walking w/out assist, requires use of an assist device and forgets to use device. The prevention update section indicated neurochecks, nonskid footwear, and education on call light use for help.</p> <p>The IDT (Interdisciplinary Team) review dated 6/3/13, indicated the resident had a balance issue but no interventions were indicated. The fall care plan interventions updated on 5/31/13, indicated the resident would be educated on the use of the call light, although the Fall Circumstance Assessment indicated Resident #25 had cognitive impairment that would affect safety and judgment.</p> <p>A Fall Circumstance Assessment and Intervention dated 6/4/13 at 1:15 p.m., indicated Resident #25 had a witnessed fall in the Time Square area, located in the center of the skilled units. The activity at the time</p>		<p>corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review all admissions/readmissions and ensure any resident identified with a fall or as a fall risk have interventions in place and noted on the resident careplan, DHS/designee will audit fall careplans 3 times per week times 2 months, then 2 times per week for 2 months then weekly times 2 months or until substantial compliance is achieved. ED/designee will audit five times per week that a staff member is present during meals. DHS/designee will audit five times per week that razors are removed out of residents room and disposed in sharps container and that no medication is in resident rooms. Activity director/designee will audit resident lounge five times per week to ensure pan cooking spray is locked in cabinet when not in use per activity staff. Above audits will be reviewed monthly during Quality Assurance meeting x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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	<p>of the fall was ambulating. The fall risk assessment section indicated the resident had cognitive impairment which affected safety and judgment, had a fall in the past three months, requires assist to ambulate safely with or w/out assist device, required the use of an assistive device, and forgets to use device (walker). The prevention update section indicated proper fitting shoes.</p> <p>The IDT review dated 6/5/13, indicated the root cause was poorly fitted shoes and no interventions were indicated. The fall care plan interventions updated on 5/31/13, indicated proper fitting footwear although the Rehabilitation screen dated 6/7/13, indicated the resident would benefit from physical therapy.</p> <p>Nursing Assessment and Data Collections note dated 6/26/13, did not indicate safety measures that were to be provided.</p> <p>An interview with the SSA (Social Service Assistant) on 6/27/13 at 11:45 a.m., indicated she had followed up on the shoes. SSA indicated the family had purchased shoes for the resident but therapy indicated the shoes were not the problem. The SSA indicated she did</p>				

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	<p>not document in the social service notes regarding the follow up of Resident #25's fall, follow up on shoes, and therapy recommendations.</p> <p>An interview with the Consultant on 6/27/13 at 3:30 p.m., indicated she was not able to locate Nursing Assessment and Data Collections notes after 2/11/13 to present day with exception to 6/26/13.</p> <p>On 6/27/13 at 11:50 a.m., SSA provided a Rehabilitation Screen form dated 6/7/13. The form indicated the resident would benefit from therapy and nursing was changing shoes. There was no documentation to indicate the shoes were not the problem as the SSA indicated.</p> <p>The care plan failed to indicate therapy screen and treatment, additional approaches such as bed pad alarm, chair pad alarm, and provide environmental adaptations.</p> <p>2. Resident #37's clinical record was reviewed on 6/26/13 at 9:30 a.m. Resident #37's diagnoses included, but were not limited to TIA's (mini strokes), muscle weakness, hypertension, bilateral hip replacements and dementia. The</p>			

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	<p>resident was admitted on 5/31/13.</p> <p>The May 2013 MAR (Medication Administration Record) indicated a bed and chair alarm were put into place on 5/31/13.</p> <p>A nursing note dated 6/2/13, indicated the resident tried to stand and ambulate. The resident was brought to the nurses station in her wheel chair. The resident continued to try to stand and ambulate without assistance. The resident was unable to be redirected. She was requiring 1:1 care all shift.</p> <p>A care plan dated 6/3/13, indicated the resident had impaired communication and cognition related to TIA's (mini strokes), short and long term memory, and decision making impaired.</p> <p>A Fall Circumstance form dated 6/3/13 at 2:00 a.m., indicated the resident had a witnessed fall. The resident received a bruise and abrasion to her bilateral knees. The activity at the time of the fall indicated transferring self and ambulating. The fall risk assessment section indicated the resident refused to comply with safety measures such as call light use, alarms, and appliances.</p>			
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	<p>The prevention update section indicated bedside mat, low bed, defined perimeter mattress, bed and or chair alarm, therapy evaluation, nonskid footwear, frequently used items within reach, room close to nurses station (6/3/13) and call bell. The IDT (Interdisciplinary Team) review dated 6/3/13, indicated the resident was to be moved closer to the nurses station.</p> <p>A Fall Circumstance form dated 6/9/13 at 12:45 a.m., indicated the resident had an unwitnessed fall. There were injuries to her right knee and right elbow. The resident indicated she was transferring herself to the toilet. The resident did not use the call light and did not use the wheelchair. The fall risk assessment section indicated the resident refused to comply with safety measures such as call light use, alarms, appliances.</p> <p>The prevention update section indicated neurochecks for 48 hours (no frequency indicated), "need" perimeter mattress, bed and/or chair alarm, bed in low position, ensure wheel chair brakes are locked, therapy evaluation, room close to the nurses station, call bell, and glasses in place. The IDT review dated</p>			

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	<p>6/10/13, indicated a perimeter mattress to be provided.</p> <p>A nursing progress note on 6/10/13 at 3:00 a.m., indicated the resident had been awake and wanted to leave all shift. Attempted to get out of bed without assistance, does not use call light and does not understand the concept. The resident had to be continuously redirected by the nurse and aide without success. Alarm to the bed intact and functioning.</p> <p>On 6/10/13 at 11:45 a.m., a nursing progress note indicated the resident admitted to a hospital after an episode of syncope. The perimeter mattress was not ordered.</p> <p>Resident #37 was readmitted to the facility on 6/12/13. An Assessment Review and Consideration [undated], indicated the resident was a fall risk related mobility impairment.</p> <p>A Nursing Admission Assessment dated 6/12/13 at 5:00 p.m., indicated the resident was restless/fidgety and trouble falling or staying asleep in the mood and behavior section. The safety section indicated the resident was to have 1/2 side rails for bed mobility only, provide assistance for transfers and ambulation as needed,</p>						

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	<p>toilet resident per toileting schedule, ensure call light was within reach, redirect resident, and instruct resident on use of the call light.</p> <p>There were lack of documentation in the Nursing Assessment and Data Collections notes from 6/13/13 to 6/16/13, to indicate if bed/chair alarms were in place, bed in low position, perimeter mattress in place, and mats on the floor.</p> <p>A Fall Circumstance form dated 6/16/13 at 6:30 p.m., indicated the resident had an unwitnessed fall. The resident indicated she was reaching for an item on the floor, the wheel chair wasn't locking and she slid out of wheel chair when it moved. The equipment inspection indicated the wheel chair was not locked. The fall risk assessment section indicated the resident had cognitive or memory impairment which affected safety and judgment and refused to comply with safety measures such as call light use, alarms, and appliances.</p> <p>The prevention update section indicated neuro checks every four hours for 72 hours, frequently used items within reach, and orient the resident to the environment. An IDT (Interdisciplinary team) reviewed the</p>			

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	<p>form on 6/17/13, indicated to place mats on the floor.</p> <p>There were lack of documentation in the Nursing Assessment and Data Collections notes from 6/17/13 to 6/20/13, to indicate if bed/chair alarms were in place, bed in low position, perimeter mattress in place, and mats on the floor.</p> <p>Review with the June 2013 MAR (Medication Administration Record), indicated the perimeter mattress, low bed and floor mats were initiated on 6/20/13.</p> <p>An interview with the DHS (Director of Health Services) on 6/27/13 at 2:30 p.m., indicated the prevention section should reflect what current interventions were in place at the time of the fall but nursing were putting both current and recommended interventions to be in place.</p> <p>The facility failed to implement safety measures upon the resident's return from the hospital (6/12/13) that were initiated prior to her 6/10/13 hospitalization.</p> <p>3. Upon entering the dining room on 6/28/13 at 8:20 a.m., approximately 10 residents were observed eating</p>			

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	<p>breakfast. CNA #49 was seen sitting at a table and left with a resident. There were no other staff members observed in the dining room for approximately 15 minutes. There was no indications of a resident having swallowing or choking problems.</p> <p>An interview with a CNA #49 and CNA #48 on 6/28/13 at 8:35 a.m., indicated the 200 hall nurse and two CNAs' were to be in the dining room for breakfast.</p> <p>An interview with LPN #27, the 200 unit nurse, on 6/28/13 at 8:45 a.m., indicated she did not know her meal time assignment. LPN #27 indicated when she came into the facility, she only had obtained her report from the night shift. LPN #27 indicated she could not leave the unit because there were only her and one CNA.</p> <p>On 6/28/13 at 8:50 a.m., an interview with the Nursing Consultant and the DHS (Director of Health Services) indicated there were normally one nurse, one QMA, and two CNAs' on the 200 unit and the daily assignments were to be found on the 300 unit. The DHS indicated there were two CNAs' on the 200 unit with the LPN #27 and she didn't know why</p>			

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	<p>she said only one CNA. DHS indicated administration would assist with meals.</p> <p>On 6/28/13 at 8:55 a.m., LPN #39 provided a schedule for 6/28/13, which was different from the schedule previously provided. The new/current schedule indicated one nurse and two CNAs' on the 200 unit. LPN #39 indicated there was a call off and staff was moved. LPN #39 indicated there had been changes with the schedules all week. The current schedule indicated a nurse from the 100 unit, 200 unit to be in the dining room for meals as well as, 1 CNA from the 200 and 1 CNA from the 100/300 unit.</p> <p>On 6/28/13 at 9:15 a.m., the DHS indicated a CNA had left to take someone back to the unit and dietary was in the kitchen, but that was not an excuse for someone not to be in the dining room.</p> <p>4. During an observation on 06/24/13 at 11:46 a.m. there were opened razors stored on the shelf in the bathroom of Resident #7's and #48's room.</p> <p>During an observation on 06/27/13 at 7:47 a.m., there were three opened razors stored on the shelf in Resident</p>			

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	<p>#7's and #48's bathroom.</p> <p>During an observation on 06/28/13 at 11:10 a.m. with the DHS (Director of Health Services) present, there were three opened razors stored on the shelf in Resident #7's and #48's bathroom.</p> <p>During an interview at the time of the observation, the DHS indicated the razors should be removed.</p> <p>Resident #48's record was reviewed on 06/27/13 at 8 a.m. The 4/7/13 Quarterly MInimum Data Set (MDS) Assessment indicated the resident was cognitively impaired.</p> <p>5. During an observation on 06/24/13 at 11:26 a.m., there was a bottle of B12 (supplement) medication stored on the shelf in resident's #B's and #35's bathroom.</p> <p>During an observation on 06/27/13 at 7:45 a.m., there was a bottle of B12 medication stored on the shelf in resident #B's and #35's shelf in the bathroom.</p> <p>During an interview at the time of the observation, Resident #B indicated the medication was hers, but she did not take it anymore.</p>			

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	<p>During an interview on 06/27/13 at 8 a.m., the DHS indicated she would take the bottle of B12 out of the resident's room.</p> <p>Resident #35's record was reviewed on 06/27/13 at 8:30 a.m. The Quarterly MDS Assessment, dated 04/07/13 indicated the resident's cognition was impaired.</p> <p>7. During the environmental tour on 06/28/13 at 11:45 a.m., with the Director of Plant Operations, Director of Housekeeping and the DHS present, there were four cans of pan coating spray stored in an unlocked cabinet under the sink in the resident lounge.</p> <p>The cans indicated inhaling the spray could be harmful or fatal and to avoid spraying in the eyes.</p> <p>The Director of Plant Operations, Director of Housekeeping and the DHS acknowledged the cans of spray were stored under the sink unlocked.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received a therapeutic diet as ordered by the physician for 2 of 3 residents reviewed for nutrition in a total sample of 27. (Residents #G and #H)</p> <p>Findings include:</p> <p>1. During an observation on 6/26/13 at 5 p.m., Resident #H received scalloped potatoes and consumed 100% of the potatoes.</p> <p>Resident #H's record was reviewed on 06/27/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, narcolepsy, and renal failure.</p> <p>A blood chemistry laboratory test, dated 05/20/13, indicated the</p>	F000325	<p>Date: August 2, 2013 F- 325 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident G discharged to hospital 7.7.13 Resident H received the low potassium diet during survey. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents have been reviewed to ensure correct therapeutic diet is received per physician order. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing and dietary staff have been inserviced on therapeutic diets and to ensure diet is correct prior to serving the resident their meal. How the corrective measures will be monitored to ensure the</p>	08/02/2013	

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	<p>resident's potassium level was 5.8 (normal 3.5-5.0).</p> <p>A Physician's order, dated 5/20/13, indicated an order for a low potassium diet and to treat with Kayexelate (medication to remove potassium from the body).</p> <p>A reference for low and high potassium foods, used by the Dietary Department, and received from the Dietary Manager on 06/27/13 at 3:30 p.m., indicated, "...High Potassium Foods...Potatoes: sweet, whit, French fries, chips..."</p> <p>During an interview on 06/27/13 at 3:30 p.m., the Dietary Manager indicated the resident should not have received scalloped potatoes on there diet.</p> <p>2. On 6/24/13 at 1:30 p.m., a family member of Resident #G's indicated a problem with the resident receiving the correct diet at least one meal a day. The family member had indicated the resident was a diabetic, his blood glucose levels had been out of control and the problem had been addressed to the Dietary Manager several times but had yet to be resolved. The family member indicated the family was having to</p>		<p>alleged deficient practice does not recur: DHS/designee or dietary manager/designee will audit diets five times per week to ensure resident receives correct diet. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>				

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	<p>take turns staying with Residnt #G on a daily basis to make sure his diet was correct.</p> <p>Resident #G's clinical record was reviewed on 6/27/13 at 9:40 a.m. Resident #G's diagnoses included, but were not limited to, insulin dependent diabetes, chronic kidney disease, congestive heart failure, and stroke.</p> <p>A Physician order dated 5/29/13, indicated Resident #G was to have a diabetic diet.</p> <p>A Nutritional Assessment dated 5/29/13, indicated the food and nutrition history was skim milk only. Nutrition assessment indicated the resident's wife was "noted" to fill out menus daily, 3:3:4 Carbohydrate choices at meals.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 6/5/13, indicated the resident was moderately cognitively impaired and was on a therapeutic diet. The resident was an insulin dependent diabetic.</p> <p>Review of Resident #G's blood sugar record from 6/1/13 to 6/26/13, indicated Resident #G's blood sugars had ranged from 51 to 326 at</p>			

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	<p>breakfast, 75 to 373 at lunch, 181 to 400 at supper, and 113 to 600 at bedtime.</p> <p>An interview with Resident #G's spouse on 6/26/13 at 5:15 p.m., indicated she had several conversations with the Dietary Manager on the meal service of appropriate and inappropriate food and the Dietary Manager indicated he had many talks with his staff. The spouse indicated when she questioned the staff, they would inform her they were not aware of the resident's restrictions.</p> <p>Observation of the resident's meal ticket during this time indicated the diet was carbohydrate controlled diet without allergies, dislikes and preferences. The spouse indicated she had informed the Dietary Manager on the resident's dislikes and preferences.</p> <p>The spouse had filled out the meal ticket which indicated for the resident to have grilled chicken, baked potato, peas and carrots, roll, skim milk and sugar free ice cream. The spouse indicated she was there daily to fill out the menu for the resident and had to be there at meal time to prevent the staff from serving wrong entrees' or</p>			

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	<p>desserts to the resident.</p> <p>During the interview, the resident was observed to have received only grilled chicken, baked potato, and skim milk. The spouse had to request the remainder of the food she had ordered on the ticket. By the end of supper, the wife had to stop the staff when they attempted to give the resident the baked apple cake. The wife indicated the Dietary Manager had informed her they did not have sugar free ice cream, but had reduced sugar.</p> <p>An interview with the resident and spouse on 6/28/13 at 8:15 a.m., indicated she had an appointment in the morning and the resident had filled out his own menu with assistance from the staff. The spouse indicated she requested Resident #G's menu from the kitchen and had to make changes on it due to the choices made were not part of his diabetic diet.</p> <p>An interview with the dietary Manager on 6/28/13 at 10:00 a.m., indicated he was aware of the problem and had spoken to his staff many times and will go back to speak with them again.</p> <p>An interview with the Executive</p>			

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	<p>Director on 6/28/13 at 11:00 a.m., indicated she was not aware the problem was continuing and would speak with the Dietary Manager and take disciplinary action with the staff for failure to follow the diet.</p> <p>This Federal Tag relates to complaint number IN00128508.</p> <p>3.1-20(g)(7) 3.1-20(g)(9)</p>			

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to gradual dose reductions (GDR), monitoring of pulses and blood pressures for blood pressure (BP) medications, monitoring blood sugars and an insulin pump, assessing and monitoring effectiveness of pain and antianxiety medications, interventions prior to administration of hypnotics (sleep medications) and effectiveness</p>	F000329	<p>Date August 2, 2013 F 329 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident H has blood pressure and pulse taken prior to administration of Metoprolol 50 mg twice a day. Resident H has been assessed for pain prior to receiving either Tylenol 325mg as needed (PRN) for pain or Oxycodone as needed (PRN) for pain and follow up for the</p>	08/02/2013			

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	<p>of the medication, and psychotropic medications given without indications for use, for 7 of 10 residents reviewed for unnecessary medications in a total sample of 27. (Residents #7, #37, #38, #151, #152, #156, #H)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed on 06/27/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, narcolepsy, and renal failure. The resident was admitted into the facility on 04/10/13.</p> <p>The 30 day Minimum Data Set Assessment (MDS), dated 5/8/13, indicated the resident's cognition was unable to be assessed, no behaviors, no trouble falling asleep or staying asleep or slept too much, and had no pain.</p> <p>The Physician's Recapitulation Orders, dated 06/13, indicated the following orders: Ambien (hypnotic) 5 mg (milligrams) as needed for insomnia (ordered 4/11/13)</p> <p>Metoprolol (BP medication) 50 mg twice a day, hold if SBP (systolic blood pressure) below 90 or heart</p>		<p>effectiveness of the pain medication (Tylenol 325 mg or Oxycodone) received. Resident H physician was notified for indication of usage of Seroquel 50mg daily at bedtime. Resident H has documentation of interventions tried to promote sleep prior to administration of Ambien 5mg for insomnia and the effectiveness noted after administration of the Ambien 5mg at bedtime for insomnia. Resident 7 has documentation of interventions tried to promote sleep prior to administration of Ambien 10mg as needed (PRN) for sleep. Resident 7 has been assessed for pain prior to administration of Tramadol 50mg as needed (PRN) for pain and follow up for the effectiveness of Tramadol 50mg. Resident 7 has documentation of the symptoms of anxiety prior to administration of Xanax 0.5mg daily as needed for increased anxiety and follow up for effectiveness of Xanax 0.5mg. Resident 152 has documentation of blood pressure and pulse prior to administration of Lopressor 25mg twice daily. Resident 152 has documentation of assessment of pain prior to administration of Norco 5/325mg and follow for</p>				

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	<p>rate (pulse) below 60. (ordered 4/16/13)</p> <p>Seroquel (anti-psychotic) 50 mg every day at bedtime (ordered 4/11/13) needed for pain rated 4-10. (ordered 4/11/13)</p> <p>Tylenol 325 mg, give two tablets every four hours as needed for pain rated 1-3 (ordered 4/11/13)</p> <p>A) The Medication Administration Record (MAR), dated 05/13, indicated on May 24, 27, 30 and 31, 2013 there was no blood pressure and/or pulse obtained prior to the administration of metoprolol in the morning.</p> <p>There was a lack of documentation on the daily Skilled Nurses' Notes to indicate the blood pressure and/or pulse had been obtained prior to the administration of the metoprolol in the morning, on the above dates</p> <p>The MAR, dated 06/13, indicated on June 12, 15, and 17, 2013 there were no blood pressure and/or pulse obtained prior to the administration of the metoprolol in the morning. The MAR indicated there was no blood pressure and/or pulse taken on June 1-12, 15-19, 21, 22, and 24, 2013 prior to the administration of the</p>		<p>effectiveness of Norco 5/325mg. Resident 37 physician notified for diagnosis for an indication for use for Trazadone 50 mg at bedtime. Resident 38 physician was notified to attempt to reduce Depakote 250mg twice a day and physician indicated to continue same dose of Depakote 250 mg twice a day due to resident stable. Resident 38 continues Celexa 30 mg daily due to resident is stable and physician indicated to continue Celexa 30mg daily. Resident 151 discharged. Resident 156 has documentation of blood pressure prior to administration of Cardizem CD 180mg Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents receiving blood pressure medications have been audited to ensure blood pressure and pulse are documented prior to administration of blood pressure medication. Current residents receiving as needed (PRN) pain medication have been audited to ensure assessment of pain prior to administration of pain medication and follow up for effectiveness of pain</p>		

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	<p>evening metoprolol dose.</p> <p>There was a lack of documentation on the Daily Skilled Nurses' Notes to indicate the blood pressure and/or pulse had been obtained prior to the administration of the metoprolol in the morning, on the above dates</p> <p>During an interview on 6/27/13 at 2:45 p.m., LPN #39 indicated the blood pressure and/or pulse should be on the MAR or on the Skilled Nurses' Notes</p> <p>During an interview on 6/28/13 at 9 a.m., the Director of Health Services indicated the facility could not find blood pressures and pulses completed on the resident.</p> <p>B) Resident #H's care plan, dated 05/13/13, indicated the resident had pain, the interventions included to administer and monitor effectiveness of the as needed pain medication.</p> <p>The MAR, dated 05/13, indicated the resident received the following pain medications: 5/17/13- Tylenol 325, two tablets, no time documented, no assessment of pain and no documented effectiveness of pain. 5/23/13 at 7:30 p.m.-oxycodone, one</p>		<p>medications is documented. Current residents receiving as needed (PRN) antianxiety medication have been audited to ensure symptoms of anxiety are documented prior to administration of antianxiety medication and follow up documentation for effectiveness of antianxiety medication. Current residents receiving antipsychotic medications have been audited to ensure diagnosis is obtained from physician to support use of antipsychotic medication along with obtaining clinical rationale to support not attempting a gradual dose reduction (GDR). Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced to obtain and document blood pressure and pulse prior to administration of blood pressure medication, assessment of pain prior to administering PRN pain medication and to follow up for effectiveness of PRN pain medication, documentation of symptoms of anxiety prior to administering PRN antianxiety medication and follow up of effectiveness of antianxiety medication, documentation of interventions tried prior to</p>		

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	<p>tablet for a rating of 10-no documentation of effectiveness. 5/25/13 at 10:30 a.m.-oxycodone, one tablet for a rating of six-no documentation of effectiveness.</p> <p>Resident #H's MAR, dated 06/13, indicated the resident received the following pain medications:</p> <p>6/01/13-Tylenol 325 mg, two tablets given at 1 p.m. for pain rated at a six(Tylenol ordered for pain rated at 1-3). 6/8/13 at 11:30 p.m.-oxycodone, one tablet for pain rated at an eight-no documentation of effectiveness. 6/13/13 at 10 a.m.-oxycodone, on tablet for pain rated at a six-no documentation of effectiveness</p> <p>During an interview on 6/27/13 at 2:45 p.m., LPN #39 indicated the nurses' should have documented the assessment of the pain and the effectiveness of pain medication.</p> <p>C) Resident #H's May and June 2013 MAR's indicated the resident received Seroquel (antipsychotic) 50 mg daily at bedtime.</p> <p>There was a lack of documentation to indicate the reason for the usage of the Seroquel.</p>		<p>administering PRN hypnotic medication and follow up for effectiveness of hypnotic medication, obtaining diagnosis for anti psychotic medication for indication of use of antipsychotic medication. notification of physician for clinical rationale to support not attempting a gradual dose reduction of psychotic medication and documenting rationale. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of nursing/designee will monitor medication administration record (MAR) for blood pressure medications for blood pressure and pulse documentation prior to administration of blood pressure medication, the PRN medication tracking sheet for documentation of assessment of pain prior to PRN pain medication and effectiveness of PRN pain medication, assessing symptoms of anxiety prior to PRN antianxiety medication and effectiveness of antianxiety medication, documentation of interventions tried prior to administration of PRN hypnotic medication and effectiveness of hypnotic medication 3 times a week for 2 months, then 2</p>		

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	<p>The Behavior Detail Report indicated the resident had no behaviors from 04/12/13 through 06/26/13.</p> <p>The Skilled Nurses' Notes, dated 04/11/13 through 06/26/13, indicated the resident had no mood or behavior concerns and no trouble falling asleep or staying asleep.</p> <p>During an interview on 6/27/13 at 2:45 p.m., LPN #39 indicated there was no indication for the use of Seroquel. She indicated there was no supportive documentation for the Seroquel usage.</p> <p>A facility policy, titled, "Antipsychotics and the elderly", dated 03/12 and received as current from the Director of Health Services, indicated, "...Appropriate indications for Antipsychotics-Schizophrenia, Schizo-affective disorder, Delusional disorder, Mood disorders-Mania, bipolar disorder, depression with psychotic features, Atypical psychosis, Psychosis, Acute psychotic disorder, Dementing illness with behavioral symptoms...Additional Criteria for Use-At least 1 of these criteria must also be met for use of an antipsychotic: Symptoms due to mania or psychosis-Auditory, visual,</p>		<p>times a week for 2 months then weekly for 2 months. DHS/designee will review antipsychotic medication orders weekly for diagnosis to support use of antipsychotic medication when ordered from physician. DHS/designee will review GDR's monthly from pharmacy recommendations with physician to ensure clinical rationale for not attempting GDR. Audits will be reviewed in Quality Assurance monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>				

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	<p>Hallucinations, Delusions, Behavior poses danger/threat to other residents or themselves, Symptoms lead resident to experience:excessive fear, continuous yelling/screaming, inconsolable distress, Decrease in daily functioning, Difficulty receiving care..."</p> <p>D) Resident #H's care plan, dated 05/13/13, indicated the resident had episodes of insomnia. The interventions included to monitor for cause of insomnia and administer the medications as ordered by the physician.</p> <p>The MAR, dated 05/13, indicated the Ambien 5 mg was administered to the resident on May 25 and 29, 2013.</p> <p>There was a lack of documentation to indicate other interventions were attempted to promote sleep and assessment of the cause of the insomnia was assessed prior to the administration of the Ambien. There was a lack of documentation to indicate the effectiveness of the Ambien after the medication was administered.</p> <p>The MAR, dated 06/13, indicated the Ambien 5 mg was administered to the resident on June 12, 14, 20, 21, and</p>				

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	<p>22, 2013.</p> <p>There was a lack of documentation to indicate other interventions were attempted to promote sleep and assessment of the cause of the insomnia was assessed prior to the administration of the Ambien on June 12, 14, 20, 21, and 22, 2013 and there was a lack of documentation to indicate the effectiveness of the Ambien on June 22, 2013.</p> <p>During an interview on 6/27/13 at 2:45 p.m., LPN#39 indicated the nurses' should have documented the effectiveness of the Ambien and interventions attempted prior to the administration of the Ambien.</p> <p>An undated, facility policy, titled, "Administration of PRN (as needed) Medications Guideline", received from the Director of Health Services as current on 06/28/13 at 8 a.m., indicated, "...2. Non-pharmacological interventions...shall be attempted and documented prior to administration of PRN medications...5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects."</p> <p>2. Resident #7's record was reviewed on 06/26/13 at 11:23 a.m. The</p>						

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	<p>resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and fibromyalgia.</p> <p>A) The Physician's Recapitulation Orders, dated 06/13, indicated and order for Ambien 10 mg prn (as needed) at bedtime for sleep, document three interventions prior to giving the prn Ambien (ordered 12/26/12).</p> <p>The MAR, dated 05/13, indicated the Ambien had been administered to the resident on May 28 and 31, 2013.</p> <p>There was a lack of documentation to indicate other interventions were attempted prior to the administration of the Ambien.</p> <p>The MAR, dated, 6/13, indicated the Ambien had been administered to the resident on June 5, 8, 18, 22, 23, and 25, 2013.</p> <p>There was a lack of documentation to indicate other interventions were attempted prior to the administration of the Ambien.</p> <p>During an interview on 06/26/13 at 10:45 a.m., LPN #39 indicated there were no other interventions to promote sleep documented prior to</p>			

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	<p>the administration of the Ambien.</p> <p>B) Resident #7's Physician's Recapitulation Orders, dated 06/13, indicated orders for hydrocodone (pain medication) 7.5/325 mg, one tablet every six hours as needed for pain rated 1-10 (ordered 01/20/13) and Tramadol (pain medication) 50 mg, one tablet every six hours as needed for pain (no pain rating given) (ordered 05/07/13).</p> <p>The MAR, dated 05/13, indicated the resident received the Tramadol for pain rated at a six on 05/22/13 at 9:30 a.m. There was a lack of documentation to indicate the effectiveness of Tramadol.</p> <p>The MAR, dated 6/13 indicated the resident received the Tramadol on June 1, 2, 3, and 5, 2013. There was a lack of documentation the resident's pain had been assessed and the effectiveness of the Tramadol had been assessed.</p> <p>The 6/13 MAR indicated the resident received the Tramadol on June 9, 17 (twice), and 19, 2013. There was a lack of documentation to indicate the effectiveness of the Tramadol had been assessed.</p>				

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	<p>The 6/13 MAR indicated the resident received the hydrocodone on 06/14/13. There was a lack of documentation to indicate the effectiveness of the hydrocodone had been assessed.</p> <p>During an interview on 06/26/13 at 2:45 p.m., LPN #39 indicated the pain should have been assessed and the effectiveness of the pain medication should have been completed.</p> <p>C) Resident #7's Physician's Recapitulation Orders, dated 06/13, indicated an order for Xanax (antianxiety) 0.5 mg daily as needed for increased anxiety.</p> <p>The MAR, dated 06/13, indicated the resident received the Xanax on June 14, 15, 17, and 21, 2013 for anxiety. There was a lack of documentation to indicate the symptoms of the anxiety and the effectiveness of the Xanax.</p> <p>During an interview on 06/26/13 at 2:45 p.m., LPN #39 indicated the anxiety should have been assessed and the effectiveness of the Xanax should have been assessed.</p> <p>3. Resident #152's record was reviewed on 06/26/13 at 2:55 p.m. The resident's diagnoses included,</p>			

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	<p>but were not limited to, stroke, hypertension and right hip fracture. The resident was admitted into the facility on 06/08/13.</p> <p>A) The Admission Physician's Orders, dated 06/08/13, indicated and order for Lopressor (blood pressure medication) 25 mg twice a day, hold for systolic blood pressure under 110 or pulse less than 60.</p> <p>The 06/13 MAR, indicated there was no blood pressure and/or pulse obtained prior to the administration of the Lopressor for the morning dose on 06/16/13 and the evening doses on June 9, 10, 12, 14, 15, 16, 18, 22, and 25, 2013.</p> <p>There was a lack of documentation on the Daily Skilled Nurses' Notes to indicate the blood pressure and/or pulse had been obtained prior to the administration of the Lopressor on the above dates.</p> <p>During an interview on 06/26/13 at 2:55 p.m., LPN #47 indicated if the medication is given more than daily, the blood pressure and pulses should be written on the MAR. She indicated the blood pressure and pulse may be documented on the Daily Skilled Nurses' Notes.</p>			

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	<p>B) The Admission Physician's Orders, dated 06/08/13, indicated an order for Tylenol 625 mg every six hours as needed for pain and Norco (pain medication) 5/325 mg every six hours as needed for pain.</p> <p>The MAR, dated 06/13, indicated the resident received the Norco 5/325 mg on June 9 ,14, and 17, 2013. There was a lack of documentation to indicate the pain had been assessed prior to the pain medication being administered on June 9 and 14, 2013 and a lack of documentation to indicate the effectiveness of the Norco had been assessed on June 9, 14, and 17, 2013.</p> <p>During an interview on 06/26/13 at 2:45 p.m., LPN #39 indicated the pain should have been assessed and the effectiveness of the pain medication should have been completed.</p> <p>An undated, facility policy, titled, "Administration of PRN (as needed) Medications Guideline", received from the Director of Health Services as current on 06/28/13 at 8 a.m., indicated, "...3. Documentation should reflect the reason for administrating the PRN medication...5. Follow up should be noted to ensure the</p>			

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	<p>effectiveness and/or assess for adverse side effects."</p> <p>4. Resident #37's clinical record was reviewed on 6/26/13 at 9:30 a.m. Resident #37's diagnoses included, but were not limited to TIA's (mini strokes), muscle weakness, hypertension, bilateral hip replacements and dementia. The resident was admitted on 5/31/13. The resident was readmitted to the facility on 6/12/13 after a 2 day hospital stay.</p> <p>A Nursing Assessment and Data Collection notes dated from 6/13/13 to 6/19/13, did not indicate the resident had difficulty sleeping through the night.</p> <p>A physician order dated 6/19/13, indicated Trazadone 50 mg (milligrams) to be given at bedtime.</p> <p>A Change of Condition form dated 6/19/13 at 9:00 p.m., indicated Trazadone 50mg 1 by mouth every bedtime for sleeplessness. The medication to start when arrived.</p> <p>A Nursing Assessment and Data Collection note dated 6/20/13 for 7-3 shift, indicated the resident slept through the night.</p>			

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	<p>The June 2013 MAR (Medication Administration Record) indicated the Trazadone was started on 6/21/13.</p> <p>An interview with the Nursing Consultant on 6/26/13 at 4:30 p.m., indicated she had known the resident was not sleeping at night prior to the hospitalization but was not aware of no supporting documentation.</p> <p>5. Resident #38's record was reviewed on 6/26/13 at 4:02 p.m. The resident's diagnoses included, but were not limited to, vascular dementia, depression, paranoia, aggressiveness, and verbal outbursts.</p> <p>Review of the Physician Recapitulation Orders dated 6/2013 indicated an order for Divalproex Sodium (Depakote, a medication that can be used to stabilize mood) 250 mg (milligrams) twice daily, originally ordered on 6/11/12.</p> <p>Review of the Medication Administration Record (MAR) for the months of 12/2012 through 6/2013 indicated the resident received the Depakote medication 250 mg twice daily.</p> <p>Continued record review indicated documentation of an attempted or</p>						

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	<p>refused gradual dose reduction (GDR) was lacking since the original order date 6/11/12.</p> <p>Interview with the DHS (Director of Health Services) on 6/27/13 at 1:45 p.m. indicated there had not been an attempt to reduce Depakote since the start date 6/11/12.</p> <p>Review of the Physician Recapitulation Orders dated 6/2013 indicated an order for Citalopram (Celexa, an antidepressant medication) 30 mg daily, originally ordered 10/11/12.</p> <p>Review of the pharmacy recommendation dated 5/7/13 indicated recommendations to decrease Celexa to 20 mg daily. Review of the Physician's response indicated to continue the same dose and was signed by the Physician on 5/13/13. The refused GDR dated 5/13/13 had lacked clinical rationale documentation.</p> <p>Review of the Medication Administration Record (MAR) for the months of 12/2012 through 6/2013 indicated the resident received the Celexa medication 30mg daily.</p> <p>Interview with the DHS on 6/27/13 at</p>			

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	<p>1:45 p.m. indicated per phone call with Resident #38's Doctor, the Celexa was not reduced due to the resident being stable. The DHS indicated there was no documentation of this clinical rationale.</p> <p>6. Resident #151's record was reviewed on 6/26/13 at 8:40 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, osteoporosis, and acute kidney injury. The resident was admitted to the facility on 6/4/13.</p> <p>Review of Physician Recapitulation Orders dated 6/2013 indicated resident was to be monitored for blood sugars AC (before meals) and HS (at bedtime) and record results and results from insulin pump on flow sheet provided.</p> <p>Review of self medication assessment tool dated 6/4/13 indicated resident was able to self administer medications.</p> <p>A Physician Order dated 6/7/13 indicated the resident was to adjust her own insulin pump per her normal directions.</p> <p>Review of resident's bedside insulin pump record sheets indicated there</p>			

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	<p>were only sheets completed for 6/4/13, 6/5/13, 6/6/13, 6/7/13, 6/8/13.</p> <p>Interview with Resident #151 on 6/26/13 at 11:30 a.m. indicated she monitors her own blood sugars and insulin pump. The resident indicated she is supposed to document the results on a flow sheet but she ran out of sheets "awhile ago", and had not been given any more.</p> <p>Interview with DHS on 6/28/13 at 1:28 p.m. indicated the resident should have been documenting the blood sugars and insulin pump readings on a flow sheet and the staff should have been providing supervision to make sure resident was completing documentation.</p> <p>7. Resident #156's record was reviewed on 6/27/13 at 12:45 p.m. The resident's diagnoses included, but were not limited to, hyperlipidemia, hypertension, atrial fibrillation, and depression. The resident was admitted to the facility on 6/13/13.</p> <p>Review of Physician Recapitulation Orders dated 6/2013 indicated an order for Cardizem CD (a medication used to lower blood pressure) 180 mg (milligrams) daily around breakfast,</p>				

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	<p>hold if SBP (systolic blood pressure) < (is less than) 100.</p> <p>Review of the Medication Admininstration Record (MAR) for 6/2013 indicated the resident had received the Cardizem medication daily, but lacked documentation of blood pressure readings.</p> <p>Interview with DHS on 6/27/13 at 2:46 p.m. indicated the resident's blood pressure was not documented in the MAR but was monitored per the Skilled Nursing Assessment sheet completed daily by the nurse. She indicated all daily blood pressures have been within the appropriate limits and the Cardizem medication was given.</p> <p>Review of the Skilled Nursing Assessment sheets dated 6/14/13 through 6/26/13 indicated there were 3 days when the resident's blood pressure was documented on the midnight shift, 1 day when the resident's blood pressure was documented on the evening shift, and 1 day when the resident's blood pressure was not documented.</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</p>						

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F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 4 of 9 residents observed during 8 medication pass observations. Five errors in medications were observed during 28 opportunities for errors in medication administration. This resulted in a medication error rate of 17.85%. (Residents #47, #59, #103, and #157)</p> <p>Findings include:</p> <p>1. During an observation of an intravenous (IV) medication administration on 06/25/13 at 9:07 a.m., LPN #48 prepared Resident #103's IV medication of Merrem (antibacterial). LPN #48 then flushed the IV with 10 cc's (cubic centimeters) of 0.9% normal saline prior to the administration of the Merrem.</p> <p>Review of the resident's Physician's Orders, dated 06/23/13, on 06/25/13 at 11 a.m., indicated an order for Merrem 1 gm (gram) IV every 12 hours and flush with 5 cc's of 0.9 % of normal saline before and after</p>	F000332	<p>August 2, 2013F 332 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 48 IV discontinued and did not have a negative outcome from 10cc of 0.9% normal saline flush after IV medication administration. Resident 157 did not have a negative outcome from the Spiriva and Ventolin inhalers. Resident 59 did not have a negative outcome from the administration of crushed Baclofen medication via g-tube. Resident 47 did not have a negative outcome from Symbicort 160/4.5 mcg inhaler. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with IV medication have been reviewed to ensure IV flush with 0.9% normal saline has correct amount of 0.9% normal saline flushed per physician orders after IV medication administration. Residents with 2 different inhaler medications have been reviewed to ensure that 1-2</p>	08/02/2013			

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	<p>administration of the medication, follow with Heperin 5 cc.</p> <p>During an interview on 06/25/13 at 11 a.m., LPN #48 indicated she had flushed the IV prior to the medication with 10 cc of normal saline, she indicated that was what the order said. LPN #48 then looked at the Medication Administration Record (MAR) and indicated the flush should have only been 5 cc.</p> <p>2. During an observation on 06/26/13 at 7:30 a.m., LPN #43 prepared Resident #157's inhalers, which included Spiriva and ventolin (breathing medication). LPN #43 then entered the resident's room, explained the medication and handed the Spiriva to the resident, gave instructions how to take the Spiriva and the resident inhaled the medication. 10 seconds later, LPN #43 handed the resident the ventolin inhaler and gave instructions for the resident to inhale the ventolin inhaler upon compressing the bottle. The resident then immediately took the second puff of the inhaled medication.</p> <p>The resident's Physician's orders, dated 06/19/13 were reviewed on 06/26/13 at 8:30 a.m., indicated an</p>		<p>minutes are between inhalation medication and inhaler is shaken again before administration. Resident with g-tube medication has been reviewed to ensure crushed medication is dissolved in 30 ml of warm water and the g-tube is flushed with 15-30 ml of water prior to medication administration. The g-tube is not reconnected to the feeding for 30 minutes after medication administration. Resident with Symbicort inhaler have been reviewed to ensure 1-2 minutes between puffs occur. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced on medication pass procedures and error prevention for IV flushes after medication administration, inhalation medications and g-tube medications. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will do medication pass competencies with three nurses weekly for 90 days, then 2 nurses weekly thereafter. Observation Competencies will take place on all shifts. Competencies will be reviewed</p>				

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	<p>order for Spiriva, one capsule daily and ventolin inhaler two puffs every six hours.</p> <p>3. During a medication pass observation on 6/27/13 at 12:30 p.m., LPN #40 prepared Resident #59's medication, which was Baclofen (a muscle relaxer) 20 mg (milligrams).</p> <p>LPN #40 took the crushed medication in a plastic medication cup and an empty small cup into the resident's room. LPN #40 filled the small cup with tap water. LPN #40 indicated the small cup held 120 cc's (cubic centimeters)(4 ounces).</p> <p>LPN #40 turned off the resident's tube feeding, disconnected the tube feeding, and confirmed PEG (percutaneous endoscopic gastrostomy) tube placement using an air bolus.</p> <p>LPN #40 removed the plunger from the irrigation syringe and connected the syringe to the PEG tube. LPN #40 poured the crushed medication into the syringe then poured the cup with 120 cc's of water into the syringe and allowed the contents to flow into the PEG tube via gravity. LPN #40 disconnected the syringe from the</p>		<p>during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>				

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	<p>PEG tube and plugged the PEG tube.</p> <p>Review of Physican Recapitulation Orders dated 6/2013 indicated an order to flush PEG tube with 120 cc water after each feeding.</p> <p>A facility policy, dated 2/2010, titled "Enteral Tube Medication Administration," received as current from the DHS (Director of Health Services), indicated "...Crush tablets and dissolve in 30 ml (milliliters) of warm water or other appropriate liquid...Flush the tube with 15-30 ml of water prior to medication administration..." The policy indicated after giving the medication to "...Flush the tube with 15-30 ml of water and plug tube for 30 minutes before reattaching to tube feeding."</p> <p>4. During a medication pass administration observation on 6/28/13 at 9:12 a.m., LPN #27 prepared Resident #47's medications, which included Symbicort 160/4.5 mcg (micrograms) inhaler (a medication used to treat asthma).</p> <p>LPN #27 administered one puff of the inhaler to the resident. LPN #27 waited 5 seconds, then administered a second puff of the medication to the resident.</p>						

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	<p>Review of the Physician's Recapitulation Orders dated 6/2013 indicated the resident was to receive Symbicort 160/4.5 mcg inhaler 2 puffs orally two times a day.</p> <p>A facility policy, dated 02/10, and received from the DHS (Director of Health Services), titled, "Specific Medication Administration Procedure", indicated, "...If another puff of the same or different medication is required, wait at least 1-2 minutes between..."</p> <p>The Manufacturer's instructions for the ventolin, received from the DHS on 06/26/13 at 9 a.m. indicated, "...If your healthcare provider has told you to use more sprays, wait 1 minute and shake the inhaler again..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure kitchen personal. who had exposed long hair outside their hat, wear a hairnet under their caps. This had the potential to affect 56 out of 57 residents who received meals from the kitchen. (Main Dining Room, 100 Unit, 200 Unit and 300 Unit)</p> <p>Findings include:</p> <p>During the kitchen tour on 6/24/13 at 8:40 a.m., kitchen staff was observed wearing hats without hair nets during food preparation. Dietary #45 was observed with her hair braided down on the back of her neck without a hair net on.</p> <p>On 6/24/13 at 12:00 p.m., Dietary #45 was observed wearing a hat with her hair braided down on the back of her neck without a hair net on.</p> <p>An interview with Dietary #45 during this time, indicated the kitchen personnel don't wear hair nets with</p>	F000371	<p>August 2, 2013 F-371 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Dietary #45, 46 and 22 all were inserviced on proper hair restraint. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: DFS/designee will inservice current dietary staff on proper hair restraint. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DFS/designee will inservice dietary staff, nursing staff and department leaders on proper hair restraint. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DFS/designee will audit 3 meals (1 breakfast, 1 lunch, and 1 dinner) 2x weekly for staff following proper hair restraint. Audits will be reviewed during Quality</p>	08/02/2013			

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	<p>hats on.</p> <p>On 6/24/13 at 12:45 p.m., Dietary #45 was observed at the steam table on the 300 Unit, serving meals without her hair in a net.</p> <p>On 6/26/13 at 4:50 p.m., Dietary #46, was observed wearing a hat with her hair braided down on the back of her neck with long loose hair observed coming out around the ears and down the side of her face. During the meal service, Dietary #22 took over for Dietary #46 and finished the meal service. Dietary #22 was observed with her hat and hair net, but had large strands of hair down the side of her face.</p> <p>A Hair Restraint Guideline/Policy [undated], was provided by the DHS (Director of Health Services) on 6/22/13 at 8:00 a.m. The policy indicated "...Those employees that have hair that extrudes out of the cap will be required to have hair wrapped into a bun style or tucked under hat..."</p> <p>This Federal Tag relates to complaint number IN00128508</p> <p>3.1-21(i)(3)</p>		<p>Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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F000411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review and interview, the facility failed to ensure dental services were offered and provided for a resident who had missing/broken teeth for 1 of 3 residents reviewed. (Resident #D)</p> <p>Findings include:</p> <p>An interview with Resident #D on 6/25/13 at 11:00 a.m., indicated she had missing/broken teeth. The resident was admitted to the facility on 5/31/13.</p> <p>Resident #D's clinical record was reviewed on 6/27/13 at 1:20 p.m. Resident #D's diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm),</p>	F000411	<p>August 2, 2013 F-411 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: . Resident D and her family refused dental services offered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents have been assessed for any dental concerns and appointment made with dentisit if indicated. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced to assess residents oral cavity and</p>	08/02/2013

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	<p>coronary artery disease, stroke, and myocardial infarction (heart attack).</p> <p>Prior to Resident #D's admission to the facility, a bedside swallow evaluation dated 5/29/13, indicated the resident had partial dentition.</p> <p>A Nursing Admission Assessment dated 6/5/13, indicated the resident had "broken or loose fitting full or partial dentures" as well as having her own teeth.</p> <p>Review of the Admission Comprehensive MDS (Minimum Data Set) Assessment dated 6/12/13, indicated the SSA (Social Service Assistant) signed off on the meeting which indicated the resident had broken teeth.</p> <p>Review of the Resident First Care Plan Conference notes dated 6/27/13, indicated the resident needed to see a dentist.</p> <p>An interview with the (SSD) Social Service Director on 6/28/13 at 8:53 a.m., indicated she was not made aware of the broken/missing teeth until the family had brought it to her attention at the care plan meeting on 6/27/13. The SSD indicated the nursing staff had not made her aware</p>		<p>notify family and social services for appointment with dentist if indicated. Social services has been inserviced to follow up with dentist for treatment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review residents for dental assessments during clinical meeting M-F. Residents with oral cavity issues will be referred to Social Services for follow up with dental appointments and notification of family. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>	

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	<p>of any abnormal oral conditions and her social service admission paperwork did not address oral conditions. The SSD indicated the Admissions Coordinator would address the Patient Choice and Right to Refuse form (outside services for dental, audiology, vision, and podiatry) prior to the admission into the facility.</p> <p>An interview with the SSD on 6/28/13 at 9:50 a.m., indicated a Patient Choice and Right to Refuse form (not dated) was found on her desk indicating the resident would like to receive outside services. She indicated the SSA did not inform her of the missing/broken teeth from the 6/12/13 MDS meeting. The SSD indicated the Admission Care Plan meetings were usually done within the first 5 days of admission, depending upon the family availability.</p> <p>This Federal Tag relates to complaint number IN00128614.</p> <p>3.1-24(3)</p>				

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F000441 SS=E	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure provide a</p>	F000441	Date: August 2, 2013 F - 441 Corrective Actions	08/02/2013			

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	<p>sanitary environment, related to uncovered bedpans and urinal, urine collection containers, and uncovered toothbrushes stored in residents bathrooms for 6 resident bathrooms, which there were 2 residents in each room, on the 200 unit. (Rooms #210, #211, #212, #215, #216, and #217)</p> <p>Findings include:</p> <p>During an observation on 06/24/13 at 11:26 a.m., there was an uncovered toothbrush stored on the back of the sink in room 210.</p> <p>During an observation on 06/24/13 at 11:46 a.m., there was an uncovered urine collection container stored on the hand rail of the toilet and uncovered toothbrushes stored on the sink and the shelf in the bathroom of room 212.</p> <p>During an observation on 06/24/13 at 11:57 a.m., there was an uncovered urinal on the rail behind the toilet in the bathroom of room 211.</p> <p>During an observation on 06/24/13 at 1:35 p.m., there was an uncovered bedpan and uncovered toothbrushes stored on the shelves in the bathroom of room 216.</p>		<p>accomplished for those residents found to have been affected by the alleged deficient practice: Room #210 had the toothbrush placed in a toothbrush covered container labeled with the resident name. Room # 211 had the urinal placed in a plastic bag labeled with resident name. The washbasin and urine collector was removed from the room. A new washbasin was placed in a plastic bag labeled with the resident name. Room # 212 had the urine collection container removed and the toothbrush placed in a toothbrush covered container labeled with the resident name. Room # 215 had the toothbrush placed in a covered toothbrush container labeled with the resident name. Room #216 had the bedpan placed in a plastic bag labeled with the resident name. The toothbrush placed in a toothbrush covered container labeled with the resident name. The washbasin was placed in a plastic bag labeled with the resident name. Room #217 had the bedpan placed in a plastic bag labeled with the resident name. The toothbrush placed in a toothbrush covered container labeled with the resident name. The shower seat was cleaned. Identification of other residents having the</p>		

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	<p>During an observation on 06/24/13 at 2:17 p.m., there was an uncovered toothbrush stored on the shelf in the bathroom of room 215.</p> <p>During an observation on 06/25/13 at 8:47 a.m., there was and uncovered bedpan on the shower seat and an uncovered toothbrush on the shelf in the bathroom of room 217.</p> <p>During an observations on 06/27/13 the following was observed: 7:45 a.m. there was an uncovered toothbrush stored on the sink in the bathroom of room 210. 7:47 a.m. there was a urine collection container stored on the shelf in the bathroom and uncovered toothbrushes in the bathroom of room 212. 7:55 a.m. there was an uncovered washbasin stored on the shower seat and an uncovered bedpan stored on the shelf of room 216. 8 a.m. there was a wash basin on the floor of the bathroom and a urine collector container on the shelf in the bathroom of room 211.</p> <p>During the environmental tour on 06/28/13 at 11:45 a.m., with the Director of Plant Operations, Director of Housekeeping and the DHS (Director of Health Services) present,</p>		<p>potential to be affected by the same alleged deficient practice and corrective actions take: Current residents have had toothbrushes placed in covered toothbrush containers labeled with their name, urinals and bedpans and urine collection containers are placed separately in plastic bags labeled with their name, washbasins are in plastic bags labeled with their name. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Nursing staff have been inserviced to have toothbrushes placed in toothbrush covered containers. Washbasins, bedpans, and urine collection containers are labeled with resident name and placed in separate plastic bags. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will make environmental rounds in 6 resident bathrooms 3 times per week for 2 months, then 2 times per week then weekly for 2 months to ensure toothbrushes are covered and bedpans, urinals and urine collection containers are in plastic bags labeled with resident names. Audits will be reviewed during Quality</p>		

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	<p>the following was observed:</p> <p>Room 212 there was an urine collection container stored on the rail behind the toilet and uncovered toothbrushes in the bathroom. The DHS acknowledged at the time of the observation.</p> <p>Room 216 there was an uncovered bedpan stored on the shelf in the bathroom and uncovered toothbrushes in the bathroom.</p> <p>Room 210 there was an uncovered toothbrush stored on the back of the sink in the bathroom. At the time of the observation, the DHS indicated the staff worked on "this" yesterday.</p> <p>3.1-18(j)</p>		<p>assurance monthly x 6 months and then quarterly thereafter until 100% compliance is achieved.</p>		

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify and implement a plan of action to correct a quality deficiency related to unnecessary medications for 7 of 10 residents reviewed for unnecessary medications in a total sample of 27, which had the potential to effect 57 of 57 residents who reside in the healthcare facility.</p> <p>Finidngs include:</p>	F000520	<p>Date August 2, 2013 F-520 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident H has blood pressure and pulse taken prior to administration of Metoprolol 50 mg twice a day. Resident H has been assessed for pain prior to receiving either Tylenol 325mg as needed (PRN) for pain or Oxycodone as needed (PRN)</p>	08/02/2013	

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	<p>The facility failed to ensure residents were free from unnecessary medications related to gradual dose reductions (GDR), monitoring of pulses and blood pressures for blood pressure (BP) medications, monitoring blood sugars and an insulin pump, assessing and monitoring effectiveness of pain and antianxiety medications, interventions prior to administration of hypnotics (sleep medications) and effectiveness of the medication, and psychotropic medications given without indications for Residents #7, # 37, # 38, #151, #152, #156, and #H.</p> <p>During an interview with the Executive Director (ED), the Director of Health services (DHS), and the RN Corporate Consultant on 07/01/13 at 11 a.m., the DHS indicated the facility had not been monitoring the unnecessary medication and psychotropic medications yet. She indicated it was one of the things they were going to start to focus on. She indicated the Medical Director looked at the sliding scales for insulin and the antibiotic use.</p> <p>The RN Corporate Consultant indicated an audit had been done to assess what AIMS (abnormal</p>		<p>for pain and follow up for the effectiveness of the pain medication (Tylenol 325 mg or Oxycodone) received. Resident H physician was notified for indication of usage of Seroquel 50mg daily at bedtime. Resident H has documentation of interventions tried to promote sleep prior to administration of Ambien 5mg for insomnia and the effectiveness noted after administration of the Ambien 5mg at bedtime for insomnia. Resident 7 has documentation of interventions tried to promote sleep prior to administration of Ambien 10mg as needed (PRN) for sleep. Resident 7 has been assessed for pain prior to administration of Tramadol 50mg as needed (PRN) for pain and follow up for the effectiveness of Tramadol 50mg. Resident 7 has documentation of the symptoms of anxiety prior to administration of Xanax 0.5mg daily as needed for increased anxiety and follow up for effectiveness of Xanax 0.5mg. Resident 152 has documentation of blood pressure and pulse prior to administration of Lopressor 25mg twice daily. Resident 152 has documentation of assessment of pain prior to administration of Norco</p>				

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	<p>involuntary movement) tests needed completed. She indicated the facility looks at the pain medications when the pain is new and a Pain Circumstance form is filled out.</p> <p>3.1-52(b)(2)</p>		<p>5/325mg and follow for effectiveness of Norco 5/325mg. Resident 37 physician notified for diagnosis for an indication for use for Trazadone 50 mg at bedtime. Resident 38 physician was notified to attempt to reduce Depakote 250mg twice a day and physician indicated to continue same dose of Depakote 250 mg twice a day due to resident stable. Resident 38 continues Celexa 30 mg daily due to resident is stable and physician indicated to continue Celexa 30mg daily. Resident 151 discharged. Resident 156 has documentation of blood pressure prior to administration of Cardizem CD 180mg Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents receiving blood pressure medications have ben audited to ensure blood pressure and pulse are documented prior to administration of blood pressure medication. Current residents receiving as needed (PRN) pain medication have been audited to ensure assessment of pain prior to administration of pain medication and follow up for</p>		

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			<p>effectiveness of pain medications is documented. Current residents receiving as needed (PRN) antianxiety medication have been audited to ensure symptoms of anxiety are documented prior to administration of antianxiety medication and follow up documentation for effectiveness of antianxiety medication. Current residents receiving antipsychotic medications have been audited to ensure diagnosis is obtained from physician to support use of antipsychotic medication along with obtaining clinical rationale to support not attempting a gradual dose reduction (GDR). Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced to obtain and document blood pressure and pulse prior to administration of blood pressure medication, assessment of pain prior to administering PRN pain medication and to follow up for effectiveness of PRN pain medication, documentation of symptoms of anxiety prior to administering PRN antianxiety medication and follow up of effectiveness of antianxiety medication, documentation of</p>	

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			<p>interventions tried prior to administering PRN hypnotic medication and follow up for effectiveness of hypnotic medication, obtaining diagnosis for anti psychotic medication for indication of use of antipsychotic medication. notification of physician for clinical rationale to support not attempting a gradual dose reduction of psychotic medication and documenting rationale. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of nursing/designee will monitor medication administration record (MAR) for blood pressure medications for blood pressure and pulse documentation prior to administration of blood pressure medication, the PRN medication tracking sheet for documentation of assessment of pain prior to PRN pain medication and effectiveness of PRN pain medication, assessing symptoms of anxiety prior to PRN antianxiety medication and effectiveness of antianxiety medication, documentation of interventions tried prior to administration of PRN hypnotic medication and effectiveness of hypnotic medication 3 times</p>	

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			<p>a week for 2 months, then 2 times a week for 2 months then weekly for 2 months. DHS/designee will review antipsychotic medication orders weekly for diagnosis to support use of antipsychotic medication when ordered from physician. DHS/designee will review GDR's monthly from pharmacy recommendations with physician to ensure clinical rationale for not attempting GDR. Audits will be reviewed in Quality Assurance Meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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F009999	<p>3.1-14 PERSONNEL</p> <p>In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six and three hours of dementia specific training annually for 33 of 61 employees who had been employed at the facility for more than six months. (Administrator in Training, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, CNA #10, CNA #11, CNA #12, CNA #13, CNA #14, Environment #15, Environment #16,</p>	F009999	<p>August 2, 2013</p> <p>F-9999Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: All employees discussed in the 2567 as not having had their 3 hour or 6 hours Dementia training class and are still employed within the facility will have their required dementia hours training. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Audit completed of current employees to ensure required dementia training hours are completed at this time. What measures will be put into place or what system changes will be made to ensure tht the deficient practice does not recur? Employees currently being hired will have dementia training completed during one of the scheduled dementia classes each month. If at 6 months training is still not completed employee will be removed from schedule until training can be completed as required.AP/Payroll or designee will keep a schedule of all employees going forward</p>	08/02/2013			

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	<p>Environment #17, Environment #18, Executive Director, Dietary #20, Dietary #21, Dietary #22, Dietary #23, Dietary #24, Dietary #25, Legacy Unit Manager #26, LPN #27, LPN #28, LPN #29, LPN #30, LPN #31, LPN #32, LPN #33, Medical Records #33)</p> <p>Findings include:</p> <p>33 employees who had been employed by the facility for over four months, records were reviewed on 07/01/13 at 8:00 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 33 of the 61 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2012 and 2013.</p> <p>During an interview on 07/01/13 at 8:20 a.m., Alzheimer's unit director indicated she had just focused on the employees on the Alzheimer's unit.</p> <p>3.1-14(u)</p>		<p>and dates of when 3 hours dementia training is due for each one. This list will be given to Dept Leaders each month so they can remind staff working in their departments of the training due. If not completed by required date, dept leader will remove the employee from the schedule until training can be completed. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: BOM/designee will review any new hires for appropriate completed dementia training as well as, employees requiring 3 hour training. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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R000000	The following State Residential findings cited are in accordance with 410 IAC 16.2.	R000000	This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the complaint survey which was conducted on July 3, 2013. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective August 2, 2013. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.				

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure the facility had one staff member with a current first aid certificate and/or CPR (cardiopulmonary resuscitation) certificate, scheduled for 15 of 39 shifts reviewed. (June 09-21 2013).</p> <p>Findings include:</p>	R000117	<p>August 2, 2013 R-117Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: No residents were affected. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Audit completed of current staff regarding who has CPR and first aid certification.</p>	08/02/2013			

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	<p>Schedules for the month of June 2013 were reviewed on 07/01/13 at 8:30 a.m., the schedules indicated there were no staff members who were first aid and/or CPR certified on day shift for dates 06/09/13, 06/15/13, 06/16/13, evening shift 06/10/13, 06/12/13, 06/13/13, 06/14/13, 06/15/13, 06/16/13, 06/17/13, 06/18/13, 06/19/13, 06/20/13, 06/21/13, and night shift 06/17/13, and 06/19/13.</p> <p>Interview with Director of Health Services on 07/01/13 at 10:00 a.m., indicated that there were no first aid and/or CPR certified staff scheduled on the above dates.</p>		<p>Director of Health Services/designee is setting up CPR with first aid training for nursing staff to ensure CPR with first aid training certification is completed by enough staff to cover every shift everyday as per regulation. What measures put into place to ensure that the deficient practice does not recur? Newly Hired Nurses will be set up for CPR with first aid training by Director of Health services/designee going forward. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>Director of Health Services/designee will review any new nursing hires for appropriate completed CPR and first aid certification. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is achieved.</p>	

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R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 resident's reviewed for individual needs assessments in a total sample of 7. (Resident #115)</p> <p>Findings include:</p> <p>Resident #115's record was reviewed on 06/28/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, anxiety, depression. The resident was admitted into the facility on 03/29/13.</p> <p>There was a lack of documentation in the resident's record to indicate a Pre-Admission Evaluation had been completed on the resident prior to being admitted into the facility.</p> <p>During an interview on 07/01/13 at 9:05 a.m., the Corporate RN indicated there was no Pre-Admission</p>	R000214	<p>August 2, 2013 R-214 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #115 has an evaluation at this time identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Residential residents were reviewed for appropriate Evaluations and all have evaluations at this time. What measures put into place to ensure that the deficient practice does not recur? Director of Health Services/designee will inservice nursing staff and Admissions staff on the importance of completing a Pre-Admission Evaluation for each residential resident prior to Admission to our residential facility areas as well as the evaluation form to be used. How the corrective measures will be monitored to ensure the alleged deficient</p>	08/02/2013			

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	Evaluation completed for the resident.		practice does not recur: Director of Health Services/designee will review any new residential resident in the Clinical meetings Monday- Fridays for appropriate completed Pre-Ad mission Evaluation. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is achieved.		

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to assess a resident for self administrating medications for 1 of 1 resident reviewed for self administration of medication in a total sample of 7. (Resident #115)</p> <p>Findings include: Resident #115's record was reviewed on 06/28/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, anxiety, depression. The resident was admitted into the facility on 03/29/13.</p> <p>There was a lack of documentation in the resident's record to indicate an assessment was completed for self</p>	R000216	<p>August 2, 2013 R-216 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident 115 does not self administer medications. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: Current residents were reviewed and there is not any residents self administering medications. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nursing staff have been inserviced that if a resident requests to self administer medications that a self administration assessment</p>	08/02/2013			

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	<p>administration medication .</p> <p>During an interview on 06/28/13 at 1:15 p.m., Resident #115 indicated that he administered some of his medications and keeps them in his drawers in his room.</p> <p>During an interview on 07/01/13 at 9:00 a.m., LPN #39 indicated that an assessment for self administering medications was not done for this resident.</p>		<p>will be completed to ensure resident an self administer medications safely. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS/designee will review any resident request for self administration medication to ensure self administration assessment is completed at the time of the request. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly thereafter until 100% compliance is obtained.</p>		

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R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure food was prepared in accordance with sanitary food handling standards, related to lack of hair covering. This had the potential to affect 27 residents in the facility, who resided in the Assisted Living Unit who received food prepared in the Health Center Kitchen. (Health Center Kitchen)</p> <p>Findings included:</p> <p>During the kitchen tour on 6/24/13 at 8:40 a.m., kitchen staff was observed wearing hats without hair nets during food preparation. Dietary #45 was observed with her hair braided down on the back of her neck without a hair net on.</p> <p>On 6/24/13 at 12:00 p.m., Dietary #45 was observed wearing a hat with her hair braided down on the back of her neck without a hair net on.</p> <p>An interview with Dietary #45 during this time, indicated the kitchen personnel don't wear hair nets with</p>	R000273	<p>August 2, 2013 F-273 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Dietary #45, 46 and 22 all were inserviced on proper hair restraint. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions take: DFS/designee will inservice current dietary staff on proper hair restraint. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DFS/designee will inservice dietary staff, nursing staff and department leaders on proper hair restraint. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DFS/designee will audit 3 meals (1 breakfast, 1 lunch, and 1 dinner) for staff following proper hair restraint. Audits will be reviewed during Quality Assurance meeting monthly x 6 months and then quarterly</p>	08/02/2013			

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	<p>hats on.</p> <p>On 6/26/13 at 4:50 p.m., Dietary #46, was observed wearing a hat with her hair braided down on the back of her neck with long loose hair observed coming out around the ears and down the side of her face. During the meal service, Dietary #22 took over for Dietary #46 and finished the meal service. Dietary #22 was observed with her hat and hair net, but had large strands of hair down the side of her face.</p>		<p>thereafter until 100% compliance is obtained.</p>		