STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the investigation of Complaints IN00144135 and IN00144481 Complaint IN00144135-Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F514. Complaint IN00144481 - Substantiated. Federal/State deficiencies related to the allegations are cited at F312, F315, and F514. Survey dates: February 26, 27, and 28, 2014 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Surveyor: Betty Retherford, RN Census bed type: SNF/NF: 67 SNF: 18 Total: 85 Census payor type: Medicare: 21	F000000	The following Plan of Correction constitues our written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.	

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

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

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	Medicaid: 53 Other: 11 Total: 85 Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure each resident received assistance with eating in a timely manner for 1 of 2 residents reviewed for assistance with dining in a sample of 6. (Resident #G) Findings include: During an observation of the lunch meal on 2/27/14 at 12:20 p.m., the following was noted:	F000312	1. Resident G has been placed at a total assist table until condition improves. 2. All residents who need assistance with eating have the potential to be affected. Rounds made to identify any other resident who needs assistance with eating. 3. Nursing staff inserviced on assisting residents with eating in the dining room. 4. DON/Designee will perform a daily audit five days a week to ensure all residents whom need assistance with eating are assisted in a timely manner for four weeks, then weekly for eight weeks, then monthly times three. Results of	03/30/2014

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	Resident #G was up in her wheelchair in the dining room at a dining room table on 2/27/14 at 12:20 p.m. Resident #G was awake. The three other residents at her table had been served and were feeding themselves. Resident #G was sitting slightly reclined in her reclining wheelchair. Her food was sitting in front of her on the dining room table. Her pie was covered with plastic. Her milk had not been opened. Her silverware was still wrapped in her napkin. No food had been eaten. Resident #H (one of Resident #G's tablemates) looked over at CNA #1 who was feeding another resident at the next table and said, "Aren't you going to help her?" (referring to Resident #G). CNA #1 indicated yes, she would help her and left the resident she was assisting, walked over to Resident #G, and began to open her milk, silverware, etc and prepare her meal. She then began to assist Resident #G. This occurred at 12:33 p.m. Within a few minutes, CNA #3, came into the dining room. She began to assist Resident #G and CNA #1 returned to the first resident she had been assisting.		the audits will be forwarded to QA for review times twelve months. Date of Completion: March 30, 2014.	

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	CNA #3 (who was feeding Resident #G) was interviewed on 2/27/14 at 12:55 p.m. She indicated Resident #G was still eating, but had already consumed around 75% of her meal. The clinical record for Resident #G was reviewed on 2/27/14 at 2:05 p.m. Diagnoses for the resident included, but were not limited to, late effects of cerebrovascular accident, dysphagia, senile dementia, and history of malnutrition. The clinical record indicated the resident was now receiving hospice services. A significant change Minimum Data Set assessment, dated 12/17/13, indicated the resident was cognitively impaired and required the assistance of one staff member for all activities of daily living. A health care plan problem, dated 12/12/13, indicated Resident #G had a terminal prognosis related to malnutrition and was receiving hospice services. One of the approaches for this problem was "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, and physical and social needs are met". This federal tag relates to Complaint			

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	IN00144481. 3.1-38(a)(3)(B)			
F000315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a resident with a urinary tract infection was followed-up on in a timely manner to ensure prompt treatment of the urinary tract infection resulting in a decline in the resident's physical condition and need for hospital admission for 1 of 2 residents reviewed for treatment of urinary tract infections in a sample of 6. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 2/26/14 at 2 p.m. Diagnoses for the resident included, but were not limited to, alcoholic	F000315	1. Unable to correct due to resident B no longer resides at the facility. 2. All residents with Urinary Tract infections have the potential to be affected. An audit was completed on residents with abnormal urinary cultures over the last thirty days to ensure that test results were reported to physician and new orders received. 3. Nursing staff inserviced on laboratory reporting. In daily morning meeting, team will review all abnormal urinary cultures cultures to ensure physician notification and follow up. 4. DON/Designee will perform a daily audit five days a week for four weeks to ensure the physician was notified and orders were obtained of any residents with abnormal urinary cultures. Then, weekly for eight weeks and then monthly times three. Results	03/30/2014

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	cirrhosis of the liver, acute renal failure, diabetes mellitus, and anemia of chronic disease. The clinical record indicated the resident received outpatient dialysis services three times a week on Mondays, Wednesdays, and Fridays. A quarterly Minimum Data Set assessment, dated 1/21/14, indicated Resident #B was severely cognitively impaired, required extensive assistance from the staff for toileting, and was occasionally incontinent of bowel and bladder. A nursing note, dated 1/11/14 at 12:11 p.m., indicated the resident's family was concerned about her and requested a urine test for possible infection. The facility contacted the physician and an order was obtained for a urinalysis and culture and sensitivity (u/a and C&S). An in and out catheterization was done and "rusty colored, cloudy" urine was obtained and sent to the lab for testing. A laboratory report, dated 1/11/14 at 9:21 a.m., indicated multiple abnormal results including the presence of blood, bulirubin, protein, and "few bacteria".		of the audits will be forwarded to QA for review times twelve months. Date of Completion: March 30, 2014.	

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	A nursing note, dated 1/11/14 at 1:21 p.m., indicated the resident's family and physician were notified of the u/a report. The note indicated the physician was awaiting the C&S results. The C&S report, dated 1/14/14, indicated the urine was positive for Vancomycin-resistant Enterococcus (VRE). The report indicated the organism was only sensitive to the antibiotics Linezolid and Quinupristin/Dalfopristin. A nursing note, dated 1/14/14 at 5:49 p.m., indicated the physician had been notified of the report and no new orders were received at that time. The physician wanted the reports to be faxed to his office in the morning for further review. A nursing note, dated 1/15/14 at 4:03 p.m., indicated a new order had been received for a one time only dose of Levaquin 250 mgs (milligrams) and the staff were to send the u/a and C&S reports to dialysis for nephrology to review and order treatment due to the resident's renal status. The next nursing note related to any follow-up from the C&S report was			

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	dated 1/21/14 at 3 p.m. The note indicated "Spoke with [name of dialysis employee] at dialysis clinic and updated on resident status as we had sent lab results to clinic and had received no response at this time dialysis clinic asked that lab results be sent again and states 'we do not typically treat an infection unless at the access site'. Explained to [name of dialysis employee] that [name of doctor] had given a initial dose of antibiotic but was hesitant to treat further due to renal function and would like the nephrologist to be made aware of the results as well." A nursing note, dated 1/21/14 at 3:08 p.m., indicated contact had been made with the resident's nephrologist and he was "updated on urinalysis positive for VRE and physician requesting nephrologist notified and concern for kidney function with treatment. [name of nephrologist] states 'he does not need to worry about renal function as hers is gone he should only renally dose her medications and treat her.' No further orders received at this time...." A nursing note, dated 1/21/14 at 3:31 p.m., indicated the resident's physician was notified of the			

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	nephrologist's comments. No new antibiotic orders were received at that time. An SBAR (Situation, Background, Assessment, Recommendation) report, dated 1/22/14 at 1:19 p.m., indicated the resident had returned from her dialysis treatment at 11:30 a.m. and had been "somewhat lethargic" at that time. Her accucheck at that time was 98. The assessment indicated the resident developed increased confusion, decreased consciousness, and needed more assistance with activities of daily living. The note indicated an accucheck taken at 1 p.m. indicated the resident's blood sugar was 30. Glucagon (a medication that increases the blood sugar) was given. The assessment indicated the resident's family arrived and requested the resident be transported to the ER. An emergency room "Progress Note", dated 1/22/14 at 3:25 p.m., included, but was not limited to, the following: ...History of Present Illness The patient presents with altered mental status, confusion as well as			

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	hypoglycemia. The onset was 2 weeks ago. The course/duration of symptoms is fluctuating in intensity.... ...Additional history: ...Patients daughter, who is her POA [power of attorney] states that over the last 2 weeks patient has been increasingly confused and has been refusing physical therapy at the nursing home. On Jan. 11th she had a UA and UC [urine culture] done in view of her waxing and waning LOC [level of consciousness] and was found to have VRE in her urine which was only sensitive to Linezolid...." The emergency room progress note also indicated the "Differential Diagnosis" was "dementia, urinary tract infection, delirium, possibly hepatic encephalopathy, not confusion". Multiple lab tests had been completed in the emergency room. Her urinalysis showed "many" bacteria. Her blood ammonia level was also elevated. The note indicated the resident would need to be admitted in view of elevated ammonia levels and urinary tract infection. The note indicated Linezolid and lactulose (a medication given to decrease blood ammonia levels) treatment had been			

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	started. The note indicated an intravenous treatment of Linezolid 600 mgs had been started to infuse over two hours 1/22/14 at 3:15 p.m. The Administrator and DoN were interviewed on 2/28/14 at 10:50 a.m. Additional information was requested related to the delay in obtaining medical treatment for Resident #B's urinary tract infection noted on 1/14/14. The dialysis center was to be contacted for treatment at the request of the resident's physician on 1/15/14. The clinical record lacked any contact with the dialysis center until 1/21/14. This indicated a time period of six days from the date the physician requested the dialysis center order treatment for the resident and a follow-up response from the dialysis center was obtained. The DoN, Assistant DoN (ADoN) and RN Consultant were interviewed on 2/28/14 at 3:40 p.m. The ADoN indicated she had reviewed the unit calendar (not part of the clinical record) which indicated contact had been made with the dialysis center on January 15, 16, and 17, 2014 related to urinalysis follow-up, but no orders had been received. She indicated she called the nephrologist			

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	herself (instead of going thru the dialysis center) on 1/21/14 and had then relayed the nephrologist's response to the resident's attending physician. This indicated a delay in six days before treatment information was obtained from the nephrologist as requested by the resident's attending physician on 1/15/14. Review of the current facility policy, revised 5/2012, provided by the DoN on 2/28/14 at 3:45 p.m., titled "Laboratory - Test Processing and Reporting", included, but was not limited to, the following: "Purpose: To assure physician-ordered diagnostic tests are performed, and to assure that test results are promptly reported to the physician. ...Standards: ...4. A nurse is responsible for monitoring all test results received...." This federal tag relates to Complaint IN00144481. 3.1-41(a)(2)			

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F000323 SS=D	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 record review and interview, the facility failed to ensure residents identified at risk for falls received supervision to prevent falls and/or had interventions in place to prevent possible falls for 2 of 4 residents reviewed for fall safety in a sample of 6. (Resident #'s D and E) Findings include: 1.) The clinical record for Resident #D was reviewed on 2/26/14 at 12:45 p.m. Diagnoses for Resident #D included, but were not limited to, history of stroke with marked right arm paresis and moderate right leg paresis, dysarthria, muscle weakness, and history of heart valve replacement. An admission Minimum Data Set assessment, dated 7/29/13, indicated the resident was moderately cognitively impaired and required extensive assistance of two staff members for transfers, ambulation, and toileting.	F000323	1. Resident D - Unable to correct due to resident no longer resides at the facility. Resident E - Discontinued the care plan intervention - use of nonskid socks due to resident refusal.. Added a dual-headed call light due to resident laying upside down in bed at times. Also, discontinued the care plan intervention - keep frequently used items within reach. 2. All residents have the potential to be affected. All fall care plans will be reviewed and updated as needed. 3. Nursing staff inserviced on fall prevention and procedure. 4. DON/Designee will perform a daily audit five days a week on five residents to ensure fall interventions are in place for four weeks, then weekly for eight weeks, then monthly times three. Results of the audits will be forwarded to QA for review times twelve months. 5. Date of Completion: March 30, 2014.	03/30/2014

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	A hospital "Discharge to Skilled Care" record for Resident #D, dated 7/22/13, indicated "fall precautions" should be considered for the resident. The Admission Nursing Assessment, dated 7/22/13 at 3:45 p.m., for Resident #D was incomplete in the following areas: "Ambulation/mobility, Physical function status, and Supportive Devices." These areas had been left blank. The assessment indicated the resident had fallen at least once or twice in the past 3 months. The husband of Resident #D was interviewed on 2/26/14 at 7:45 p.m. He indicated he was upset over falls his wife had incurred while she was a resident in the facility. He indicated the CNA's had not used a gait belt when they ambulated his wife and she fell off of the toilet while being assisted by the CNA's and then fell backwards hitting her head on the wall under and behind the sink. He indicated they had not provided any walker or wheelchair for the resident to use. The progress notes (nursing notes)			

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	for 7/23/14 lacked any information related to a fall occurring on the morning of 7/23/13 (the morning after her admission). A progress note, dated 7/24/14 at 4:21 p.m., indicated "IDT [interdisciplinary team] met and reviewed fall - resident to be evaluated by therapy for transfers and ambulation...." The Administrator, DoN, and RN Consultant were interviewed on 2/28/14 at 10:20 a.m. Additional information was requested to the lack of any fall information for Resident #D on 7/23/14. The RN Consultant was interviewed on 2/28/14 at 11:30 a.m. She provided a copy of a facility fall investigation (not part of the clinical record) that indicated Resident #D did have a fall on the morning of 7/23/14. A description of the fall was noted on the investigation form. The investigation indicated the resident had fallen off of the toilet after being assisted to the bathroom by two CNAs. The note indicated assessments and neurochecks were done. The resident was not injured. The investigation lacked any information related to whether the			

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	CNAs were using a gait belt or any other equipment at the time of the fall. Under the section titled "Immediate Action Taken" was "Description: Staff equipped with gate (sic) belts, wheelchair provided for transportation, personal alarm in place, complete assessment done by this nurse with vital signs taken." CNA #1 was interviewed on 2/28/14 at 2:30 p.m. CNA #1 indicated she had assisted Resident #D to the bathroom on the morning of 7/23/13. She indicated she had not received any information about the resident's ambulatory status from the nursing staff prior to assisting the resident to the bathroom. She indicated there was no walker or wheelchair in the room yet because the resident had not yet been evaluated by the therapy department. She indicated CNA#2 had helped her ambulate the resident to the bathroom that morning. She indicated they did use a gait belt on the resident. She indicated CNA #2 had kneeled down to put the resident's shoes on the resident and she had turned to the sink to wet washcloths for peri care when the resident slid off of the toilet to the floor and then fell backwards			

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	and her head made contact with the wall. CNA #1 indicated she was unable to grab the resident and prevent the fall. CNA #1 indicated they did not move the resident at that time, but obtained the nurse on duty to assess the resident. CNA #2 was interviewed on 2/28/14 at 3:05 p.m. CNA #2 indicated she had assisted Resident #D to the bathroom on the morning of 7/23/13. She indicated she had not received any information about the resident's ambulatory status from the nursing staff prior to assisting the resident to the bathroom. She indicated there was no walker or wheelchair in the room yet because the resident had not yet been evaluated by the therapy department. She indicated CNA #1 had helped her ambulate the resident to the bathroom that morning. She indicated they did use a gait belt on the resident. She indicated she was kneeling down to put the resident's shoes and socks on when CNA #1 turned to the sink to wet washcloths for peri-care when the resident slid off of the toilet to the floor and then fell backwards and her head made contact with the wall. CNA #2 indicated she was unable to grab the resident and prevent the fall. CNA #2 indicated			

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	they did not move the resident at that time, but obtained the nurse on duty to assess the resident. 2.) During an observation on 2/27/14 at 9:05 a.m., Resident #E was observed to be lying in bed. The resident's feet were sticking out from under the covers and his feet were bare. The resident's call light was clipped to it's own cord and was hanging up on the wall at the end of the resident's bed. The call light was not within the resident's reach. Housekeeper #4 was cleaning in the resident's bathroom. When asked if the resident could reach his call light, she indicated "no". She then unclipped the call button from the cord on the wall and placed it within reach of the resident. During an observation on 2/28/14 at 8:50 a.m., Resident #E was lying in bed. The resident's feet were sticking out from under the covers and his feet were bare. The resident's over the bed table (containing water and personal items) was approximately two feet away from the bed. The resident's walker was at the foot of the bed and approximately 18 inches away from the bed.			

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	The clinical record for Resident #E was reviewed on 2/27/14 at 9:40 a.m. Diagnoses for the resident included, but were not limited to, chronic obstructive asthma, chronic pain, and dementia with behavior disturbances. A quarterly Minimum Data Set assessment, dated 1/31/14, indicated the resident required the assistance of one staff member for toileting and transfers. The assessment indicated the resident used a walker. The clinical record indicated the resident had a history of two falls on 2/13/14 and one fall on 2/16/14. A health care plan problem, revised on 2/17/14, indicated the resident was at risk for falls due to a history of falls, dementia, and antipsychotic medication use. Two of the approaches for this problem were "Gripper socks applied" and "Keep frequently used items in reach". A health care plan problem, revised on 12/2/13, related to the resident's potential for incontinence and the need for staff assistance, indicated "Encourage resident to use call light for assistance with toileting."			

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	3.) Review of the current facility policy, dated 8/2013, provided by the RN Consultant on 2/28/14 at 2:45 p.m., titled "Fall Evaluation and Investigation", included, but was not limited to, the following: "Purpose: 1. To detect room cause of falls to extent possible and to identify supportive aides to prevent falls. 2. To identify high-risk residents and implement interventions to reduce falls and the consequences of falls. Policy: ...2. All residents will have a care plan developed by the interdisciplinary team. This federal tag relates to Complaint IN00144135. 3.1-45(a)(2)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented in regards to accuchecks, insulin administration, fall documentation, admission assessment information, and dialysis center contact for 2 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 6. (Resident #'s B and D) Findings include: 1.) The clinical record for Resident #B was reviewed on 2/26/14 at 2 p.m. Diagnoses for the resident included, but were not limited to, alcoholic cirrhosis of the liver, acute renal failure, diabetes mellitus, and	F000514	1. Resident B and D - Unable to correct due to resident no longer resides at the facility. 2. All residents have the potential to be affected. All fall care plans have been reviewed and updated as needed. All dialysis resident charts will be reviewed for the last thirty days for any physician request for the facility to contact the dialysis center for treatment orders. Medication administration record reviewed for residents who receive accuchecks and insulin for completeness. An Admission Assessment audit was completed on all new residents in the last thirty days to ensure completeness. 3. Nursing staff inserviced on documentation. If the physician requests that the facility contact the dialysis center for treatment orders, it will be documented in the resident's clinical record. 4. DON/Designee	03/30/2014

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	anemia of chronic disease. The clinical record indicated the resident received outpatient dialysis services three times a week on Mondays, Wednesdays, and Fridays. A nursing note, dated 1/11/14 at 12:11 p.m., indicated the resident's family was concerned about her and requested a urine test for possible infection. An order was obtained for a UA (urinalysis) with C&S (culture and sensitivity) and a urine specimen was sent to the lab for testing. The C&S report, dated 1/14/14, indicated the urine was positive for Vancomycin-resistant Enterococcus (VRE). The report indicated the organism was only sensitive to the antibiotics Linezolid and Quinupristin/Dalfopristin. A nursing note, dated 1/15/14 at 4:03 p.m., indicated a new order had been received for a one time only dose of Levaquin (an antibiotic) 250 mgs (milligrams) and the staff were to send the u/a and C&S reports to dialysis for nephrology to review and order treatment due to the resident's renal status. The next nursing note related to any		will perform weekly audits times four to ensure that any physician requests for the facility to contact the dialysis center for treatment orders was documented within the clinical record. Then, audit weekly for eight weeks and monthly times three thereafter. Results of the audts will be forwarded to QA for review times twelve months. EMR/Designee will perform an Admission Assessment audit on all new residents admitted to the facility to ensure completeness. This audit will be ongoing. Results of the audits will be forwarded to QA for review times twelve months. DON/Designee will perform a daily audit five days a week for four weeks to ensure all residents with a fall has appropriate documentation, then weekly for eight weeks, then monthly times three. Results of the audits will be forwarded to QA for review times twelve months. 5. Date of Completion: March 30, 2014.	

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	follow-up from the C&S report was dated 1/21/14 at 3 p.m. The note indicated "Spoke with [name of dialysis employee] at dialysis clinic and updated on resident status as we had sent lab results to clinic and had received no response at this time dialysis clinic asked that lab results be sent again and states 'we do not typically treat an infection unless at the access site'. Explained to [name of dialysis employee] that [name of doctor] had given a initial dose of antibiotic but was hesitant to treat further due to renal function and would like the nephrologist to be made aware of the results as well." The Administrator and DoN were interviewed on 2/28/14 at 10:50 a.m. Additional information was requested related to the delay in obtaining medical treatment for Resident #B's urinary tract infection noted on 1/14/14. The dialysis center was to be contacted for treatment at the request of the resident's physician on 1/15/14. The clinical record lacked any contact documentation with the dialysis center until 1/21/14. This indicated a time period of six days from the date the physician requested the dialysis center order treatment for the resident and a follow-up			

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	response from the dialysis center was obtained. The DoN, Assistant DoN (ADoN) and RN Consultant were interviewed on 2/28/14 3:40 p.m. The ADoN indicated she had reviewed the unit calendar (not part of the clinical record) which indicated contact had been made with the dialysis center on January 15, 16, and 17, 2014 related to the urinalysis report and request for follow-up, but no orders had been received. She indicated the nursing staff had failed to document the dialysis contact information in the clinical record. The January, 2014 Medication Administration Record (MAR) for Resident #B indicated the resident was to receive Lantus Solution 30 units twice daily at 5 a.m. and 8 p.m. The MAR lacked any information related to the insulin having been given at 5 a.m. on 1/14 and 1/18/14. Both areas were blank. The January,2014 and February, 2014 MAR indicated sliding scale insulin coverage was to be given four times daily based on accucheck results at 5 a.m., 12 noon, 5 p.m., and 9 p.m. The MAR lacked any accucheck results for 1/4, 1/10, and			

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	1/14/14 at 5 a.m. The areas were blank. The MAR lacked any accucheck results for 2/2/14 at 12 noon. The area was blank. The Administrator and DoN were interviewed on 2/28/14 at 10:50 a.m. Information was requested related to the lack of insulin and accucheck documentation noted above. The facility failed to provide any additional information as of exit on 2/28/14. 2.) The clinical record for Resident #D was reviewed on 2/26/14 at 12:45 p.m. Diagnoses for Resident #D included, but were not limited to, history of stroke with marked right arm paresis and moderate right leg paresis, dysarthria, muscle weakness, and history of heart valve replacement. The Admission Nursing Assessment, dated 7/22/13 at 3:45 p.m., for Resident #D was incomplete in the following areas: "Ambulation/mobility", Physical function status", and "Supportive Devices." These areas had been left blank. The assessment indicated the resident had fallen at least once or twice in the past 3 months.			

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	The husband of Resident #D was interviewed on 2/26/14 at 7:45 p.m. He indicated he was upset over falls his wife had incurred while she was a resident in the facility. He indicated he had observed two CNAs' assist the resident with walking from her bed to the bathroom on the morning after she was admitted. He indicated the CNAs did not use a gait belt or any other equipment when ambulating the resident. The progress notes (nursing notes) for 7/23/14 lacked any information related to a fall occurring on the morning of 7/23/13 (the morning after her admission). A progress note, dated 7/24/14 at 4:21 p.m., indicated "IDT [interdisciplinary team] met and reviewed fall - resident to be evaluated by therapy for transfers and ambulation...." The Administrator, DoN, and RN Consultant were interviewed on 2/28/14 at 10:20 a.m. Additional information was requested related to the lack of any nursing notes for the fall occurring on 7/23/14..			

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	The RN Consultant was interviewed on 2/28/14 at 11:30 a.m. She provided a copy of a facility fall investigation (not part of the clinical record) that indicated Resident #D did have a fall on the morning of 7/23/14. A "nursing description" of the fall was noted on the investigation form. The description indicated the resident had fallen off of the toilet after being assisted to the bathroom by two CNAs. The note indicated assessments and neurochecks were done. The description lacked any information related to whether the CNAs were using a gait belt at the time of the fall. The RN Consultant indicated the "nursing description" of the fall noted previously should also have been documented in the progress notes (which is part of the clinical record), but the nurse on duty at the time of the fall had failed to document it both places. 3.) Review of the current facility policy, dated 1/2012, provided by the RN Consultant on 2/28/14 at 2:45 p.m., titled "Documentation Procedure and Guidelines", included, but was not limited to, the following:			

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	"Purpose: 1. To reflect the quality of care provided to each resident. 2. To document the resident's progress toward care plan goals, interventions and responses to treatment.... ...General Guidelines: An admission evaluation will be entered at the time of admission with data collected as appropriate.... Nursing Documentation: 1. Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable. ...3. Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner... 7. Verbal and telephone communication with all parties concerning the care and treatment of the resident will be entered in the			

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	clinical record...." This federal tag relates to Complaint IN00144135 and IN00144481. 3.1-50(a)(1) 3.1-50(a)(2)			