

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00201733, IN00201757, & IN00200565.</p> <p>Complaint IN00201733-Substantiated. Federal/State deficiencies related to the allegations are cited at 282.</p> <p>Complaint IN00201757-Substantiated. Federal/State deficiencies related to the allegations are cited at 282, 309, & 502.</p> <p>Complaint IN00200565-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 15, 16, 17, 20, 21, 22, & 23, 2016.</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Census Bed Type: SNF: 2 SNF/NF: 78 Total: 80</p> <p>Census Payor Type:</p>	F 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. The facility is kindly requesting consideration of paper compliance.	

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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F 0157 SS=D Bldg. 00	<p>Medicare: 2 Medicaid: 50 Other: 28 Total: 80</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 30, 2016</p> <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>			

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	<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 interview and record review, the facility failed to notify the physician medication was not available to administer as ordered, and the refusal of a lab for 1 of 6 residents reviewed for unnecessary medications. (Resident #C)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #C was reviewed on 6/17/16 at 9:27 a.m. The diagnoses for Resident #C included, but were not limited to: insomnia, and mixed hyperlipidemia.</p> <p>A physician order dated, 12/22/14, indicated the staff was to administer melatonin 5mg (milligrams) by mouth to Resident #C for insomnia.</p> <p>A physician order dated, 4/29/16, indicated the staff was to administer monistat 7 simply cure cream 2% to</p>	F 0157	<p>F157 D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>RC received her med when it arrived.</p> <p>RC had lab orders reviewed</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>DNS/Designee will review nurse's notes during Clinical StartUp to ensure any medication not available or if lab refused that physicians have been notified.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not</p>	07/19/2016

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	<p>Resident #C. The directions on the order was to "insert 1 applicatorful vaginally at bedtime for yeast infection until 5/6/16".</p> <p>A physician order dated, 10/26/15, indicated the staff was to administer to Resident #C a docusate capsule by mouth two times a day for constipation.</p> <p>A physician order dated, 1/22/16, indicated the staff was to administer 600mg of gemfibrozil by mouth two times a day for HLD (hyperlipidemia) to Resident #C.</p> <p>A physician note dated 4/29/16, indicated "...Chief Complaint/Nature of Presenting Problem: Vaginal yeast infection. History of Present Illness:...evaluated for an acute visit due to having a vaginal yeast infection...She (Resident #C) was recently treated for vaginal yeast infection but it did not completely resolve. She is bothered with discharge and irritation in her vaginal area she states...DIAGNOSIS, ASSESSMENT AND PLAN..I will order monistat vaginal cream 1 applicatorful per vagina/labia daily x (times) 7 days."</p> <p>The April, May, and June 2016, Medication Administration Records (MAR) indicated Resident #C did not receive the following medications, days</p>		<p>recur are as follows:</p> <p>DNS/Designee will review nurse's notes during Clinical StartUp to ensure any medication not available or if lab refused that physicians have been notified.</p> <p>Licensed staff educated on Notification of Change by July19, 2016.</p> <p>These corrective actions will be monitored and a qualityassurance program implemented to ensure the deficient practice will not recurper the following:</p> <p>DNS/Designee will review IPNs 5 x a week for 4 weeks. Then 3 times a weekfor 4 weeks, then weekly during Clinical Start Up</p> <p>DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan writtenand interventions implemented.</p>	

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	<p>and times:</p> <p>melatonin - April 29th - 9:30 p.m., melatonin - April 30th - 9:30 p.m.,</p> <p>monistat 7 simply cure cream - April 29th - 9:00 p.m., monistat 7 simply cure cream - April 30th - 9:00 p.m., monistat 7 simply cure cream - May 1st - 9:00 p.m., monistat 7 simply cure cream - May 2nd - 9:00 p.m.,</p> <p>docusate - May 24th - 9:00 p.m., docusate - May 25th - 9:00 p.m.,</p> <p>gemfibrozil - June 4th - 9:00 a.m.,</p> <p>The April 2016, MAR indicated Resident #C received the monistat 7 simply cure cream 4 of the 7 days as ordered by the physician (May 3rd, May 4th, May 5th, and May 6th).</p> <p>An "e-MAR-Medication Administration Note" dated, 4/30/16 at 12:00 a.m., indicated "Melatonin Capsule by mouth at bedtime for insomnia supply out"</p> <p>An "e-MAR-Medication Administration Note" dated, 4/29/16 at 8:47 p.m., indicated "Monistat 7 cream not available Pharmacy notified"</p>			

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	<p>An "e-MAR-Medication Administration Note" dated, 4/30/16 at 9:51 p.m., indicated "Monistat 7 cream not available. Pharmacy notified"</p> <p>An "e-MAR-Medication Administration Note" dated, 5/1/16 at 8:57 p.m., indicated "Monistat 7 cream not available, Pharmacy notified"</p> <p>The May 2016, MAR indicated on 5/2 for Monistat the nursing staff entered a number "7". The chart codes indicated "7 = Other/see nurses notes." The nursing note indicated "An e-MAR-Medication Administration Note" dated, 5/2/16 at 10:28 p.m., indicated "not available at this time"</p> <p>An "e-MAR-Medication Administration Note" dated, 5/24/16 at 10:13 p.m., indicated "Dok (docusate) cap (capsule) 250mg one tab (tablet) po (mouth) not available. Pharmacy notified."</p> <p>An "e-MAR-Medication Administration Note" dated, 5/25/16 at 8:45 p.m., indicated "Dok Cap 250mg one tab po not available. Pharmacy notified."</p> <p>The June 2016, MAR indicated on 6/4 for gemfibrozil a number "7" was entered. The chart codes indicated</p>			

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	<p>"7=Other/See nurses notes" The nursing notes indicated "An e-MAR-Medication Administration Note" dated, 6/4/16 at 10:00 a.m., indicated "on order".</p> <p>There was no documentation in the progress notes the physician was aware medications were not available to administer.</p> <p>An interview was conducted on 6/17/16 at 11:00 a.m., with license practical nurse (LPN) #2. She indicated the monistat was not available to start. LPN #2 indicated if the progress notes do not have the physician was notified than it was not done.</p> <p>An interview was conducted on 6/22/16 at 10:00 a.m., with the Director of Nursing Services (DNS). The DNS indicated the physician should be notified if a resident misses a dose of medication.</p> <p>1b. A physician order dated, 12/15/15, indicated a lab draw of a CMP (comprehensive metabolic panel) was to be done on Resident #C every 6 months in April and October.</p> <p>A progress note dated, 4/13/16, indicated "Resident refused AM Lab for CMP. she stated she ask the Lab Tech which Lab was being drawn and Tech would not tell</p>			

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	<p>her. this Writer went into room to inform Resident of lab work that was ordered and see if she would let the Lab Tech draw it. Resident then stated that she did not like being awoken at 3:30am (sic) and that the Tech was rude to her."</p> <p>A lab document was provided on 6/21/16 at 10:09 a.m., by the DNS. It indicated "...Reported 4/13/16. Specimen Collected 4/13/16...Refusal (FIRST ATTEMPT) resident has refused lab work for today. We will try to obtain specimens two more times and then order will be discontinued due to residents wishes. Please inform physician of patient's refusal for lab work..."</p> <p>An interview was conducted with the DNS on 6/21/16 at 10:09 a.m. She indicated the physician should have been notified Resident #C refused the lab draw.</p> <p>A "Lab Processing/Tracking Guideline" was provided on 6/22/16 at 9:23 a.m., by the DNS. It indicated "GUIDELINE STATEMENT" To ensure that Diagnostic tests are processed, ordered, obtained, performed, and results received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record."</p>			

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F 0225 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <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</p>			

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse immediately for 1 of 2 residents reviewed for abuse. (Resident #126)</p> <p>Findings include:</p> <p>The clinical record for Resident #126 was reviewed on 6/22/16 at 9:00 a.m. The diagnoses for Resident #126 included, but were not limited to, paranoid personality disorder and postmenopausal bleeding.</p> <p>The completed investigation file was provided by the Director of Nursing Services (DNS) on 6/23/16 at 9:00 a.m. It included but were not limited to, an incident report submitted to the Indiana State Department of Health on 6/6/16, interviews from residents, staff, abuse policy, care plans for Resident #126, progress notes of the time of occurrence, and inservices provided to the staff.</p> <p>A progress note dated, 6/5/16 at 2:06 p.m., indicated "was called to residents room r/t (related to) reporting that staff</p>	F 0225	<p>F225D The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: The abuse allegation involving R126 was reported to ISDH as soon as management was informed. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows: Staff educated on reporting allegations immediately by 7/19/16 The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nurse that did not call management was disciplined and given one on one education. Licensed staff was given one on one education on reporting immediately. Staff was inserviced by 7/19/16 on reporting allegations. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur</p>	07/19/2016

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	<p>was sexually abusing her 'by wiping my bottom and sticking their fingers into my rectum and vagina'. She said that she 'had been abused, harassed, and verbally abused by many staff.' She said 'I want to have the prosecutor out here to see me.' She continued to yell and it was attempted to calm resident. She told me about her caregiver that was treated the same way and she died. She started to cry. I talked with her informed her she needed to speak with the social worker. She said that she spoken with her and other staff. 'They don't care' she replied. Staff was encouraged to attend to her needs only with 2 staff present."</p> <p>A progress note dated, 6/6/16, at 11:14 a.m., indicated "Writer and RNAC (Registered Nurse Assessment Coordinator) went resident's room 6/6 a.m. (sic) to interview in ref. (reference) to allegations and comments made over the weekend by resident to staff...Resident told writer and RNAC that she really liked the CNA (certified nursing assistant) who just helped with her bathing and said her weekend went fine. When asked if anything happened that she wanted to talk about, resident remained pleasant and positive and positive stating 'not really'..Resident was observed to show no s/s (signs or symptoms) of distress and made no</p>		<p>per thefollowing: Nursing notes will be audited daily 5 x a week for 4 weeks,3 times a week for 4 weeks, then once a week for 6 months. DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an Action plan written and interventions implemented</p>	

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	<p>reference to, and may not recall, her statements and allegations made earlier on Sunday to staff."</p> <p>A progress note dated, 6/6/16, at 2:30 p.m., indicated "Clarification of 6/5/16.: Resident is not alleging current abuse at this time by current staff that were providing care. Resident stated she was referring to an incident that happened in the past. Writer present while care being delivered and observed CNA providing pericare (care to privates) w/o (without) incident. Resident has a past hx (history) of making false accusations per care plan as reviewed by this writer."</p> <p>An investigation document, "Interview with name of staff (license practical nurse (LPN) #12) on 6/6/16 at 2:00 p.m., regarding name of resident (Resident #126)...When asked about her documentation regarding that 'staff was sexually abusing her by wiping my bottom and sticking their fingers inti (sic) my rectum and vagina' . Name of staff (LPN #12) stated that the resident stated that this incident had happened in the past not recently, so she did not report to management. Nurse then documented a clarification note in chart"</p> <p>An interview was conducted with the DNS on 6/23/16 at 12:42 p.m. She</p>			

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F 0226 SS=D Bldg. 00	<p>indicated this abuse allegation should have been reported immediately.</p> <p>An abuse policy was provided by the DNS on 6/23/16 at 11:00 a.m. It indicated "POLICY STATEMENT: It is the responsibility all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violation') are reporting immediately to the Executive Director or Director of Nursing of the Living Center."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident</p>			

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	<p>property. Based on interview and record review, the facility failed to implement the abuse policy to report an allegation of abuse immediately for 1 of 2 residents reviewed for abuse. (Resident #126)</p> <p>Findings include:</p> <p>The clinical record for Resident #126 was reviewed on 6/22/16 at 9:00 a.m. The diagnoses for Resident #126 included, but were not limited to, paranoid personality disorder and postmenopausal bleeding.</p> <p>The completed investigation file was provided by the Director of Nursing Services (DNS) on 6/23/16 at 9:00 a.m. It included but were not limited to, an incident report submitted to the Indiana State Department of Health on 6/6/16, interviews from residents, staff, abuse policy, care plans for Resident #126, progress notes of the time of occurrence, and inservices provided to the staff.</p> <p>A progress note dated, 6/5/16 at 2:06 p.m., indicated "was called to residents room r/t (related to) reporting that staff was sexually abusing her 'by wiping my bottom and sticking their fingers into my rectum and vagina'. She said that she 'had been abused, harassed, and verbally</p>	F 0226	<p>F226D The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: The abuse allegation involving R126 was reported to ISDH as soon as management was informed. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows: Staff educated on reporting allegations immediately by 7/19/16 The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nurse that did not call management was disciplined and given one on one education. Licensed staff was given one on one education on reporting immediately. Staff was inserviced by 7/19/16 on reporting allegations. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: Nursing notes will be audited daily 5 x a week for 4 weeks, 3 times a week for 4 weeks, then once a week for 6 months. DNS/Designee will report</p>	07/19/2016

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	<p>abused by many staff.' She said 'I want to have the prosecutor out here to see me.' She continued to yell and it was attempted to calm resident. She told me about her caregiver that was treated the same way and she died. She started to cry. I talked with her informed her she needed to speak with the social worker. She said that she spoken with her and other staff. 'They don't care' she replied. Staff was encouraged to attend to her needs only with 2 staff present."</p> <p>A progress note dated, 6/6/16, at 11:14 a.m., indicated "Writer and RNAC (Registered Nurse Assessment Coordinator) went resident's room 6/6 a.m. (sic) to interview in ref. (reference) to allegations and comments made over the weekend by resident to staff...Resident told writer and RNAC that she really liked the CNA (certified nursing assistant) who just helped with her bathing and said her weekend went fine. When asked if anything happened that she wanted to talk about, resident remained pleasant and positive and positive stating 'not really'..Resident was observed to show no s/s (signs or symptoms) of distress and made no reference to, and may not recall, her statements and allegations made earlier on Sunday to staff.."</p>		<p>findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>				

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	<p>A progress note dated, 6/6/16, at 2:30 p.m., indicated "Clarification of 6/5/16...: Resident is not alleging current abuse at this time by current staff that were providing care. Resident stated she was referring to an incident that had happened in the past. Writer present while care being delivered and observed CNA providing pericare (care to privates) w/o (without) incident. Resident has a past hx (history) of making false accusations per care plan as reviewed by this writer."</p> <p>A document, "Interview with license practical nurse (LPN) #12 on 6/6/16 at 2:00 p.m., regarding name of resident (Resident #126)...When asked about her documentation regarding that 'staff was sexually abusing her by wiping my bottom and sticking their fingers inti (sic) my rectum and vagina' . Name of staff (LPN #12) stated that the resident stated that this incident had happened in the past not recently, so she did not report to management. Nurse then documented a clarification note in chart"</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 6/23/16 at 12:42 p.m. She indicated this abuse allegation should have been reported immediately.</p> <p>An abuse policy was provided by the</p>			

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F 0242 SS=D Bldg. 00	<p>DNS on 6/23/16 at 11:00 a.m. It indicated "POLICY STATEMENT: It is the responsibility all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violation') are reporting immediately to the Executive Director or Director of Nursing of the Living Center."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review,</p>	F 0242	F242D	07/19/2016
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	<p>the facility failed to ensure a resident was receiving the number of showers as preferred for 1 of 3 residents reviewed for choices. (Resident #12)</p> <p>Findings include:</p> <p>The clinical record for Resident #12 was reviewed 6/17/16 at 11:06 a.m. The diagnoses included, but were not limited to: history of traumatic brain injury and paraplegia.</p> <p>The 4/13/16 Quarterly MDS (minimum data set) assessment indicated Resident #12 had a BIMS (Brief Interview for Mental Status) score of 14/15 indicating Resident #12 was cognitively intact.</p> <p>An interview was conducted with Resident #12 on 6/16/16 at 9:12 a.m. He indicated he received two showers a week and preferred to have three showers a week to prevent from having an unpleasant smell.</p> <p>A document titled Bathing Frequency & Type Preference was provided by DON (Director of Nursing) on 6/20/16 at 11:35 a.m. The document indicated the following: "... [Facility Name]...Bathing Frequency & Type Preference...I understand that I will receive 2 showers per week, unless I state another preference ...Alternative frequency and type of bathing preferences: Prefer 3 showers a week, days not concern...."</p>		<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R12 had his shower immediately changed to day shift and 3times a week per his choice.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>An audit of facility residents to review and ensure that shower preference is correct was completed.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Admissions will ask and document on any new admissions what their shower preference is.</p> <p>Other residents will have shower preference reviewed at time of care plan meeting</p> <p>These corrective actions will</p>	

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	<p>Bathing Frequency & Type Preference document was signed by Resident #12 on 4/22/16.</p> <p>A document titled Bathing Type Detail Report was provided by DON on 6/20/16 at 2:25 p.m. The document indicated Resident #12 received a shower on the following days:</p> <p>5/2/16 5/5/16 5/9/16 5/12/16 5/19/16 5/30/16 6/2/16 6/6/16 6/9/16 6/11/16 6/13/16 6/16/16</p> <p>An interview was conducted with LPN (Licensed Practical Nurse) #1 on 6/20/16 at 9:59 a.m. She indicated Resident #12 received a shower on Monday's and Thursday's on evening shift.</p> <p>An interview was conducted with LPN #2 on 6/20/16 at 10:53 a.m. She indicated Resident #12 received a shower twice a week in the evening.</p> <p>An interview was conducted with SSD (Social Services Director) #3 on 6/20/16 at 11:24 a.m. She indicated individual</p>		<p>be monitored and a quality assurance program implemented to ensure the deficient practice will not recurper the following:</p> <p>DNS/Designee will audit new admits/readmits shower preferences 5 x a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 6 months.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 0279 SS=D Bldg. 00	<p>preference sheets are completed upon admission to facility and changed as needed on a quarterly basis during care plan meetings or if a there is a concern in between care plan meetings.</p> <p>A policy titled Resident Rights, revised 3/31/16, was provided by DON on 6/20/16 at 1:40 p.m. Policy indicated the following, "Resident Rights...Recreation Services...The Resident has the right to choose activities schedules and health care consistent with his or her interests, assessments, and plans of care." 3.1-3(v)(1)</p> <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,</p>			

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	<p>including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to develop a care plan for a preference to wear a gown for 1 of 1 residents reviewed for dignity. (Resident #113)</p> <p>Findings include:</p> <p>The clinical record for Resident #113 was reviewed on 6/17/16 at 9:00 a.m. The diagnosis for Resident #113 included, but was not limited to: intellectual disabilities. The Brief Interview Mental Status (BIMS) Assessment indicated Resident #113 was cognitively impaired.</p> <p>An observation was made on 6/16/16 at 9:34 a.m., of Resident #113. She was observed wearing a hospital gown.</p> <p>An observation was made on 6/16/16 at 3:42 p.m., of Resident #113. She was observed wearing a hospital gown.</p> <p>An observation was made on 6/17/16 at 8:30 a.m., of Resident #113. She was observed wearing a hospital gown.</p> <p>An observation was made on 6/17/16 at 9:45 a.m., of Resident #113. She was observed wearing a hospital gown.</p>	F 0279	<p>F279D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R113 care plan was immediately updated.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Review of residents to see if any other did not choose todress for the day and care plan updated</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>New admissions and readmissions will have care plans reviewed in morning to ensure that any resident that does not wish to dress daily will have that preference care planned.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the</p>	07/19/2016

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	<p>An observation was made on 6/20/16 at 9:27 a.m., of Resident #113. She was observed wearing a hospital gown.</p> <p>An observation was made on 6/20/16 at 12:21 p.m., of Resident #113. She was observed wearing a hospital gown.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) #11 on 6/21/16 at 12:45 p.m. CNA #11 indicated she did not have any trouble dressing Resident #113 today. CNA #11 indicated Resident #113 sometimes does like to stay in her gown and not get dressed.</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 6/22/16 at 10:00 a.m. She indicated a care plan normally was written about wearing gowns. Resident #113 wears hospital gowns at times by choice. DNS could not locate a care plan for Resident #113's preference to wear a hospital gown.</p> <p>3.1-35(a)</p>		<p>deficient practice will not recurper the following:</p> <p>DNS/Designee will audit new/readmit residents that do notwish to dress daily 5 x a week for 4 weeks. Then 3 times a week for 4 weeks,then weekly</p> <p>DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan writtenand interventions implemented.</p>	

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F 0282 SS=E Bldg. 00	<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 interview and record review, the facility failed to follow Resident's plan of care for daily measurements of an abscess, provide medication as ordered, drain a resident's pleurx catheter (tube to drain fluid from chest) daily, thoroughly investigate a resident's fall, per policy, and discontinue a resident's medication as ordered for 5 of 24 residents reviewed for plan of care (Residents #45, #103, #140, #C, #D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #140 was reviewed on 6/20/16 at 10:30 a.m. The diagnoses for Resident #140 included, but were not limited to, failure to thrive, profound intellectual disability, convulsions, and blindness.</p> <p>A Wound Evaluation Flow Sheet, dated 4/13/16, indicated Resident #140 had an abscess measuring 0.6 cm x 1.3 cm, on the left gluteal fold.</p>	F 0282	<p>F282E</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R140-area is healed RC-medications were dispensed as soon as delivered by pharmacy RD-No longer a resident R103 investigation was corrected R45 order was corrected</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>DNS/Designee will review new orders during Clinical Start Upto ensure orders, medications are correct.</p> <p>The measures put into place</p>	07/19/2016

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	<p>A Nurse Practitioner Progress Note, dated 4/26/16, indicated, "...Assessment...abscess improved but still indurated. She has completed antibiotic therapy. I will have nursing measure induration daily. if it increases call [name of medical practice]...."</p> <p>A Physician's Order, dated 4/26/16, indicated, " measure induration or knot of abscess daily if increases call [name of medical practice]."</p> <p>Daily measurements of the abscess were not located in the clinical record, including the treatment administration records and skin assessments, from 4/26/16 until the clinical record indicated the abscess was healed on 5/13/16.</p> <p>During an interview with LPN #2, on 6/22/16 at 10:55 a.m., LPN #2 indicated the facility was not able to locate daily measurements of the abscess as ordered. LPN #2 further indicated the order was not captured correctly in the computer.</p> <p>On 6/22/16 at 2:27 p.m., the Director of Nursing Services indicated staff were expected to follow Physician's Orders as written.</p> <p>2. The clinical record for Resident #C was reviewed on 6/17/16 at 9:27 a.m. The diagnoses for Resident #C included,</p>		<p>and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Orders will be reviewed daily during Clinical Start up to ensure meds are available, supplies are available and orders have transcribed correctly. Investigations will be reviewed by IDT Monday-Friday. Night shift licensed staff was educated on reviewing new orders to ensure orders transcribed correctly</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit the above 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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	<p>but were not limited to: insomnia, and mixed hyperlipidemia.</p> <p>A physician order dated, 12/22/14, indicated the staff was to administer melatonin 5mg (milligrams) by mouth to Resident #C for insomnia.</p> <p>A physician order dated, 10/26/15, indicated the staff was to administer to Resident #C a docusate capsule by mouth two times a day for constipation.</p> <p>A physician order dated, 1/22/16, indicated the staff was to administer 600mg of gemfibrozil by mouth two times a day for HLD (hyperlipidemia) to Resident #22.</p> <p>The April, May, and June 2016, Medication Administration Records (MAR) indicated Resident #C did not receive the following medications, days and times:</p> <p>melatonin - April 29th - 9:30 p.m., melatonin - April 30th - 9:30 p.m.,</p> <p>docusate - May 24th - 9:00 p.m., docusate - May 25th - 9:00 p.m.,</p> <p>gemfibrozil - June 4th - 9:00 a.m.,</p> <p>An "e-MAR-Medication Administration</p>			

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	<p>Note" dated, 4/30/16 at 12:00 a.m., indicated "Melatonin Capsule by mouth at bedtime for insomnia supply out"</p> <p>An "e-MAR-Medication Administration Note" dated, 5/24/16 at 10:13 p.m., indicated "Dok (docusate) cap (capsule) 250mg one tab (tablet) po (mouth) not available. Pharmacy notified."</p> <p>An "e-MAR-Medication Administration Note" dated, 5/25/16 at 8:45 p.m., indicated "Dok Cap 250mg one tab po not available. Pharmacy notified."</p> <p>The June 2016, MAR indicated on 6/4 for gemfibrozil a number "7" was entered. The chart codes indicatd "7=Other/See nurses notes" The nursing notes indicated "An e-MAR-Medication Administration Note" dated, 6/4/16 at 10:00 a.m., indicated "on order".</p> <p>An interview was conducted on 6/22/16 at 10:00 a.m., with the Director of Nursing Services (DNS). She indicated residents' medications were to be reordered 5 days prior to the supply running out. She indicated Resident #C's medications were missed to be reordered prior to running out.</p> <p>A "Medication Ordering and Receiving From Pharmacy" was provided on</p>						

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	<p>6/20/16 at 2:31 p.m., by the DNS. It indicated "...Policy. Medications and related products are received from the dispensing pharmacy on a timely bases. The facility maintains accurate records of medication order and receipt. Procedures...c. Reorder medication five days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand.." 3. The clinical record was reviewed for Resident #D on 6/17/16 at 3:11 p.m. The diagnoses for Resident #D included, but were not limited to, pleural effusion and atelectasis.</p> <p>The May, 2016 Physician Orders indicated Resident #D was to have pleural tube drained every day shift effective 5/5/16.</p> <p>The May, 2016 and June, 2016 TARs (treatment medication records) for Resident #D indicated a checkmark code to document the treatment was administered and a chart code of a number to indicate reasoning why a treatment was not administered or completed.</p> <p>The May, 2016 TAR indicated, on 5/31/16, a number 7 was documented without a checkmark present. The TAR further indicated number 7 Chart Code/Follow Up Code refers to the</p>			

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	<p>following: "...7 = Other/See Nurses Notes...."</p> <p>The May, 2016 Progress Notes reviewed for Resident #D indicated, "...5/31/16 14:25 [2:25 p.m.]...Type: eMAR [medication administration record] - Medication Administration Note...Note text: Drain pleural tube every day shift...Resident pleural tube intact, site is without s/s [signs and symptoms] of infection noted. No Pleural Drain completed on this shift per UC Pleurex Drain Bottles will arrive this pm, evening shift to complete task."</p> <p>The June, 2016 Progress Notes reviewed for Resident #D indicated, "...6/1/16 14:03 [2:03 p.m.]...Type: General Note...reviewed the TAR with daughter and it was not drained yesterday due to no canisters in facility...."</p> <p>Grievance Form for Resident #D, dated 6/1/16, indicated, "...Grievance Form ...Today's date: 6/1/16...Nature of resolution: Review of TAR and site was drained everyday but 5/31...." Grievance Form was signed by DNS (Director of Nursing Services) on 6/1/16.</p> <p>An interview was conducted with the DNS on 6/21/16 at 10:08 a.m. She indicated Resident #D did not have pleurx catheter drained, as ordered, on 5/31/16 due to facility not having</p>			

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	<p>canisters for the procedure.</p> <p>An interview was conducted with the DNS on 6/20/16 at 2:15 p.m. She indicated there was no policy on following physician's orders. She expects the nursing staff to follow physician orders.</p> <p>4. The clinical record for Resident #103 was reviewed on 6/15/16 at 1:30 p.m. The diagnoses for Resident #103 included, but were not limited to: dementia and history of falls.</p> <p>The 3/17/16 Quarterly MDS (minimum data set) Assessment indicated Resident #103 required extensive assistance of one person for transfers, personal hygiene, dressing, and toilet use.</p> <p>The 6/3/16 M.D. progress note indicated Resident #103 fell frequently and was fearful of falling.</p> <p>An interview was conducted with LPN #9 on 6/15/16 at 1:48 p.m. She indicated Resident #103 had a fall the morning of 6/14/16.</p> <p>The Verification of Investigation to Resident #103's 6/14/16 fall was provided by the DON (Director of Nursing) on 6/21/16 at 8:30 a.m. It indicated Resident #103 lost her balance</p>			

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	<p>standing up, and fell in the bathroom. It indicated she complained of hitting her head. It indicated, "Resident stated 'she was dressing on (sic) bathroom, stood up from wheel chair to pull clothes up and fell.'" The interview summary with CNA (Certified Nursing Assistant) #8 indicated, "Saw resident going to stand, was unable to get to resident in time. Resident slide (sic) down to the floor, hit head on sink." The interviewer was LPN #10. The intervention specified to prevent reoccurrence was, "Staff is to stay close by resident when in bathroom."</p> <p>The 6/17/2016, 12:03 p.m. IDT (Interdisciplinary Team) Fall Note, written by the DON, indicated, "Resident had a witnessed fall in her bathroom on 6/14/16, she id (sic) hit her head on sink but had no injuries. Started on neurochecks that were WNL (within normal limits) at that time. CNA reported that resident stood up from wheel chair to pull up pants and fell. CNA stated she attempted to catch her but was not quick enough. Current care plan interventions (sic) are appropriate at this time."</p> <p>On 6/20/16 at 1:48 p.m., an interview was conducted with CNA #8, the CNA indicated in the Verification of Investigation as having witnessed Resident #103's 6/14/16 fall. She</p>			

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	<p>indicated she thought Resident #103 was trying to straighten her shirt or something when she fell. CNA #8 indicated she didn't know for sure, because she was not present when Resident #103 fell. She indicated she was in the hallway with another resident.</p> <p>On 6/20/16 at 2:00 p.m., an interview was conducted with LPN #10, the nurse indicated as having interviewed CNA #8 in the Verification of Investigation. She indicated it was her understanding after speaking with CNA #8 and Resident #103 that Resident #103 was attempting to pull her pants up when she fell. LPN #10 indicated she, herself, did not witness the fall.</p> <p>An interview was conducted with the DON on 6/20/16 at 2:26 p.m. She indicated she would discuss the fall with nursing staff.</p> <p>An interview was conducted with the DON on 6/21/16 at 12:13 p.m. At this time, the DON provided a written statement from CNA #14. It indicated, "Another CNA had dressed (name of Resident #103) but the other CNA forgot her bra, I went and got her bra, placed it on her with her shirt. Resident was in doorway of bathroom while I was in the room and heard resident make a noise</p>			

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	<p>and seen (sic) her on the floor of the bathroom." The DON indicated CNA #14's statement was not her understanding of what happened, until today (6/21/16). She indicated the 6/14/16 investigation was not accurate, in that CNA #14 should have been interviewed, and the fall was "obviously" not witnessed.</p> <p>The Post Fall analysis Summary & Guidelines for Completion was provided by the DON on 6/23/16 at 8:30 a.m. It indicated, "It is the policy of the Living Center to complete the Post Fall Analysis Summary after every known resident fall to assess the individuals condition and to identify the reason and/or risk factor for the fall in order to prepare a plan of care to reduce the potential for future falls."</p> <p>5. The clinical record for Resident #45 was reviewed on 6/15/16 at 12:10 p.m. The diagnoses for Resident #45 included, but were not limited to, gout.</p> <p>The Order Summary Report for Resident #45 indicated, "Voltaren Gel 1% (Diclofenac Sodium) Apply 2 gram transdermally two times a day" with a start date of 7/29/15.</p> <p>The 6/7/16 Physician's Orders and Signature Form indicated to discontinue</p>			

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F 0309 SS=D Bldg. 00	<p>the voltaren gel.</p> <p>The June, 2016 Medication Administration Record indicated Resident #45 was applied the voltaren gel daily from 6/7/16 to 6/17/16.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/22/16 at 9:22 a.m. She indicated the voltaren gel was not discontinued, as ordered, until 6/20/16.</p> <p>This Federal Tag relates to Complaint #IN00201733 This Federal tag relates to Complaint #IN00201757.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of</p>			

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	<p>care.</p> <p>Based on interview and record review, the facility failed to ensure pain medication was provided for 2 of 2 residents reviewed for pain management. (Resident #C and Resident #63)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #63 was reviewed on 6/21/16 at 10:00 a.m. The diagnosis for Resident #63 included, but were not limited to: palliative care and dementia.</p> <p>A care plan, dated, 2/3/16, indicated Resident #63 was on "Hospice care related to end of of life care." The interventions were included but not limited to the following: "Evaluate effectiveness of medications/interventions to address comfort."</p> <p>A care plan, dated, 6/17/13, indicated Resident #63 was "At risk for pain related to chooses not to initiate conversations anticipate resident's pain/discomfort; Gout; DX (diagnosis) Arthritis" The interventions were included but were not limited to the following: "Administer Pain medication as ordered, Offer non-pharmacological pain relief strategies".</p>	F 0309	<p>F309D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R63 received her pain med. RC received her pain med.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Facility now receives a weekly report that shows any medications that are close to needing a new script. Nursing contacts medical director for new scripts.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Facility now receives a weekly report that shows any medications that are close to needing a new script. Nursing contacts medical director for new scripts. Licensed staff educated on calling MD if script expired and having med STATED to</p>	07/19/2016

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	<p>A physician order dated, 2/9/16, indicated the staff was to administer to Resident #63 one tab of hydrocodone 5/325mg (milligrams) by mouth every 6 hours for pain.</p> <p>The May 2016, Medication Administration Record (MAR) indicated Resident #63 did not receive her hydrocodone pain medication the following days and times:</p> <p>May 14 - 12:00 a.m., 6:00 a.m., 12:00 p.m., May 15 - 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m., May 16 - 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m., May 17 - 12:00 a.m., 6:00 a.m., 12:00 p.m.,</p> <p>An "eMAR-Medication Administration Note" dated, 5/14/16 at 1:40 a.m., indicated "Resident sript (sic) is on reorder, (name of medical provider) is notified per Pharmacy".</p> <p>An "eMAR-Medication Administration Note" dated, 5/14/16 at 5:18 a.m., indicated "med unavailable, needs new script".</p> <p>A physician progress note dated, 5/17/16,</p>		<p>facility Licensed staff educated on nonpharmalogical interventions prior to giving prn pain medication</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee receives report from pharmacy weekly and will ensure any medications that will need new scripts are received from medical director.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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	<p>indicated "...Chief Complaint/Nature of Presenting Problem: Pain: History of Present Illness: The pt (patient) was seen urgently due to pain...She needs a new RX (script) for hydrocodone 5/325 1 po q (every) 6 hr (hours) routinely...She has dementia and cannot quantify pain".</p> <p>There was no documentation the staff provided non-pharmacological interventions to control Resident #63's pain.</p> <p>2. The clinical record for Resident #C was reviewed on 6/17/16 at 9:27 a.m. The diagnoses for Resident #C included, but were not limited to: unspecified fracture of unspecified femur, subsequent encounter for closed fracture with nonunion, age-related osteoporosis without current pathological fracture, and restless legs syndrome.</p> <p>A care plan dated, 2/17/14, indicated Resident #C has history of osteomyelitis, osteoporosis, and obesity. The interventions were included but not limited to: "administer pain medication as order, offer non-pharmacological pain relief strategies, such as repositioning, or rest."</p> <p>A physician order dated, 10/19/15, indicated the staff was to administer to</p>			

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	<p>Resident #C 1 tab of hydrocodone 5/325mg by mouth every 4 hours for pain.</p> <p>A physician order dated, 10/19/15, indicated the staff was to administer to Resident #C 1 tab of hydrocodone 5/325mg by mouth every 8 hours as needed for breakthrough pain.</p> <p>The April 2016, MAR indicated Resident #C did not receive her hydrocodone pain medication the following days and times:</p> <p>April 10 - 8:00 a.m., 12:00 p.m., 4:00 p.m., April 21 - 12:00 a.m., 4:00 a.m., 8:00 a.m.,</p> <p>An "eMAR-Medication Administration Note" dated, 4/10/16 at 5:14 p.m., indicated "not available, MD (medical provider) aware and to call in script to pharmacy".</p> <p>An "eMAR-Medication Administration Note" dated, 4/21/16 at 3:48 a.m., "medication expected from pharmacy".</p> <p>The May 2016, MAR indicated Resident #C did not receive her hydrocodone pain medication the following days and times:</p> <p>May 24 - 8:00 p.m.,</p>			

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	<p>May 25 - 12:00 a.m., and 4:00 a.m.,</p> <p>An "eMAR-Medication Administration Note" dated, 5/24/16 at 10:12 p.m., "Norco (hydrocodone) 5/325mg 1 tab po (oral) not available. Pharmacy notified".</p> <p>The June 2016, MAR indicated Resident #C did not receive her hydrocodone pain medication the following days and times:</p> <p>June 9 - 8:00 a.m., and 12:00 p.m.,</p> <p>An "eMAR-Medication Administration Note" dated 6/9/16 at 10:51 a.m., "holding for script".</p> <p>A physician progress note dated, 6/9/16, "...Chief Complaint/Nature of Presenting Problem: Pain. History Of Presenting Illness:...Nursing staff is requesting a new written prescription for her scheduled Norco (hydrocodone) and PRN (as needed) Norco...Today she (Resident #C) is rating her pain at a 7/10 and yesterday an 8/10. The patient (Resident #C) stated adamantly that she wants to stay on Norco every 4 hours. She (Resident #C) states it is absolutely necessary for her well-being and daily functioning. The patient stated she had already missed 2 doses of Norco today and that she was miserable...".</p>			

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	<p>There was no documentation the staff provided non-pharmacological interventions to control Resident #C's pain.</p> <p>An interview was conducted on 6/22/16 at 10:00 a.m., with the Director of Nursing Services (DNS). She indicated the facility should be notified by the pharmacy 7-10 days prior to running out of narcotic medication. She is unsure why Resident #63 and Resident #C's hydrocodone medication was not reordered 7-10 days prior to their medication running out.</p> <p>An interview was conducted on 6/22/16 at 2:24 p.m., with the DNS. She indicated the staff would document in the progress notes if non-pharmacological interventions were used to control the residents' pain. She was unable to provide documentation Resident #63 or Resident #C was provided non-pharmalogical interventions to manage their pain.</p> <p>A "Pain Management Guideline" provided by the DNS on 6/23/16 at 8:30 a.m. It indicated the following: "GUIDELINE STATEMENT: To provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced qualify</p>			

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F 0428 SS=D Bldg. 00	<p>of life, in concert with the patient's/resident's plan of care and goals for pain management. GUIDELINE: Functions of appropriate pain management include, but are not limited to:..Intervening to treat pain before the pain becomes severe...Using non-drug interventions to assist in pain management... Recognize that patients who have chronic pain will benefit most from an effective, scheduled pain medication regimen..."</p> <p>This Federal tag relates to complaint IN00201757.</p> <p>3.1-37(a)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on interview and record review, the facility failed to act on pharmacy</p>	F 0428	F428D The corrective actions accomplished for those	07/19/2016

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	<p>recommendations for 2 of 6 residents reviewed for unnecessary medications. (Residents #45 and #103)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #103 was reviewed on 6/15/16 at 12:32 p.m. The diagnoses for Resident #103 included, but were not limited to, depression.</p> <p>The Order Summary Report for Resident #103 indicated, "Citalopram Hydrobromide (generic Celexa, an antidepressant medication) Tablet 20 mg Give 1 tablet by mouth one time a day" with a start date of 10/1/13.</p> <p>The 5/31/16 Pharmacy Recommendation for Resident #103 indicated, "Please evaluate the continued need for Celexa 20 mg daily and consider Celexa 10 mg daily. If a gradual dose reduction is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."</p> <p>There was no information in the clinical</p>		<p>residents found to have been affected by the deficient practice are as follows:</p> <p>R103 (should be R75) Had Celexa decreased to 10mg daily on 6/26.16 R45 had Zyprexa reduced to 5mg in am and 10mg q hs on 6/24/16 and Mucinex was changed to prn on 6/27/16.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>May and June 2016 Pharmacy recommendations were given to the medical director to review and changes were implemented by 6/30/16.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Pharmacy consultant will send recommendations to DNS/Designee this recommendations will be logged, copies made and originals be given to Medical Director. Completed recommendations will be implemented and copies of all recommendations will be returned to DNS/Designee who</p>	

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	<p>record to indicate he above recommendation was acted upon.</p> <p>An interview was conducted with the DON (Director of Nursing) on 6/21/16 at 12:10 p.m. She indicated she was unaware the pharmacy began sending a resident roster and recommendations via email in May, 2015.</p> <p>An interview was conducted with the DON on 6/22/16 at 9:22 a.m. She indicated she was unable to locate a response to the 5/31/16 pharmacy recommendation. She indicated, "Obviously our system is broken for tracking these."</p> <p>An interview was conducted with the DON on 6/23/16 at 9:37 a.m. She indicated, to her knowledge, there was no official written process in place regarding pharmacy recommendations, and the facility did not have a policy on following up with pharmacy recommendations.</p> <p>2. The clinical record for Resident #45 was reviewed on 6/15/16 at 12:10 p.m. The diagnoses for Resident #45 included, but were not limited to, anxiety and chronic airway obstruction.</p> <p>The Order Summary Report indicated,</p>		<p>will review and check off from originals to ensure all recommendations have been reviewed by Medical Director and orders changed. Log will be kept in Nursing Office in binder.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Recommendations will be reviewed monthly.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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	<p>"Mucinex DM Tablet Extended Release 12 Hour 30-600 MG (DM-Guaifenesin ER) Give 1 tablet by mouth every 12 hours" with a start date of 7/29/15. It indicated, "Olanzapine Tablet 10 mg (generic zyprexa, antipsychotic medication) Give 10 mg by mouth at bedtime" with a start date of 7/29/15. It indicated, "Olanzapine Tablet 5 mg Give 5 mg by mouth in the morning" with a start date of 7/30/15.</p> <p>The 2/17/15 care plan for Resident #45 indicated there was a potential for drug related complications associated with use of psychotropic medications related to: anti-depressant and anti-psychotic medications. An intervention was for psychotropic medication evaluation/risk/benefit and reduction plan as recommended by physician and pharmacist.</p> <p>The 4/19/16 Pharmacy Recommendation for Resident #45 indicated, "Please consider reducing the current medication dose to Zyprexa 7.5 mg daily (psych notes indicate ok to review again). If a GDR (gradual dose reduction) is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted dose reduction would likely impair the resident's function or</p>			

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	<p>cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."</p> <p>There was no information in the clinical record to indicate the above recommendation was acted upon.</p> <p>The 5/31/16 Pharmacy Recommendation for Resident #45 indicated, "Please consider reducing the current medication dose to Zyprexa 7.5 mg daily (psych notes indicate ok to review again). If a GDR (gradual dose reduction) is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."</p> <p>There was no information in the clinical record to indicate the above recommendation was acted upon.</p> <p>The 4/19/16 Pharmacy Recommendation for Resident #45 indicated, "Please consider a trial discontinuation at this time. The Mucinex may not be a necessar (sic) medication for this resident and could be contributing to the increase in behaviors."</p>			

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	<p>There was no information in the clinical record to indicate the above recommendation was acted upon.</p> <p>The 5/31/16 Pharmacy Recommendation for Resident #45 indicated, "Please consider a trial discontinuation at this time. The Mucinex may not be a necessar (sic) medication for this resident and could be contributing to the increase in behaviors."</p> <p>There was no information in the clinical record to indicate the above recommendation was acted upon.</p> <p>An interview was conducted with the DON (Director of Nursing) on 6/21/16 at 12:10 p.m. She indicated she was unaware the pharmacy began sending a resident roster and recommendations via email in May, 2015.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/22/16 at 9:22 a.m. She indicated she was unable to locate responses for Resident #45's Mucinex and Zyprexa pharmacy recommendations.</p> <p>An interview was conducted with the DON on 6/23/16 at 9:37 a.m. She indicated, to her knowledge, there was no</p>			

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F 0441 SS=D Bldg. 00	<p>official written process in place regarding pharmacy recommendations, and the facility did not have a policy on following up with pharmacy recommendations.</p> <p>3.1-25(j)</p> <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</p>						

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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, interview, and record review, the facility failed to properly dispose of a container with a yellow liquid substance wrapped with a glove present in the sink of 1 of 4 medication rooms observed during an random observation.</p> <p>Findings include: An observation was conducted of the East Unit medication room on 6/23/16 at 9:50 a.m. There was a container in the sink located inside the medication room with a yellow substance present in the container with a glove wrapped on the outside of the container.</p> <p>An interview was conducted with LPN (Licensed Practical Nurse) #2 on 6/23/16 at 9:52 a.m. She indicated it appeared to be a substance in a specimen container and told staff to discard of the container.</p> <p>An interview was conducted with LPN #2 on 6/23/16 at 10:52 a.m. She indicated</p>	F 0441	<p>F441D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Liquid found in med room sink was disposed immediately.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>All other med rooms were immediately checked to ensure noother liquids were in sinks.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>DNS/Designee will audit med</p>	07/19/2016

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F 0465 SS=F Bldg. 00	<p>she didn't know what was in the container. She further indicated the container should have not been in the sink.</p> <p>A policy titled "Infection Control" was provided by the DON (Director of Nursing) on 6/23/16 at 10:55 a.m. The policy indicated the following: "Infection Control Program...Infection Control...Policy Statement: The Company shall maintain a safe, sanitary, and comfortable work environment and take appropriate steps to prevent the development of transmission of disease or infection in its facilities...." The policy was revised on 4/6/15.</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a clean environment for 4 of 35 residents whose rooms were observed and 79 residents who eat food from the kitchen.</p>	F 0465	<p>rooms to ensure no liquids are left in sinks. License staff educated on disposal of liquids.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit med rooms 5 x a week for 4 weeks, then 3 times a week for 4 weeks, then daily for 6 months.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p> <p><u>F 465</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The resident #76, 44, 8, 63 and all residents receiving daily meals have to potential to be affected. 1. Resident #76's bathroom door frame was cleaned immediately.</p>	07/19/2016			

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	<p>Findings include:</p> <p>1. An observation of Resident #76's room was made on 6/16/16 at 9:07 a.m. There was a blackish substance on the door frame of his bathroom door.</p> <p>An environmental tour of the facility was conducted with the Housekeeping Supervisor (HS) and Maintenance Director on 6/22/16 at 1:20 p.m. The same blackish colored substance was observed halfway up the right side of Resident #76's bathroom door frame. The HS indicated bathrooms were cleaned daily, and the blackish colored substance looked like feces to her. She indicated staff should have cleaned it.</p> <p>2. An observation of Resident #44's restroom was made on 6/15/16 at 2:30 p.m. The mobility bars used around her commode were corroded, with a white substance along the back bar.</p> <p>An environmental tour of the facility was conducted with the Housekeeping Supervisor and Maintenance Director on 6/22/16 at 1:20 p.m. The corroded mobility bar in Resident #44's restroom was observed. The Maintenance Director indicated it needed replaced.</p>		<p>2. Resident #44's mobility bar has been replaced by the maintenance.</p> <p>3. Resident #8's privacy curtain was immediately removed and replaced.</p> <p>4. Resident #63's blind was wiped and dust build up removed by the Housekeeping supervisor.</p> <p>5. Stove exhaust hood inspected and cleaned free of cob webs.</p> <p>6. Food (hot dogs & hamburgers) were cooking on the stove and do not need to be covered per policy.</p> <p>7. Walk-in cooler floor was inspected and cleaned. Onion peels occasionally fall on the floor but were not observed during the inspection times noted.</p> <p>8. Dry food storage floor was inspected and cleaned</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. Dietary Manager/Designee will monitor the cleaning procedure via audit tool.</p> <p>2. HK Supervisor/Designee will conduct an inspection of all the rooms with grab bars, blinds and privacy curtain and address concerns noted during inspection and submit the audit tool to ED for review.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur;</p> <p>Dietary Manager/Designee will monitor 1 x per day x 5 days per week x 4 weeks, thereafter 4x a week for a month until compliance is in</p>	

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	<p>3. An observation of Resident #8's privacy curtain in her room was made on 6/15/16 at 12:56 p.m. There was a large, tire sized brown spot toward the bottom, middle of the curtain. Resident #8 indicated the area had been there for a long time.</p> <p>An environmental tour of the facility was conducted with the Housekeeping Supervisor and Maintenance Director on 6/22/16 at 1:20 p.m. The Housekeeping Supervisor observed the area on the privacy curtain, and indicated it looked like a spill. She indicated any staff member could report that, and it could be changed out in a day.</p> <p>4. An interview was conducted with Resident #63's family member, Family Member #15 on 6/16/16, at 10:17 a.m. She indicated the blinds in Resident #63's room were "nasty", and she'd tried to dust them herself.</p> <p>An environmental tour of the facility was conducted with the Housekeeping Supervisor and Maintenance Director on 6/22/16 at 1:20 p.m. The blinds had a visible layer of dust on them. The Housekeeping Supervisor indicated the blinds should be dusted daily, but it looked to her like it had been a few days. The Housekeeping Supervisor wiped the</p>		<p>place as deemed by QA committee. The results of the audit will be reviewed during QA meeting.</p> <p>HKsupervisor/designee will audit 3 x 2weeks, thereafter 1 x a week and willsubmit the results of the audit during QA meeting for review and compliance.</p>	

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	<p>right blind with her hand and displayed a significant amount of dust on her fingers.</p> <p>A blank Housekeeping In-Service was provided by the Executive Director on 6/23/16 at 8:30 a.m. It indicated, "Vertical surfaces are not completely wiped down daily - but must be spot-cleaned daily. Walls - especially by trash cans, light switches and door handles -will need special attention."</p> <p>5. A tour of the kitchen was conducted on 6/15/16 at 10:35 a.m. The stove exhaust hood had a cob web stretching from the front of the hood to the first sprinkler on the left of the hood. An uncovered pan of hot dogs and uncovered pan of burgers were on the stove. The walk in cooler was observed with debris in the front left corner of the floor. There was an onion peel, the size of a golf ball, on the floor towards the middle of the walk way. The dry storage area was observed with 2 brown drips of an unknown liquid on the floor, underneath one of the food racks. The Dietary Manager (DM) was present during the dry storage observation and the walk in cooler observation.</p> <p>A tour of the kitchen was made with the DM on 6/17/16 at 2:10 p.m. The cob web previously observed on the exhaust hood remained. The DM observed the</p>			

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	<p>cob webs and indicated it was cleaned on a daily basis, which included wiping down the front of the hood where the cob web was still observed. The dry storage area was observed with same 2 brown drips of liquid on the floor. The DM observed the drips and indicated the floor was swept twice weekly. The walk in cooler was observed with same debris in the front left corner on the floor. The same onion peel was in the same location as previously observed. The DM observed the onion peel and indicated the floor was supposed to be swept twice a day.</p> <p>An interview was conducted with the DM on 6/20/16 at 10:20 a.m. She indicated she thought the staff did not mop the dry storage area well, and that was why the drips were still on the floor.</p> <p>The June, 2016 Daily Cleaning Logs were provided by the DM on 6/20/16 at 10:00 a.m. They indicated the exterior of the exhaust hood was wiped only one time by dietary staff in June, 2016.</p> <p>The Cleaning Walk-In Refrigerators and Freezers policy was provided by the DM on 6/21/16 at 9:50 a.m. It indicated, "Sweep and mop floors of walk-in refrigerators daily. The Cleaning Storage Areas policy was provided by the DM on</p>			

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F 0496 SS=D Bldg. 00	<p>6/21/16 at 9:50 a.m. It indicated, "Store Room Floors: Follow the steps below to clean storeroom floors daily: 1. Sweep complete floor, under shelving and moving any items on wheels. 2. Place wet floor signs at entrance door. 3. Using warm water and a floor cleaning chemical, mop the complete floor and under shelving, an move any items on wheels to mop those areas well."</p> <p>3.1-19(f)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually</p>			

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	<p>becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 30 actively employed CNAs (Certified Nursing Assistants) had an active license when worked. (CNA #12)</p> <p>Findings include:</p> <p>1. The Employee Records form and 30 CNA licenses were reviewed on 6/23/16 at 12:43 p.m. The Employee Records form indicated the following start date for CNA #12 was 3/29/16.</p> <p>CNA #12's license indicated her license expired on 5/22/16.</p> <p>A document provided by HRG (Human Resource Generalist) #4, on 6/23/16 at 1:02 p.m., indicated CNA #12 worked 38.89 hours from 5/23/16 to 6/5/16.</p> <p>An interview was conducted with HRG</p>	F 0496	<p>F496D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>C.N.A. #12 was immediately removed from schedule and informed that her certificate must be renewed prior to returning to work.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>DNS did a complete audit of all CNAs employed by the facility</p>	07/19/2016

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	<p>#4 on 6/23/16 at 1:03 p.m. She indicated CNA #12 was working PRN (as needed) at this time. She further indicated that staff are to have active licenses when they work.</p> <p>A policy titled "Professional License and Certification Tracking", revised 12/20/15, was provided by HRG #4 on 6/23/16 at 1:45 p.m. Policy indicated, "...Personnel Administration...Enforcement...The ED [Executive Director], DOR [Director of Rehabilitation], Director 360 or Human Resources will not allow a licensed and/or certified employee that has not submitted a renewed unrestricted license or certification to be called in to work or to work without a current unrestricted license...."</p> <p>3.1-14(q)(5)</p>		<p>to</p> <p>Ensure all had current certificates.No one else was found to be without a certificate.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>DNS/Designee has a binder will all certificates and HumanResources are to give DNS a copy of any new hire CNAs to add to binder.</p> <p>DNSreviews the first of each month and posts at time clock that is ready for renewal, she then reviews this every week.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recurper the following:</p> <p>DNS will audit certificates 5 x a week for 4 weeks, then 3times a week for 4 weeks, then weekly.</p> <p>DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan writtenand interventions implemented.</p>	

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F 0502 SS=D Bldg. 00	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure labs were drawn as ordered for 2 of 6 residents reviewed for unnecessary medications. (Residents #84 & #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #84 was reviewed on 6/17/16 at 10:30 a.m. The diagnoses for Resident #84 included, but were not limited to, diabetes mellitus, convulsions, insomnia, anxiety, and Alzheimer's disease.</p> <p>The June 2016 Physician's Orders indicated the following lab orders: Dilantin Levels (lab for seizure medication levels) in the morning every 2 weeks on Monday; initiated on 2/2/16, Hemoglobin A1C (long term blood sugar monitoring) every 3 months in October, January, April, and July; initiated on 8/6/13, TSH (thyroid level lab) every 6 months in Jan and July; initiated 9/22/14.</p> <p>A Psychiatric Progress Note, dated 3/2/16, indicated to draw a valproic acid</p>	F 0502	<p>F502D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R 84 had labs drawn and MD and family notified on results. R22 has routine labs ordered</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Facility lab will do a complete audit of facility labs on 7/14/16 to ensure facility lab orders and lab orders match.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Facility lab will do a complete audit of facility labs on 7/14/16 to ensure facility lab orders and lab orders match.</p> <p>DNS/Designee will run daily lab</p>	07/19/2016

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	<p>level (lab for medication level) and cbc (complete blood count lab) before meals in 1 week.</p> <p>A nursing Progress Note, dated 3/2/2016 at 6:55 p.m., indicated, "...Psych MD in to see resident new orders rec'd [received] resident, family and lab notified..."</p> <p>A Nurse Practitioner Progress Note, dated 3/16/16, indicated "...Treatment Plan: Dementia w/ [with] behaviors...recheck VPA level [valproic acid lab] in week..."</p> <p>A Physician's Order, dated 3/16/16, indicated to check VPA level in 1 week.</p> <p>The following labs were not located in the clinical record: Dilantin Levels since March 2016, Hemoglobin A1C for April 2016, TSH for January 2016, valproic acid and cbc for 3/9/16, or valproic acid for 3/23/16.</p> <p>A Seizure disorder care plan, dated 8/1/13, indicated the intervention, "...lab work as ordered by physician...."</p> <p>A Diabetes Mellitus care plan, dated 8/1/13, indicated the intervention, "...labs per Physician order...."</p>		<p>orders for lab tech andplace in lab book at nurse's station. Lab tech will initial each lab that wasdrawn and DNS/Designee will review the next morning to ensure labs have beendrawn book is kept in ADNS office.</p> <p>These corrective actions will be monitored and a qualityassurance program implemented to ensure the deficient practice will not recurper the following:</p> <p>DNS/Designee will audit lab orders 5 x a week for 4 weeks,then 3 times a week for 4 weeks, then weekly for 6 months.</p> <p>DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan writtenand interventions implemented.</p>	

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	<p>During an interview with the Director of Nursing Services (DNS) on 6/17/16 at 1:40 p.m., the DNS indicated the above labs were not drawn as ordered.</p> <p>On 6/20/16, at 11:20 a.m., Social Services Assistant #20, indicated Social Services follows up with behavior monitoring and visit schedule, while nursing was supposed to follow up with nursing measures such as lab orders or medication changes after a Psychiatric visit.</p> <p>The DNS indicated, on 6/20/16 at 2:27 p.m., staff were expected to follow Physician's Orders as written.</p> <p>2. The clinical record for Resident #22 was reviewed on 6/17/16 at 9:27 a.m. The diagnoses for Resident #C included, but were not limited to: insomnia, and mixed hyperlipidemia.</p> <p>A physician order dated, 12/15/15, indicated a lab draw of a CMP (comprehensive metabolic panel) was to be done on Resident #C every 6 months in April and October.</p> <p>A progress note dated, 4/13/16, indicated "Resident refused AM Lab for CMP. she stated she ask the Lab Tech which Lab was being drawn and Tech would not tell her. this Writer went into room to inform</p>			

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	<p>Resident of lab work that was ordered and see if she would let the Lab Tech draw it. Resident then stated that she did not like being awoken at 3:30am (sic) and that the Tech was rude to her."</p> <p>A lab document for Resident #C was provided on 6/21/16 at 10:09 a.m., by the DNS. It indicated "...Reported 4/13/16. Specimen Collected 4/13/16...Refusal (FIRST ATTEMPT) resident has refused lab work for today. We will try to obtain specimens two more times and then order will be discontinued due to residents wishes. Please inform physician of patient's refusal for lab work...</p> <p>An interview was conducted on 6/17/16 at 11:00 a.m., with the License practical nurse (LPN) #2. She indicated the lab was refused, and it should have been attempted again.</p> <p>An interview was conducted with the DNS on 6/21/16 at 10:09 a.m. The DNS indicated the lab had made an error. The lab technician had not returned to the facility for another attempt to draw Resident #C's CMP per their protocol.</p> <p>A "Lab Processing/Tracking Guideline" was provided on 6/22/16 at 9:23 a.m., by the DNS. It indicated "GUIDELINE STATEMENT" To ensure that</p>			

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F 0504 SS=D Bldg. 00	<p>Diagnostic tests are processed, ordered, obtained, performed, and results received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record."</p> <p>This Federal tag relates to complaint IN00201757.</p> <p>3.1-49(a)</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on interview and record review, the facility failed to ensure a lab draw was only done when ordered by Physician for 1 of 6 residents reviewed for unnecessary medications (Resident #84).</p> <p>Findings include:</p> <p>The clinical record for Resident #84 was reviewed on 6/17/16 at 10:30 a.m. The diagnoses for Resident #84 included, but</p>	F 0504	<p>F504D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R84 has routine order for lab draw</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective</p>	07/19/2016

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	<p>were not limited to, diabetes mellitus, convulsions, insomnia, anxiety, and Alzheimer's disease.</p> <p>A Psychiatric Progress Note, dated 3/2/16, indicated to draw a valproic acid level (lab for medication level) and cbc (complete blood count lab) before meals in 1 week.</p> <p>A Physician's Order, dated 3/16/16, indicated to check VPA level in 1 week.</p> <p>A lab report, dated 3/3/16, indicated the following: "...FREE VALPROIC ACID Problem: Quantity Not Sufficient Resolution: Per Nurse [name of nurse], Redraw 3/4/16...Notified Nurse to have new Req [request] completed...."</p> <p>A lab report indicated a valproic acid level was drawn on 3/4/16.</p> <p>No other Physician's Order for the valproic acid level lab was located in the clinical record, besides the orders listed above to indicate a need for a valproic acid level lab to be drawn on 3/3/16.</p> <p>On 6/23/16 at 10:26 a.m., the Director of Nursing Services indicated the facility was not able to locate a Physician's Order for the lab draw nor was the facility able to determine why the lab was drawn,</p>		<p>actions taken areas follows:</p> <p>Facility lab will do a complete audit of facility labs on 7/14/16 to ensure facility lab orders and lab orders match.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>DNS/Designee will audit lab orders 5 x a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 6 months to ensure labs have orders.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit lab orders 5 x a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 6 months.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 0514 SS=A Bldg. 00	<p>even after calling lab corporation.</p> <p>3.1-49(f)(1)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure an annual assessment was completely documented for 1 of 24 residents reviewed for documentation. (Resident #95)</p> <p>Findings include:</p> <p>The clinical record for Resident #95 was reviewed on 6/20/16 at 10:15 a.m. The diagnoses for Resident #95 included, but were not limited to, cerebrovascular</p>	F 0514	The 2567 did not include this tag	07/19/2016

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F 9999 Bldg. 00	<p>accident, carcinoma in situ of prostate, and chronic kidney disease.</p> <p>A Clinical Health Status assessment, dated 4/25/16, was located in the clinical record. The assessment was part of Resident #95's annual assessment. The assessment was blank in the "Risk for Dehydration" section.</p> <p>During an interview with the Director of Nursing Services (DNS), on 6/22/16 at 1:40 p.m., the DNS indicated the Clinical Health Status assessment was used to determine a Resident's plan of care and if further assessments were needed. The DNS indicated the Risk for Dehydration portion of the assessment was not filled out. The DNS further indicated the Registered Dietician would usually review the section and determine if further interventions were needed.</p> <p>On 6/22/16, at 2:25 p.m., the DNS indicated the Clinical Health Status assessment should've been filled out, in its entirety.</p> <p>3.1-50(a)(1)</p>	F 9999	9999	07/19/2016	
	3.1-14 Personnel				

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	<p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The state rule was not met as evidenced</p>		<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: An audit of all current staff was completed on TB status.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken areas follows:</p> <p>Any staff that needed TB vaccination was given immediately</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>DNS/ADNS will be responsible for new hire or yearly TB tests.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>During Clinical Start Up the TB status of employees will be reviewed and any staff due for TB test will be administered that week. Audit sheet will be updated weekly.</p>	

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	<p>by:</p> <p>Based on interview and record review, the facility failed to ensure staff received a 1st and 2nd step PPD (purified protein derivative) (skin test that determines if you suffer from tuberculosis) in a timely manner for 2 of 5 employees reviewed for employee records. (CNA #6 and RN #5)</p> <p>Findings include:</p> <p>The Employee Records form and 5 employee personnel files were reviewed on 6/23/16 at 10:30 a.m. The Employee Records form indicated the following start dates:</p> <p>CNA #6- 2/24/16 RN #5- 4/12/16</p> <p>The employee personnel file for CNA #6 indicated the 1st step PPD was given on 2/9/16 and read on 2/11/16. There was no indication a 2nd step PPD, following the 1st step PPD, was given. The employee personnel file further indicated CNA #6 received another 1st step PPD on 5/16/16 and was read on 5/19/16, as well as, a 2nd step PPD given on 6/7/16 and read on 6/10/16.</p> <p>The employee personnel file for RN #5 indicated the 1st step PPD was given on 4/13/16 and read on 4/15/16. There was no indication a 2nd step PPD, following the 1st step PPD, was given. The</p>		<p>DNS/Designee will report findings of audits to monthly QAm meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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	<p>employee personnel file further indicated RN #5 received another 1st step PPD on 5/18/16 and was read on 5/21/16, as well as, a 2nd step PPD given on 5/28/16 and read on 5/31/16.</p> <p>A document was provided by HRG (Human Resource Generalist) #4 on 6/23/16 at 11:42 a.m. The document indicated the following number of hours worked from date of hire until receiving 1st step PPD for the second time: CNA #6- 607. 67 hours RN #5- 378.42 hours</p> <p>A policy titled "Tuberculosis, Screening Employees and New Hires", revised on 8/14/15, was provided by DON (Director of Nursing) on 6/23/16 at 10:55 a.m. The policy indicated, "...Tuberculin Skin Testing...2. The initial TB testing will be a two-step TST [tuberculin skin test] performed by injecting 0.1ml [milliliters] of purified protein derivative [PPD] intradermally [injection of a substance into the dermis] ...a. If the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test. The employee may begin duty assignments after the first skin test (if negative) unless prohibited by state regulations...." 3.1-14(t)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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