

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  01/16/2013
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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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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 9, 10, 11, 14, 15, 16, 2013</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Karina Gates, Medical Surveyor</p> <p>Census Bed Type: SNF/NF: 107 Total: 107</p> <p>Census Payor Type: Medicare: 13 Medicaid: 76 Other: 18 Total: 107</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/24/13 by Suzanne Williams, RN</p>	F0000		

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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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to immediately notify a MD (medical doctor) of a critical lab value for 1 of 3 residents reviewed for physician</p>	F0157	<p><b>F157</b></p> <p>It is the practice of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's legal</p>	02/15/2013			

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	<p>notification of labs. (Resident #186)</p> <p>Findings include:</p> <p>The clinical record for Resident #186 was reviewed 1/15/13 at 1:30 p.m. The diagnoses for Resident #186 included, but were not limited to, chronic obstructive asthma.</p> <p>A review of the January 2013 Physician's Orders indicated a Theophylline level (lab test to determine level of Theophylline, a drug used to help with lung function in the the body) was to be drawn on 1/9/13 with the goal between 5-10mg/L. The order was initiated on 1/8/13.</p> <p>The above lab was drawn on 1/9/13 at 7:20 a.m. and was reported on 1/9/13 at 7:36 p.m., according to the laboratory report which was received from Unit Manager #1 on 1/16/13 at 10:55 a.m. The result was less than 0.5 (no units indicated) with the letters "RL" next to the result. The normal range was listed as 10-20 ug/mL on the lab report.</p> <p>During an interview with Unit Manager #1 on 1/16/13 at 11:05 a.m., she indicated staff was supposed to notify the MD (medical doctor) immediately</p>		<p>representative when there is a change in the resident's physical status.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>The physician for resident #186 was notified on 01/16/13 of a critical lab value obtained on 01/09/13.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. All residents who had January lab draws have had their records reviewed to ensure that physician was notified of results. Lab Tracking will be reviewed daily 5 days a week during clinical start-up to ensure that notification has been made to physicians and family.</p> <p><b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b></p>		

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	<p>whenever there was a critical lab value. If the notification was after hours, the staff member was supposed to leave a message and wait for a call back. Unit Manager #1 indicated staff was supposed to document the MD notification in the clinical record. She also indicated she was unable to locate a MD notification of the lab in the clinical record, but LPN #2 was calling/notifying the MD now.</p> <p>At 11:08 a.m., on 1/16/13, LPN #2 indicated she just got off the phone with the NP (Nurse Practitioner) for the MD. LPN #2 also indicated this appeared to be the first time the MD office was notified of the lab result, and the lab needs to be redrawn the next morning.</p> <p>On 1/16/13 at 11:10 a.m., during an interview with Unit Manager #1 and LPN #2, they indicated there was a lab tracking form that was supposed to be used, to ensure labs were being followed up on, after the lab(s) were drawn. LPN #2 indicated the form was supposed to be filled out when labs were returned and when the MD was notified. LPN #2 also indicated the lab tracking form was not working, since it was not filled out appropriately for most labs that were</p>		<p>Re-in-servicing of nurses will be completed on 2/6/13 and 2/7/13 regarding need for follow-through on notification of physician for lab values, and completion and follow-through of the lab tracking form. Resident's labs will be reviewed weekly by the Unit Managers.</p> <p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>Lab audits will be completed weekly x 8 weeks and then monthly as an ongoing process. Results of audits will be reviewed by the Quality Assurance / Performance Improvement committee monthly and trends or patterns noted, will have an action plan written, and interventions implemented. The Executive Director and the Director of Nursing Services will oversee this process.</p> <p><b>By what date the systemic changes will be completed is as follows:</b></p> <p>2/15/13.</p>				

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	<p>drawn on the residents on the unit.</p> <p>A review of the January Diagnostic Testing Form, no date, indicated Resident #186 was to have the above lab drawn on 1/9/13. There was no information in the "Date Returned" spot or the "MD notified" spot on the form.</p> <p>On 1/16/13 at 12:35 p.m., Unit Manager #1 indicated the letters, "RL" on the lab report, indicated this was a critical lab value and it should've been reported immediately to the MD. Unit Manager #1 indicated MD notification of this critical lab value was overlooked.</p> <p>3.1-5(a)(3)</p>				

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F0278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview and record review, the facility failed to correctly assess a pressure ulcer on the MDS (minimum data set) assessment, for 1 of 40 residents whose assessments were reviewed. (Resident #30)</p>	F0278	<p><b>F278</b> It is the practice of this facility that the assessments reflect the residents' status. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Resident #30's MDS was corrected and re-submitted.</p>	02/15/2013	

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	<p>Findings include:</p> <p>1. The clinical record for Resident #30 was reviewed on 1/14/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #30 included, but were not limited to: rheumatoid arthritis, hypertension, and congestive heart failure.</p> <p>Review of the 11/30/12 quarterly MDS (minimum data set) assessment indicated Resident #30 did not have 1 or more unhealed pressure ulcers at stage 1 or higher. It also indicated no pressure ulcers were present on the prior assessment.</p> <p>An observation of Resident #30's pressure ulcer treatment to her right heel on 1/14/13 at 12:18 p.m. was made with Physical Therapist Assistant (PTA) #14. During the observation, PTA #14 indicated she had been treating this particular pressure sore of Resident #30's since June, 2012 and that it was a stage 3.</p> <p>Review of the previous quarterly MDS, dated 9/5/12, indicated Resident #30 had one stage 2 pressure ulcer and one unstageable pressure ulcer.</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b> MDS review was completed for last 30 days to ensure MDS accuracy. Those identified as inaccurate were corrected per RAI guidelines. <b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b> _ IDT will be in-serviced on 2/6/13 and 2/7/13 related to MDS accuracy. The MDS coordinator and MDS Assistant or designee will review each other's MDS for accuracy prior to locking for submission. <b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> The Assistant Director of Nursing Services or designee will complete weekly audits of the MDS's for 6 months Findings from the audits will be presented to the Quality Assurance / Performance Improvement committee for further review and recommendations. <b>By what date the systemic changes will be completed is as follows:</b> _ 2/15/13.</p>		

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	<p>During an interview with the MDS Coordinator on 1/16/13 at 3:35 p.m., she indicated if Resident #30 had a pressure sore during the assessment period of the 11/30/12 quarterly MDS, that the MDS should indicate as such.</p> <p>3.1-31(i)</p>			

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview, observation, and record review, the facility failed to develop a plan of care for mental retardation, resident's preference for dressing, skin integrity, and dehydration, for 5 of 40 residents whose care plans were reviewed. (Resident #s 182, 65, 82, 23, 30)</p> <p>Findings included:</p> <p>1. The clinical record of Resident #182 was reviewed on 1/15/2013 at 2:00 pm. The resident's diagnoses included, but were not limited to; MR</p>	F0279	<p><b>F279</b></p> <p>It is the practice of this facility to use the results of the assessment to develop, review and revise residents' comprehensive plan of care.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>A "MR" Care Plan was developed for Resident #182. A "Preference to Dress" Care Plan was developed for</p>	02/15/2013	

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	<p>(mental retardation) and brain cancer.</p> <p>No care plan addressing the resident's MR diagnosis could be found in the clinical record.</p> <p>An interview with the Director of Nursing on 1/16/2013 at 11:58 am indicated Resident #182 did not have a mental retardation care plan.</p> <p>An interview with CNA #7 on 1/16/2013 at 11:45 am indicated she did not know whether or not Resident #182 had a MR diagnosis.</p> <p>A care plan dated as initiated on 1/16/2013 and provided on 1/16/2013 at 1:30 pm by Consultant #8 indicated, "Focus: I have impaired cognition related to diagnosis of intellectual disabilities and cancer with metastasis to brain. Goals: My wants and needs will be met by staff through next review. Interventions: Be objective when talking with me, use open-ended questions to encourage verbalization. Check for understanding of content, repeat the questions and answers if needed. Empower me to remain independent by providing me with choices in my care, preferences, and activities. Encourage activities of interest. Make eye contact when communicating with</p>		<p>resident's #65 and #23.</p> <p>An "At-Risk for Dehydration" Care Plan was developed for resident #30.</p> <p>A "Skin Integrity" Care Plan was developed for resident #82.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b></p> <p>Residents who have the potential to be affected have been identified for having appropriate care plans through chart review. Residents found to require care plans have been updated. New residents will be identified upon admission and will have comprehensive care plans implemented as a result of their assessment.</p> <p>- <b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b></p> <p>- Re-in-servicing of nurses will be completed on 2/6/13 and 2/7/13 on the development of comprehensive care plans for each resident to include measurable objectives that are identified as a result of their assessment.</p>				

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	me."  An interview with the Social Services Director on 1/16/2013 at 1:42 pm indicated the date on the MR care plan was today, so that means it was created today.		New Residents' admission charts will be reviewed by the IDT team in the morning clinical meeting using the admission audit tool within 48 hours of admission to ensure comprehensive care plans are developed. New orders will be reviewed in the morning clinical meeting to ensure that comprehensive care plans have been developed. The Director of Nursing Services or designee will audit new admission charts within 48 hours of admission to ensure that care plans have been developed. This will be an ongoing process per Policy.  <b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b>  - The results of these audits will be presented to the Quality Assurance / Performance Improvement committee x 6 months or longer until acceptable practice is obtained. The Executive Director will oversee this process. The Assistant Director of Nursing or designee is responsible for compliance.  <b>By what date the systemic changes will be completed is as follows:</b>  2/15/13.		

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	<p>2. The clinical record for Resident #65 was reviewed on 1/14/13 at 11:30 a.m. The diagnoses for Resident #65 included, but were not limited to: renal failure and traumatic amputation of unilateral leg below the knee.</p> <p>During an interview with Resident #65 on 1/10/13 at 1:39 p.m., the resident was observed to be wearing a hospital gown and the resident indicated this was his preference for attire.</p> <p>During the following observations, Resident #65 was observed to be dressed in a hospital gown: 1/14/13 at 10:20 a.m., 1/14/13 at 11:35 a.m., 1/15/13 at 12:45 p.m., 1/15/13 at 3:02 p.m., and 1/16/13 at 12:50 p.m.</p> <p>The care plans reviewed for Resident #65 included, but were not limited to: I have episodes of not following facility LOA (leave of absence) protocol and will leave without letting staff know, dated 9/26/11; I have a history of purposefully turning my tv volume loud to cause disruption to my roommate, dated 8/8/12; I have unrealistic expectations related to the response of my call light, dated 9/6/12; and at risk for pressure ulcer,</p>			

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	<p>dated 9/26/11.</p> <p>During an interview with Unit Manager #1 and the DoN (Director of Nursing), on 1/14/13 at 1:30 p.m., they indicated the most current care plans were in the clinical record.</p> <p>A care plan for preference to dress in a hospital gown was not located in the clinical record.</p> <p>On 1/15/13 at 1:45 p.m., the DoN indicated during an interview, care plans were initiated/developed when there were new orders, new behaviors, or there was something unique about the resident that was different than the "typical" of the facility. The DoN indicated all residents should be dressed in "street clothes" and if a resident had a preference to wear a hospital gown, that is something that should've been care planned. She also indicated care plans were typically developed the next day or two after a new order, behavior, etc was noted and she definitely does not want the care plan to be developed later than 72 hours.</p> <p>At 1:25 p.m., on 1/16/13, Consultant #8 indicated the facility identified there was an issue with care plan and the development of care plans. She</p>				

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	<p>also indicated there is always room for improvement where care plans were concerned. During the same interview, Unit Manager #1 also indicated care plans were resident specific.</p> <p>3. The clinical record for Resident #23 was reviewed on 1/14/13 at 12:30 a.m. The diagnoses for Resident #23 included, but were not limited to: cardiac pacemaker, hypothyroidism, and acute systolic heart failure.</p> <p>During an interview with Resident #23 on 1/10/13 at 2:38 p.m., the resident was observed to be wearing a hospital gown and the resident indicated this was her preference for attire.</p> <p>During the following observations, Resident #23 was observed to be dressed in a hospital gown: 1/14/13 at 9:26 a.m., 1/14/13 at 1:44 p.m., 1/15/13 at 12:45 p.m., and 1/16/13 at 12:40 p.m.</p> <p>During an interview with Unit Manager #1 and the DoN (Director of Nursing), on 1/14/13 at 1:30 p.m., they indicated the most current care plans were in the clinical record.</p>						

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	<p>The care plans reviewed for Resident #23 included, but were not limited to: at risk for falls, dated 9/5/12; I have difficulty falling or staying asleep related to diagnosis of insomnia, dated 9/14/12; pressure ulcer risk, dated 9/14/12; and impaired communication due to hearing impairment, dated 8/23/12.</p> <p>A care plan for preference to dress in a hospital gown was not located in the clinical record.</p> <p>On 1/15/13 at 1:45 p.m., the DoN indicated during an interview, care plans were initiated/developed when there were new orders, new behaviors, or there was something unique about the resident that was different than the "typical" of the facility. The DoN indicated all residents should be dressed in "street clothes" and if a resident had a preference to wear a hospital gown, that is something that should've been care planned. She also indicated care plans were typically developed the next day or two after a new order, behavior, etc was noted and she definitely does not want the care plan to be developed later than 72 hours.</p> <p>At 1:25 p.m., on 1/16/13, Consultant #8 indicated the facility identified</p>				

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	<p>there was an issue with care plan and the development of care plans. She also indicated there is always room for improvement where care plans were concerned. During the same interview, Unit Manager #1 also indicated care plans were resident specific.</p> <p>4. The clinical record for Resident #30 was reviewed on 1/14/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #30 included, but were not limited to: rheumatoid arthritis, hypertension, and congestive heart failure.</p> <p>The 11/26/12 Nutrition Assessment indicated Resident #30 had the following dehydration risk factors: diuretic use, daily laxative use, and dementia.</p> <p>During review of Resident #30's care plans, no care plan for dehydration potential could be found.</p> <p>The 1/1/13 progress note indicated, "Unable to start IV fluids as ordered, due to res (resident) being dehydrated."</p> <p>During an interview with Consultant #8 on 1/16/13 at 1:23 p.m., she indicated Resident #30 should</p>				

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	<p>"absolutely" have a dehydration care plan.</p> <p>5. The clinical record for Resident #82 was reviewed on 1/14/13 at 11:30 a.m.</p> <p>The diagnoses for Resident #82 included, but were not limited to: Alzheimer's disease and hypertension.</p> <p>Review of a 1/1/13 incident investigation for Resident #82 provided by Unit Manager #6 indicated, "Resident had midsternum bruising that measured 4 cm x 4 cm. Bruising had striation markings that were various purple discolorations with green/yellowish edges. Resident also had bruising that measured 17 cm x 9 cm from the outer half of right nipple to side of right chest underneath arm. Bruising is various shades of dark purple with light purple edges."</p> <p>During review of Resident #82's care plans, no skin integrity care plan could be found.</p> <p>During an interview with Unit Manager #1 on 1/16/13 at 1:34 p.m., she indicated, "There should be an altered skin integrity care plan for</p>						

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	her."  3.1-35(a)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to administer a medication, as ordered by the physician, for 1 of 40 residents reviewed for physician orders. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record for Resident #30 was reviewed on 1/14/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #30 included, but were not limited to: pneumonia, dehydration, and hypotension.</p> <p>The 1/4/13 hospital discharge summary for Resident #30 indicated the following:</p> <p>"Current Discharge Medication List</p> <p>START taking these medications Details cephalexin (Keflex) 500 MG capsule (500 mg total) by mouth 2 (two) times daily for 3 days.</p>	F0282	<p><b>F282</b> It is the practice of this facility that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's plan of care. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Patient # 30's physician was notified of a missed dose of antibiotic medication and no new orders were received. <b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b> All residents with new orders have the potential to be affected. January antibiotic orders have been reviewed to ensure accuracy of transcription and administration. <b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b> Licensed nurses will be re-in-serviced on 2/6/13 and 2/7/13 on how to properly transcribe the physician</p>	02/15/2013	

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	<p>Qty: 6 capsule, Refills 0"</p> <p>The January 2012 MAR (medication administration record) for Resident #30 indicated, "Keflex (500 MG) (Cephalexin) - By mouth Dose: 500mg Order Date: 1/4/2013 Two times a day X 3 days end date 1/7/13 Capsule". The MAR indicated the medication was administered once on 1/5/13, twice on 1/6/13, and twice on 1/7/13 for a total of 5 administrations.</p> <p>During an interview with Unit Manager #6 on 1/16/13 at 12:42 p.m., she indicated, "She should have gotten another dose on 1/5/13."</p> <p>During an interview with Unit Manager #1 on 1/16/13 at 3:02 p.m., she indicated Resident #30 should have been administered 6 doses of the Keflex in the facility, but she only received 5.</p> <p>3.1-35(g)(2)</p>		<p>order onto the MAR for administration. New antibiotic orders will be reviewed by the IDT during the morning clinical meeting ensuring the physician order has been transcribed to the MAR according to physician order. <b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> Antibiotic documentation on the MAR will be monitored 5X per week for 4 weeks then 4 xs per week for 4 weeks then 3xs per week for 4 weeks then 2 xs per week for 4 weeks then weekly for 8 weeks by the Unit Manager or designee to ensure that antibiotics are being administered according to the physician orders. Findings from the audits will be presented to the Quality Assurance / Performance Improvement committee for further review and recommendations. The Executive Director will oversee this process. The Director of Nursing Services is responsible for compliance. <b>By what date the systemic changes will be completed is as follows.</b> 2/15/13.</p>		

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F0309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to address a resident's pain immediately following a fall and failed to consider ordering a scheduled pain medication for a resident experiencing pain, for 2 of 2 residents reviewed for hospice. (Resident #182, Resident #152)</p> <p>Findings included:</p> <p>1. The clinical record of Resident #182 was reviewed on 1/15/2013 at 2:00 pm. The resident's diagnoses included, but were not limited to, MR (mental retardation) and brain cancer.</p> <p>A progress note dated 12/10/2012 at 3:05 p.m. indicated, "Situation: Resident on floor in room at 7 am. Assessment:...Resident complains of right arm and shoulder pain, limited range of motion, painful for resident." There was no mention of pain medication given to resident in the progress notes and no further mention of any complaints of pain.</p>	F0309	<p><b>F309</b></p> <p>It is the practice of this facility to provide the necessary services to maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the plan of care.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>- Resident #182 has been re-assessed for pain and physician and Hospice informed of findings. Resident # 152 has been re-assessed for pain and physician and Hospice informed of findings.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b></p> <p>Residents that have the potential to be affected have been</p>	02/15/2013	

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	<p>Review of the December 2012 MD orders indicated no pain medication ordered for the resident. Review of the December medication administration record indicated no pain medications were given to Resident #182.</p> <p>An interview with Unit Manager #6 on 1/16/2013 at 2 p.m. indicated the resident hasn't had any issues in regard to pain, though she is on hospice currently. She was unsure why the resident did not have any as needed pain medications ordered, but the nurse taking care of the resident at the time of the fall probably should have gotten a one time order right after she fell.</p> <p>2. The clinical record of Resident #152 was reviewed on 1/15/2013 at 1:00 pm. The resident's diagnoses included, but were not limited to, pain in joint (shoulder region) and dementia.</p> <p>A care plan dated 8/28/2013 indicated, "Focus: Needs pain management and monitoring related to: osteoarthritis, complaints of headache, right rotator cuff tear. Goals: Will maintain adequate level of comfort as evidenced by no signs and</p>		<p>identified through chart review and have been re-assessed for pain and the physician informed of any findings.</p> <p><b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b></p> <p>Licensed nurses will be re-inserviced on pain assessments. Physician orders, including recommendations for those patients receiving PRN pain meds are reviewed in the morning clinical meeting. This is an on-going process. The Director of Nursing Services or designee is responsible for oversight of this process.</p> <p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>Unit Managers will audit PRN pain medications weekly x 6 weeks and make recommendations to the physician if routine meds are indicated. Information gathered from the audits will be forwarded to the Quality Assurance / Performance Improvement Committee for review x 6 months</p>		

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	<p>symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort. Interventions: Evaluate need for routinely scheduled medications rather than prn (as needed) pain med administration."</p> <p>Review of MD orders for pain medications included the following: A MD order dated 1/15/2013 indicated, "Acetaminophen 325mg tablet by mouth prn (as needed) 2- 325mg tabs to equal 650mg q (every) 4 hours for pain/fever. Roxanol 5mg by mouth prn (as needed) give 5mg q (every) 4 hours prn for pain."</p> <p>There were no orders for scheduled pain medication.</p> <p>An interview with Resident #152's daughter on 1/11/2013 at 2 pm indicated she had requested the MD and hospice nurses prescribe her mother scheduled pain medication, but they wouldn't and she doesn't understand why.</p> <p>An interview with Unit Manager #6 on 1/16/2013 at 12:52 pm indicated Resident #152 complains of pain by moaning and pointing to her eyes and shoulder, this is how she communicates with staff. Her daughter has said she has headaches. The resident would</p>		<p>or longer until substantial compliance is achieved. Trends or patterns noted will have action plans written and interventions implemented. The Executive Director and Director of Nursing Services will oversee this process.</p> <p><b>By what date the systemic changes will be completed is as follows:</b></p> <p>- 2/15/13.</p>				

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	<p>probably do well with a scheduled pain med, she probably should have had one ordered earlier.</p> <p>An interview with LPN #5 on 1/16/2013 at 2:14 pm indicated Resident #152 always says she has a headache and she is always given prn roxanol for pain.</p> <p>Review of the January medication administration record printed on January 14th, 2013 at 1:03 pm indicated the resident received a dose of, "Roxanol (a pain medication) by mouth 5 mg ordered every 4 hours prn (as needed) for pain;" January 2nd at 9:40 am, January 6th at 4:35 pm, January 7th at 6:03 pm, January 9th at 11:08 am and at 3:25 pm, January 10th at 3:16 pm, January 13th at 3:10 pm and at 7:49 pm.</p> <p>A MD order dated 1/15/2013 indicated, "Acetaminophen 325mg tablet by mouth- three times a day everyday: give 2 tabs to = 650mg tid (three times a day) for pain."</p> <p>No progress notes could be found addressing considering scheduled pain medication.</p> <p>3.1-37(a)</p>						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to timely address a malfunctioning bed for 1 of 1 resident reviewed for safe transfers. (Resident #82)</p> <p>Findings include:</p> <p>The clinical record for Resident #82 was reviewed on 1/14/13 at 11:30 a.m.</p> <p>The diagnoses for Resident #82 included, but were not limited to: Alzheimer's disease and hypertension.</p> <p>The 9/26/12 quarterly MDS (minimum data set) assessment indicated Resident #82 was an extensive assist of 2 person for bed mobility and transfers.</p> <p>An observation of Resident #82 being transferred by CNA #9 and CNA #10 from her wheelchair onto her bed was made on 1/14/13 at 3:05 p.m. After the transfer onto the bed was</p>	F0323	<p><b>F323</b> It is the practice of this facility to ensure that the resident's environment remains as free of accident hazards as is possible. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> _ Resident #85's bed was replaced during survey. <b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b> All beds in the facility were checked by maintenance for proper function. Any issues noted were immediately corrected. <b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b> Staff will be re-in-serviced on 2/6/13 and 2/7/13 on use of "Building Engines" Maintenance Program into which staff can enter requisitions for maintenance issues that are reviewed daily by the maintenance department.</p>	02/15/2013

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	<p>complete, CNA #10 raised the bed with the bed controller. The bed raised and immediately began to lower, on its own, as soon as CNA #10 took her finger off of the remote control. CNA #10 raised the bed again. Again, the bed began to lower on its own. CNA #10 stated, "It's been like this a while." CNA #9 stated, "It doesn't always do it."</p> <p>During an interview with CNA #10 on 1/14/13 at 3:32 p.m., she indicated she noticed Resident #82's bed malfunctioning "maybe a couple weeks ago". She indicated she didn't tell anyone because she checked the bed again and it didn't do it.</p> <p>During an interview with CNA #9 on 1/15/13 at 12:25 p.m., she indicated the first time she noticed Resident #82's bed malfunctioning was "a couple weeks ago". She indicated, "As long as you have your thumb on the button, it will stop where you want it, but when you take your thumb off, it lowers by itself. We just keep the bed in the lowest position, because it can't go any further. It's hard for me to do a.m. care." She indicated she told maintenance about the bed the previous week, but did not tell nursing staff.</p>		<p>Maintenance department will place bed maintenance on preventative maintenance audits.</p> <p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> Maintenance director/designee will audit montly through preventative maintenance program and audtis will be reviewed by ED /designee and reported to QAPI monthly for 6 months and then as needed and any trends or patterns identified will result in an action plan being implemented. <b>By what date the systemic changes will be completed is as follows:</b> 2/15/13.</p>		

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	<p>During an interview with the Maintenance Director on 1/14/13 at 3:35 p.m., he indicated he just found out about Resident #82's malfunctioning bed "10 minutes ago."</p> <p>During an interview with Maintenance Staff #15 on 1/16/13 at 2:10 p.m., he indicated he looked at the bed the previous week after being told it was malfunctioning, but he didn't find anything wrong with it. He indicated he did not document any of this.</p> <p>During an interview with Unit Manager #1 on 1/16/13 at 1:34 p.m., she indicated, "(Name of CNA #9) should have told nursing about the bed when she first noticed it."</p> <p>3.1-45(a)(1)</p>			

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to recognize a potential significant weight loss for 1 of 3 residents reviewed for weight loss, of 13 residents who met the criteria for weight loss (Resident #123).</p> <p>Findings include:</p> <p>The clinical record for Resident #123 was reviewed on 1/14/13 at 1:30 p.m. The diagnoses for Resident #123 included, but were not limited to: unspecified dementia, unspecified psychosis, and depressive disorder.</p> <p>A review of the clinical record indicated the following weights: 8/8/12=115.0 9/6/13=114.6 10/9/12=121 11/3/12=124.8 12/1/12=125.4</p>	F0325	<p><b>F325</b></p> <p>It is the practice of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>Resident 123 was re-weighed on 1/15/13 and weighed 121.2 pounds. Registered Dietitian assessed and documented new interventions and updated her care plan.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective</b></p>	02/15/2013			

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	<p>1/7/13=116.6</p> <p>A Progress Note dated 1/7/13 at 3:16 p.m., indicated, "Resident (#123) currently weighs 116.6 pounds. Resident has had a sig (significant) weight gain (symbol for times) 90 days and continues to be stable (symbol for times) 30 days...IDT recommends to continue to plan of care..." The progress note was signed by Unit Manager #1.</p> <p>A review of the Weight Monitoring policy, no date, received from the DoN (Director of Nursing), on 1/14/13 at 1:00 p.m., indicated a 5% weight loss during one month was considered significant.</p> <p>During an interview with the DoN (Director of Nursing), on 1/15/13 at 1:45 p.m., she indicated the facility will notify the Registered Dietician (RD) if there is a weight loss/gain of 5 pounds for a Resident. She also indicated the facility reweighs residents if there was a weight loss noted and would consult the RD for interventions, if needed, for weight loss.</p> <p>On 1/15/13 at 2:02 p.m., the Registered Dietician (RD) indicated during an interview, she did not recall</p>		<p><b>actions will be taken are as follows:</b></p> <p>All residents had weights reviewed in the last 30 days to ensure the Dietician had assessed and written new interventions as needed.</p> <p>Nursing staff will be in-serviced on 2/6/13 and 2/7/13 regarding reporting weight loss.</p> <p>District Registered Dietitian will in-service Director of Nursing Services, Unit Managers and Dietary Service Manager on 2/6/13 on weight meeting protocol.</p> <p>Dietary Services Manager or designee will bring Registered Dietitian recommendations to morning clinical meeting to review and ensure all have been addressed.</p> <p><b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b></p> <p>Resident weights will be reviewed daily, 5 days a week in morning clinical meeting to ensure any weight loss is referred to the Registered Dietitian to assess.</p> <p>Dietary Services Manager or designee will bring Registered</p>		

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	<p>the weight loss this month for Resident #123, but if there was one, the resident should've been reweighed. She also indicated if the resident did have a significant weight loss of almost 9 pounds, she would've added/recommended a supplement with meals and she could do that now. The RD indicated she relied on staff to let her know about a resident's weight loss. She also indicated she looked at the weight difference more than the percentage gained/loss to determine if there was a problem.</p> <p>A Progress Note, dated 1/15/13 at 2:15 p.m., indicated, "Resident wt (weight) near 117 (symbol for pounds) this month, showing significant wt loss of 6% (symbol for times) 30d (days), down 3.3% (symbol for times) 90d. PO (by mouth) intakes recorded at average 71% of meals. Recommend resume house supplement with meals (symbol for times) 30d and have resident eat in dining room for increased supervision with meals." The Progress Note was signed by the RD.</p> <p>At 2:45 p.m., on 1/15/13, the RD indicated she just entered a new progress note for Resident #123 and recommended house supplements with meals after she was notified</p>		<p>Dietitian recommendations to morning clinical meeting to review and ensure all have been addressed.</p> <p>Director of Nursing Services or designee will audit the Registered Dietitian recommendations 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly.</p> <p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>Director of Nursing Services or designee will report findings of audits to monthly Quality Assurance / Performance Improvement meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p> <p><b>By what date the systemic changes will be completed is as follows:</b></p> <p>2/15/2013.</p>		

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	<p>about the weight loss. The RD also indicated she overlooked the significant weight loss for Resident #123.</p> <p>During an interview with DoN, on 1/15/13 at 2:50 p.m., she indicated the unit managers, dietary manager, and the dietician attend the IDT (Interdisciplinary Team) weight meetings. She also indicated she had been unable to attend the IDT weight meetings, as much as she would've liked, since she became the interim DoN.</p> <p>At 2:52 p.m., on 1/15/13, the RD indicated she doesn't remember the IDT meeting from 1/7/13.</p> <p>On 1/15/13 at 3:00 p.m., Unit Manager #1 indicated she was unsure why the IDT note from 1/7/13 indicated the resident's weight had been stable the past 30 days or why the note indicated a gain when there was a weight loss. She also indicated she must've read the weights wrong during the meeting.</p> <p>A Progress Note dated 1/15/13 4:44 p.m., indicated, "correction to IDT weight variance note. Instead of resident having a significant weight gain, resident actually had a</p>				

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	<p>significant weight loss 90 days prior." The Progress Note was signed by Unit Manager #1.</p> <p>An IDT Weight Variance Progress Note, dated 1/15/13 at 6:26 p.m., indicated, "In re-evaluating weight variances from October to present, today's weight is 121.2 lbs. In referenced to RD note indicating a 6% weight loss in 30 days, it is the opinion of the IDT team that the noted weight variance was calculated from an incorrect weight on 1/7/12 [sic]. Using today's weight, this resident has had a 3.3% weight loss 30 days prior. Will follow RD recommendations of house supplements with meals and will resume weekly weights (symbol for times) 4 weeks." The progress note was signed by Unit Manager #1.</p> <p>During an interview with Unit Manager #1, on 1/16/13 at 10:50 a.m., she indicated the possible significant weight loss was overlooked, but corrections were made after the facility was notified of the possible significant weight loss.</p> <p>During an interview with Consultant #8, on 1/16/13 at 1:20 p.m., she indicated they (the facility/Consultant) identified a system problem in house</p>						

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	<p>regarding identification of weight issues, about a month ago. The current system was not following policy and they (the facility/company) were revamping the system with some new changes.</p> <p>3.1-46(a)(1)</p>			

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F0327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on interview and record review, the facility failed to ensure a resident was adequately hydrated to prevent dehydration, resulting in a 4 day hospital admission, for 1 of 2 residents reviewed for dehydration. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record for Resident #30 was reviewed on 1/14/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #30 included, but were not limited to: pneumonia, dehydration, and hypotension.</p> <p>The 11/30/12 quarterly MDS (minimum data set) assessment indicated Resident #30 required extensive assistance of one person for eating.</p> <p>The 11/26/12 Nutrition Assessment indicated Resident #30 had the following dehydration risk factors: diuretic use, daily laxative use, and dementia. It also indicated the</p>	F0327	<p><b>F327</b> It is the practice of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Resident #30 returned to the facility on 1/4/13, and was encouraged to drink fluids every shift. A care plan was implemented for dehydration. <b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b> Residents' had intakes reviewed and if decreased will be placed on I&amp;Os for 7 days. All new admits/re-admits will be placed on I&amp;Os for 7 days and the IDT will meet and document if I&amp;Os are to continue and will be weighed daily for 3 days. <b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b> Resident intakes will be reviewed daily 5 days a week through morning clinical meeting and if intake</p>	02/15/2013

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	<p>feeding ability of Resident #30 was total dependence and limited assistance. This assessment did not indicate Resident #30's estimated needs for fluid.</p> <p>During review of Resident #30's care plans, no care plan for dehydration potential could be found.</p> <p>The 1/8/13 nutrition assessment indicated Resident #30's estimated nutrient needs for fluid as "1580-1895 ml free fluids."</p> <p>During an interview with Unit Manager #6 on 1/16/13 at 12:40 p.m., she indicated the facility tracked the percentages of food and fluids consumed for residents. She indicated intake and output were not recorded for Resident #30. She also indicated, "We typically put residents on I's and O's (intake and output) if we see that they are not drinking or eating a whole lot, if they're on fluid restrictions. We didn't notice anything on (name of Resident #30)."</p> <p>Unit Manager #6 provided the "Resident Meals by Day Report" for Resident #30 on 1/16/13 at 3:25 p.m. She indicated the report combined food and fluid in its percentages. They were not tracked separately.</p>		<p>decreases the resident will be placed on I&amp;Os for 7 days and daily weights for 3 days, then IDT will meet to determine if I&amp;Os are to continue. Nursing staff will be in serviced on 2/6/13 and 2/7/13 regarding documentation of potential dehydration symptoms.</p> <p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> Director of Nursing Services or designee will report findings to monthly Quality Assurance / Performance Improvement meetings for 6 months, any patterns or trends, will have an action plan written, and interventions implemented.</p> <p><b>By what date the systemic changes will be completed is as follows:</b> 2/15/13.</p>		

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	<p>Breakfast, lunch, dinner, and evening snack were accounted for in the report. It indicated the average meal intake percentages for the following days:</p> <p>12/22/12 - 25% 12/23/12 - 16.7% 12/24/12 - 58.3% 12/25/12 - 25% (dinner was only meal included for this day) 12/26/12 - 50% 12/27/12 - 25% 12/28/12 - 25% 12/29/12 - 33.3% 12/30/12 - 66.7% 12/31/12 - 16.7% 1/1/13 - 50% (breakfast and lunch were only meals included for this day)</p> <p>During another interview with Unit Manager #6 on 1/16/13 at 3:45 p.m., she indicated the facility would know a resident was receiving adequate fluids if the "Resident Meals by Day Report" indicated meals above 50% and through skin assessments. She then stated, "I'm not sure," followed by, "If they're eating less than 25% of meals, they may not be receiving adequate fluids. We don't have a policy to monitor fluids."</p> <p>The progress notes indicated the following:</p>				

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	<p>12/23/12, 10:39 p.m. - "...extra fluids encouraged &amp; tolerated."                      12/24/12, 4:36 a.m. - "Fluids encouraged."                      12/24/12, 10:24 p.m. - "...extra fluids encouraged &amp; tolerated."                      12/25/12, 2:34 p.m. - "...continue to encourage extra fluids."                      12/26/12, 7:17 a.m. - "Fluids encouraged."                      12/26/12, 2:49 p.m. - "continue to encourage extra fluids."                      12/26/12, 9:52 p.m. - "...extra fluids encouraged &amp; tolerated."                      12/27/12, 9:50 p.m. - "...extra fluids encouraged &amp; tolerated."                      12/28/12, 10:49 p.m. - "...fluids encouraged."                      12/29/12 - Did not indicate fluids encouraged or tolerated                      12/30/12 - Did not indicate fluids encouraged or tolerated                      12/31/12 - Did not indicate fluids encouraged or tolerated</p> <p>The 1/1/13, 3:43 p.m. progress note indicated, "Change of Condition. Situation: appetite poor, and decrease fluid intake. Background: dx: infiltrates. Assessment: breath sounds congested appetite poor, res lethargic easily aroused. MD notified. v/s: 97.2, 94/70, 48 faint difficult to palpate (pulse), 20 (respirations) MD</p>			

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	<p>notified. Response: order for IV fluids. D51/2 normal saline @75ml hr give 2 liters. orders noted. family aware of new orders."</p> <p>The 1/1/13, 7:10 p.m. progress note indicated, "Resident unable to take po (by mouth) fluids or eat well. Unable to start IV fluids as ordered, due to res being dehydrated. VS T97.8, P78, R20, BP 127/46. Sats 97%. Alert and oriented with periods of lethargy. Resp easy and unlaboured. cracles and wheezes heard on all four lobes. Res transfer to (name of hospital) per (name of transport company). Family notified."</p> <p>The 1/2/13, 10:38 a.m. hospital progress note indicated the following:</p> <p>"...presenting to the (name of hospital) emergency department with complaints of sever [sic] fatigue, thirsty, and confusion, she lives at ECF (extended care facility) and claims that nobody was able to access her vein for IV trx (treatment). She is oriented at the time I saw her for T/P/P (time, place and person) and looked very dehydrated. She denies any cp (complaint of pain). Sob (shortness of breath), fever. chills. Ha (headache). LOC (level of consciousness), n (nausea), vomiting,</p>			

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	<p>she constantly asking for water. She was found to be hypotensive and was started on IV fluids. chest xray showed possible pneumonia and was started on levaquin."</p> <p>The 1/1/13 9:08 p.m. hospital labwork for Resident #30 was provided by Consultant #8 at 3:05 p.m. on 1/16/13 who stated, "She was barely dehydrated." It indicated normal lab values and Resident #30's actual lab values as follows:</p> <p>Sodium - 142 (Normal: 134-143) Potassium - 4.8 (Normal: 3.5-4.9) Chloride - 107 (Normal: 98-109) BUN - 23 (Normal: 8-26) hemoglobin - 13.6 (Normal: 11.6-15.2) hematocrit - 40 (Normal: 34.4-45.6)</p> <p>The 1/4/13 hospital discharge summary indicated the following:</p> <p>"Discharge diagnosis: Principle Problems: *Fatigue Active Problems: Anorexia Dehydration...</p> <p>Hospital Course and Physical Exam: ...admitted on 1/1/2013 for Dehydration and Hypotension. In the</p>			

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	<p>process of her workup a UTI (urinary tract infection) was also found. The pt (patient) has been treated with IV hydration and ABx (antibiotics)...."</p> <p>During an interview with Consultant #8 on 1/16/13 at 1:23 p.m., she indicated, "She should absolutely have a dehydration care plan. Residents are assessed weekly and dehydration status should be part of that. We had a lot of upper respiratory going on and it got the best of a lot of people. We rely heavily on communication from CNAs (Certified Nursing Assistants) and nursing. We need them to tell us if someone needs more assistance with feeding."</p> <p>3.1-46(b)</p>			

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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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to discard expired insulin in 2 of 2 medication carts reviewed for medication storage. This had the potential to affect 3 of 13 residents on insulin. (Resident #54, #35, and #126)</p> <p>Findings include:</p> <p>1. During a medication cart/storage review with LPN #3, of the West Medication Cart, on 1/16/13 at 2:10 p.m., a vial of Novolog (insulin) 100u/ml (units/milliliter) had a</p>	F0425	<p><b>F425</b></p> <p>It is the practice of this facility to provide pharmaceutical service (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>Resident #54 multidose vial of Novolog Mix 70/30 (insulin) was discarded on 1/16/13 and a new</p>	02/15/2013			

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	<p>handwritten open date of 12/13/12 on it. The medication was for Resident #54. LPN #3 indicated the medication was just used for the resident around noon. A vial of Lantus (insulin) 100u/ml had a handwritten open date of 12/12/12 on the vial. The medication was for Resident #35. LPN #3 indicated at this time, the medication was last the previous evening. LPN #3 confirmed there were insulins for 5 residents in the medication cart.</p> <p>In an interview with LPN #3 at 1/16/13 at 2:15 p.m., she indicated insulins expire 28-30 days after opened, depending on the insulin brand/type.</p> <p>A review of the January MAR (medication administration record) for Resident #54, indicated Novolog 100u/ml was given on 1/16/13 at 11:30 a.m., as indicated by the checkmark in the dated/timed slot on the MAR.</p> <p>On the January MAR for Resident #35, it indicated Lantus 100u/ml was last given on 1/15/13 at 9:00 p.m., as indicated by the checkmark in the dated/timed slot on the MAR.</p> <p>2. During a medication cart/storage review with LPN #4, on 1/16/13 at</p>		<p>vial was provided and dated. Resident #35 multidose vial of Lantus (insulin) was discarded on 1/16/13 and a new vial was provided and dated. Resident #126 multidose vial of Lantus (insulin) was discarded on 1/16/13 and a new vial was provided and dated.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</b></p> <p>All med carts and medication refrigerators were checked for open vials of multidose medications. No further vials were identified as being past the expiration date.</p> <p><b>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</b></p> <p>Nursing staff will be re-in-serviced on 2/6/13 and 2/7/13 on policy for "Medication Storage in the Facility" which includes the removal of outdated medications. Medication carts will be audited weekly to assure that multidose vials of medication have been dated and not expired.</p>				

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	<p>2:20 p.m., of the East Medication Cart #2 near the Alzheimer Care Unit, a vial of Lantus 100u/ml had a handwritten open date of 12/14/12 on it. The medication was for Resident #126. LPN #4 confirmed there was insulin for 8 residents in the medication cart.</p> <p>On 1/16/13 at 2:17 p.m., LPN #4 indicated, during an interview, insulins expire 28-30 days after the open date, depending on the insulin. LPN #4 was unsure of when the insulin for Resident #126 was last used.</p> <p>A review of the January MAR (medication administration record) for Resident #126, indicated Lantus 100u/ml was last given at 9:00 p.m. on 1/15/13, as indicated by a checkmark in the dated slot for 9:00 p.m.</p> <p>A review of the, "Determining Medication Expiration Dates" policy, received from the DoN (Director of Nursing), on 1/16/13 at 2:43 p.m., indicated Lantus expires after 28 days after it is open and room temperature insulin (Novolog) expires 28 days after it is removed from the refrigerator.</p> <p>At 3:07 p.m., on 1/16/13, the DoN</p>		<p><b>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>Audits will be completed weekly x 8 weeks and then monthly as on going process. Results of audits will be reviewed by the Quality Assurance / Performance Improvement committee monthly and trends or patterns noted will have an action plan written and interventions implemented. The Executive Director and the Director of Nursing Services will oversee this process.</p> <p><b>By what date the systemic changes will be completed is as follows:</b></p> <p>2/15/13.</p>				

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	<p>indicated a checkmark on the MAR indicates the medication was given at the date/time on the MAR.</p> <p>3.1-25(o)</p>			