

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2015
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NAME OF PROVIDER OR SUPPLIER  BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date: April 13, 14, 15, 16, 17, and 20, 2015.</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Census bed type: SNF: 41 SNF/NF: 26 Residential: 63 Total: 130</p> <p>Census payor type: Medicare: 34 Medicaid: 16 Other: 80 Total: 130</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on April 20, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's</p>			

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

TITLE

(X6) DATE

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

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	<p>physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, clinical record review and interview, the facility failed to notify the physician of weight gain in accordance with the physician's orders for 2 of 4 residents reviewed for weight and nutrition. (Resident #35 and Resident #43)</p> <p>Findings include:</p>	F 157	<p><b>F 157 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #43 - MD was notified of any weight changes in accordance with the MD orders and / or significant loss/gain parameters. Resident #35 has been discharged. <b>Identification of other residents</b></p>	05/20/2015

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	<p>1. The clinical record for Resident #35 was reviewed on April 14, 2015 at 4:13 p.m. Diagnoses for Resident #35 included, but were not limited to, end stage renal disease, hypertension, anemia, congestive heart failure and distal tibia/fibula fracture with cast.</p> <p>A physician's order, dated March 2, 2015, indicated Resident #35 was to be weighed daily. The physician was to be notified if the resident had a weight gain of two pounds in one day.</p> <p>Review of the March 2015 and April 2015 daily weights indicated Resident #35 weights were on the following dates:</p> <p>March 4, 2015 weight 168.2 pounds and on March 5, 2015 Resident #35 weighed 170.2 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>March 6, 2015 Resident #35 weighed 169.4 pounds and on March 7, 2015 Resident #35 weighed 172.2 pounds, a weight gain of 2.8 pounds. No physician documentation was noted in the clinical record.</p> <p>March 9, 2015 Resident #35 weighed 172.2 pounds and on March 10, 2015</p>		<p><b>having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with weight monitoring in place to ensure the MD was notified of any weight changes in accordance with the MD orders and / or significant loss/gain parameters. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Physician Notification of Diagnostic Testing and Change in Condition <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted on 5 residents by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: review weights to ensure MD was notified of any weight changes in accordance with the MD orders and / or significant loss/gain parameters. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Resident #35 weighed 175.8 pounds, a weight gain of 3.6 pounds. No physician documentation was noted in the clinical record.</p> <p>March 11, 2015 Resident #35 weighed 172 pounds and on March 12, 2015 Resident #35 weighed 174.4 pounds, a weight gain of 2.4 pounds. No physician documentation was noted in the clinical record.</p> <p>March 13, 2015 Resident #35 weighed 169.2 pounds and on March 14, 2015 Resident #35 weighed 172.4 pounds, a weight gain of 3.2 pounds. No physician documentation was noted in the clinical record.</p> <p>March 15, 2015 Resident #35 weighed 167.2 pounds and on March 16, 2015 Resident #35 weighed 173.2 pounds, a weight gain of 6 pounds. No physician documentation was noted in the clinical record.</p> <p>March 16, 2015 Resident #35 weighed 173.2 pounds and on March 17, 2015 Resident #35 weighed 175.8 pounds, a weight gain of 2.6 pounds. No physician documentation was noted in the clinical record.</p> <p>No weights for the following dates were</p>			

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	<p>available: March 20, 21, 22, 25, 28, and 29, 30, and 31 2015.</p> <p>April 3, 2015 Resident #35 weighed 170.2 pounds and on April 4, 2015 Resident #35 weighed 172.2 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>April 6, 2015 Resident #35 weighed 168.4 pounds and on April 7, 2015 Resident #35 weighed 173.8 pounds, a weight gain of 5.4 pounds. No physician documentation was noted in the clinical record.</p> <p>April 13, 2015 Resident #35 weighed 168.3 pounds and on April 14, 2015 Resident #35 weighed 170.3 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>April 14, 2015 Resident #35 weighed 170.3 pounds and on April 15, 2015 Resident #35 weighed 173.8 pounds, a weight gain of 3.5 pounds. No physician documentation was noted in the clinical record.</p> <p>Review of Nursing Notes, dated December 31, 2014 through April 16, 2015, lacked any documentation of</p>			

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	<p>physician notification of weight gains.</p> <p>Review of Change in Condition forms, from January 6, 2015 through March 23, 2015, lacked any documentation of physician notification of weight gains.</p> <p>A Heights and Weights care plan for Resident #35 stated: "I am on DAILY weights. My weight is up presently from my UBW (Usual Body Weight) of 180#, likely due to my cast and some fluid possibly as I am on dialysis. Please review my overall weight trends at least once monthly and make any necessary recommendations to my physician for approval should I experience any undesired weight change. My weight should remain at a healthy range for me and be without any unwarranted significant weight change. To ensure my needs have not changed and desired outcomes are achieved, please review my individualized care plan on or before 6/2/15. Please also coordinate care efforts with myself, my family/care-givers/responsible parties and the IDT."</p> <p>An Acute Care care plan for Resident #35 stated: "I have ESRD [End Stage Renal Disease] and I attend dialysis 3X [times] weekly. Please send a sack lunch with me on dialysis days. Please obtain</p>			

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	<p>my weight as ordered and report any significant changes to my physician. I have a shunt to my left antecube [sic] that is used during dialysis. Please check this for a bruit/thrill daily. Do not use my left arm to obtain a blood pressure. My goal is to attend my dialysis per my schedule, for my weight to remain stable, and for there to be no complications related to my shunt throughout this review period...."</p> <p>During an observation on April 16, 2015 at 10:00 a.m., Resident #35 was observed being put on a gurney by transporters to be taken to dialysis. Resident #35 stated she was short of breath and was taken to dialysis.</p> <p>During an interview on April 16, 2015 at 2:00 p.m., LPN #9 indicated Resident #35 had been sent to the hospital by the dialysis center and admitted. LPN #9 did not have an admitting diagnoses.</p> <p>During an interview, April 17, 2015 at 1:00 p.m., the Director of Nursing indicated the physician notification of Resident #35's weight gains should have been documented in the clinical record.</p> <p>During an interview, April 17, 2015 at 1:12 p.m., the Director of Nursing indicated she was not able to find any</p>			

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	<p>information regarding the MD notification of the weight gain or the missing dialysis communication sheets.</p> <p>During a hospital clinical record review on April 20, 2015 at 3:00 p.m., the clinical record review indicated the admitting diagnoses for Resident # 35 was shortness of breath and chest pain. The clinical record also indicated the resident received dialysis at the hospital. A notation from the nephrologist, dated April 16, 2015, indicated 3.2 kilograms (7.05 pounds) of fluid weight was taken off during dialysis.</p> <p>2. The clinical record for Resident #43 was reviewed on 4/15/15 at 9:48 a.m., who had diagnoses which included, but were not limited to, left lower extremity cellulitis and deep vein thrombosis, spinal stenosis, peripheral neuropathy, neurogenic bladder, cervical degenerative disease and chronic obstructive pulmonary disease.</p> <p>The review of weights indicated Resident #43 had a significant weight gain of 20.6 pounds from 1/9/15 to 2/10/15. The weight on 1/9/15 was 150.8 pounds. The weight on 2/10/15 was 171.4 pounds.</p> <p>A current care plan review for Resident #43 indicated "...review my overall weight trends at least once monthly and</p>			

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	<p>make any necessary recommendations to my physician for approval should I experience any undesired weight change..."</p> <p>The clinical record lacked documentation of physician notification regarding the Resident's weight gain on 2/10/15.</p> <p>A review of a progress note, with a date of service of 2/11/15, for Resident #43, indicated the resident was seen by the Nurse Practitioner and it indicated "...no recent weight gain...."</p> <p>A review of a nutrition progress note, dated 2/9/15, indicated "171.4# ? Wt [weight] [up] -? accuracy (P) [pending] Rewt [re-weight]...."</p> <p>The Director of Nursing was interviewed on 4/17/15 at 1:12 p.m. She indicated she was unable to provide any documentation regarding notification of the physician for the weight gain between 1/9/15 to 2/10/15.</p> <p>A current facility policy titled "Physician Notification of Diagnostic Testing and Change in Condition", dated 12/6/2007, provided by the Director of Nursing on 4/16/15 at 2:53 p.m., indicated the following:</p>			

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F 223 SS=D Bldg. 00	<p>"Purpose:</p> <p>To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care.</p> <p>...Procedure:</p> <p>1. Resident assessments for change in condition...should be completed in a timely manner."</p> <p>3.1-5(a)(2)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 21 residents interviewed regarding abuse. (Resident #85)</p> <p>Findings include:</p>	F 223	<p><b>F 223</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #85 - An</b></p>	05/20/2015	

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	<p>On 4/13/15 at 8:31 a.m., during an interview Resident #85 indicated this morning during the medication pass, the nurse said he must take his medication. When he indicated he would take his medication later, RN #2 strongly insisted he would take the medication now.</p> <p>A detailed investigation, dated 4/13/2015 (no time), was provided by the Administrator on 4/16/15 at 3:35 p.m. for the allegation by Resident # 85. This investigation indicated the following:</p> <p>Resident #85's interview indicated to RN #2 he wasn't feeling well. The nurse stated "here are your medications. He stated to her that he would take them in a minute and RN #2 responded, "oh no, you will take them and you will take them now." He stated RN #2 was rude and had a poor bedside manner.</p> <p>Resident #85's wife was interviewed. She indicated the resident was receiving personal care when RN #2 came in to administer his medications. She indicated the resident did not want to take his medication during personal care (washing chest), but RN #2 stated to (Resident's name) " you can and you will."</p> <p>CNA #4 was interviewed and indicated</p>		<p>investigation for the allegation of verbal abuse was investigated and reported to the ISDH by the Executive Director.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The campus staff will be re-educated on the following guideline: Abuse and Neglect.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interviews of residents and staff regarding any allegations of</p>	

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	<p>when Resident #85 refused to take some medication, RN #2 had told him he really needed to take it. CNA # 4 "stated that (RN #2's name) could could [sic] have spoken to (Resident's name) differently."</p> <p>CNA #5 was interviewed and indicated when RN #2 came in to give the resident medication, Resident #85 indicated he was not going to take it. RN #2 told resident "yes you are, you have to take it." CNA #5 indicated RN #2 "sounded kind of rude when she said it-like she was pushy."</p> <p>Resident #85's clinical record review was on 4/16/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, debility with difficulty walking, hepatic encephalopathy, uncontrolled insulin dependent diabetes mellitus. The "Skilled Charting Evaluation," dated 4/13/15, indicated the resident's cognition was alert and oriented.</p> <p>The "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" was provided by the Administrator, on 4/13/15, during the entrance conference. This current policy indicated the following:</p> <p>"Purpose: (The corporate office's name) had</p>		<p>abuse / neglect and immediate notification to the Executive Director.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 225 SS=D Bldg. 00	<p>developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.</p> <p>Procedure: ...3. Definitions: ...b. VERBAL ABUSE-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. i. Staff to resident-any episode; ...d. Identification ...iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...."</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was reported timely to the Administrator for 1 of 21 residents interviewed regarding abuse. (Resident #85)</p> <p>Findings include:</p> <p>On 4/13/15 at 8:31 a.m., during an interview Resident #85 indicated this</p>	F 225	<p><b>F 225</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #85 - An investigation for the allegation of verbal abuse was investigated and reported to the ISDH by the</p>	05/20/2015

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	<p>morning during the medication pass, the nurse said he must take his medication. When he indicated he would take his medication later, RN #2 strongly insisted he would take the medication now.</p> <p>A detailed investigation, dated 4/13/2015 (no time), was provided by the Administrator on 4/16/15 at 3:35 p.m. for the allegation by Resident # 85. This investigation indicated the following:</p> <p>Resident #85's interview indicated to RN #2 he wasn't feeling well. The nurse stated "here are your medications. He stated to her that he would take them in a minute and RN #2 responded, "oh no, you will take them and you will take them now." He stated RN #2 was rude and had a poor bedside manner.</p> <p>Resident #85's wife was interviewed. She indicated the resident was receiving personal care when RN #2 came in to administer his medications. She indicated the resident did not want to take his medication during personal care (washing chest), but RN #2 stated to (Resident's name) " you can and you will."</p> <p>CNA #4 was interviewed and indicated when Resident #85 refused to take some medication, RN #2 had told him he really</p>		<p>Executive Director.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The campus staff will be re-educated on the following guideline: Abuse and Neglect.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interviews of residents and staff regarding any allegations of abuse / neglect and immediate notification to the Executive Director.</p>	

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	<p>needed to take it. CNA # 4 "stated that (RN #2's name) could could [sic] have spoken to (Resident's name) differently."</p> <p>CNA #5 was interviewed and indicated when RN #2 came in to give the resident medication, Resident #85 indicated he was not going to take it. RN #2 told resident "yes you are, you have to take it." CNA #5 indicated RN #2 "sounded kind of rude when she said it-like she was pushy."</p> <p>Resident #85's clinical record review was on 4/16/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, debility with difficulty walking, hepatic encephalopathy, uncontrolled insulin dependent diabetes mellitus. The "Skilled Charting Evaluation," dated 4/13/15, indicated the resident's cognition was alert and oriented.</p> <p>On 04/16/15 at 3:41 p.m., CNA #4 indicated an allegation of abuse she be reported immediately.</p> <p>The "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" was provided by the Administrator on 4/13/15 during the entrance conference this current policy indicated the following:</p> <p>"Purpose:</p>		<p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 226 SS=D Bldg. 00	<p>(The corporate office's name) had developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.</p> <p>Procedure: ...3. Definitions: ...b. VERBAL ABUSE-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. i. Staff to resident-any episode; ...d. Identification ...iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...."</p> <p>3.1-28(a)</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 property. Based on interview and record review,</p>	F 226		05/20/2015

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	<p>the facility failed to immediately identify and report an allegation of verbal abuse to the Administrator for 1 of 21 residents interviewed regarding abuse. (Resident #85)</p> <p>Findings include:</p> <p>On 4/13/15 at 8:31 a.m., during an interview Resident #85 indicated this morning during the medication pass, the nurse said he must take his medication. When he indicated he would take his medication later, RN #2 strongly insisted he would take the medication now.</p> <p>A detailed investigation, dated 4/13/2015 (no time), was provided by the Administrator on 4/16/15 at 3:35 p.m. for the allegation by Resident # 85. This investigation indicated the following:</p> <p>Resident #85's interview indicated to RN #2 he wasn't feeling well. The nurse stated "here are your medications. He stated to her that he would take them in a minute and RN #2 responded, "oh no, you will take them and you will take them now." He stated RN #2 was rude and had a poor bedside manner.</p> <p>Resident #85's wife was interviewed. She indicated the resident was receiving personal care when RN #2 came in to</p>		<p><b>F 226</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #85 - An investigation for the allegation of verbal abuse was investigated and reported to the ISDH by the Executive Director.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The campus staff will be re-educated on the following guideline: Abuse and Neglect.</p> <p><b>How the corrective measures will be monitored to ensure the</b></p>		

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	<p>administer his medications. She indicated the resident did not want to take his medication during personal care (washing chest), but RN #2 stated to (Resident's name) " you can and you will."</p> <p>CNA #4 was interviewed and indicated when Resident #85 refused to take some medication, RN #2 had told him he really needed to take it. CNA # 4 "stated that (RN #2's name) could could [sic] have spoken to (Resident's name) differently."</p> <p>CNA #5 was interviewed and indicated when RN #2 came in to give the resident medication, Resident #85 indicated he was not going to take it. RN #2 told resident "yes you are, you have to take it." CNA #5 indicated RN #2 "sounded kind of rude when she said it-like she was pushy."</p> <p>Resident #85's clinical record review was on 4/16/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, debility with difficulty walking, hepatic encephalopathy, uncontrolled insulin dependent diabetes mellitus. The "Skilled Charting Evaluation," dated 4/13/15, indicated the resident's cognition was alert and oriented.</p> <p>On 04/16/15 at 3:41 p.m., CNA #4</p>		<p><b>alleged deficient practice does not recur:</b> The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interviews of residents and staff regarding any allegations of abuse / neglect and immediate notification to the Executive Director.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>indicated an allegation of abuse she be reported immediately.</p> <p>The "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" was provided by the Administrator on 4/13/15 during the entrance conference. This current policy indicated the following:</p> <p>"Purpose: (The corporate office's name) had developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.</p> <p>Procedure: ...3. Definitions: ...b. VERBAL ABUSE-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. i. Staff to resident-any episode; ...d. Identification ...iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...."</p> <p>3.1-28(a)</p>			

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F 241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to promote care and services in a manner to protect dignity when serving meals to dependent residents and when encouraging therapy participation for 6 of 6 residents reviewed for dignified care and services (Residents #162, #69, #3, #64, #141 and #169).</p> <p>Findings include:</p> <p>1. During a 4/17/15, 10:39 a.m., interview, the Director of Nursing (DON) indicated the following: Residents, who required assistance to dine, should have their plates placed in front of them, have trays sit-up for the meal and be prompted/cued to eat or assisted to eat. She further indicated if a resident did not respond to cueing immediately, the resident should be assisted to eat either by placing a utensil in his/her hand and asking them to eat or actually offering the resident a bite of food. The DON indicated the resident should be engaged</p>	F 241	<p><b>F 241 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Resident #162 has been discharged. Residents #69, #3, and #169 were observed at 3 meal to ensure the following: The staff promote care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: a) plates placed in front of residents b)trays set up for meals c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service. Resident #141 has been discharged 2). Resident #64 has been discharged related to the staff promote care and services in a manner to protect dignity when encouraging therapy participation.</p> <p><b>Identification of other residents having the potential</b></p>	05/20/2015
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	<p>in their meal before the staff member left the resident. The DON indicated once a staff member began to feed a resident, the staff member should not repeatedly leave the resident and return, barring emergencies. The DON indicated all residents at a dining table should be served their meals at close to the same time as possible. Lastly, the DON indicated the desired time for a dependent resident to be seated at the table before meal service was no more than 10 minutes.</p> <p>2. During a 4/13/15, 11:50 a.m. to 12:45 p.m., lunch observation in the Rehab Dining Room, the following was observed: The Rehab Dining Room did not have any diversionary materials such as books, puzzles or games. Dependent residents were escorted into the dining room by staff members. The residents were assisted to sit facing their table as if ready to dine. There was not a structured activity being offered in the dining room. Seven dependent residents sat facing the tables without activities or stimulation for a period of 29 to 39 minutes. Residents #141, #69, #3 and #169 were included in the group of seven residents.</p> <p>Resident #141 sat facing the table waiting for his meal from 11:50 a.m. to 12:28 p.m. (38 minutes), at which time his meal</p>		<p><b>to be affected by the same alleged deficient practice and corrective actions taken:</b> 1). DHS or designee will observe 3 meals at to ensure the following: The staff promote care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: a) plates placed in front of residents b)trays set up for meals c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service 2). All residents have the potential to be affected by this same deficient practice related to the staff promote care and services in a manner to protect dignity when encouraging therapy participation. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> 1). DHS or designee will re-educate the nursing staff on the following expectations in regards to the staff promote care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: : a) plates placed in front of residents b)trays set up for meals c)prompting/cueing or assisted to eat d) engaged in</p>	

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	<p>was served.</p> <p>Resident #69 sat facing the table waiting for her meal from 11:51 a.m. to 12:22 p.m. (31 minutes) at which time her plate was placed on the table in front of her. Resident #69 was not cued to eat or assisted to eat when her plate was placed in front of her. The staff member walked away after placing the food on the table and did not return to feed the resident until 12:29 p.m. (7 minutes). Resident #69's meal sat on the table in front of her for 7 minutes before she was offered assistance to eat.</p> <p>Resident #3 sat facing the table waiting for her meal from 11:52 a.m. to 12:23 p.m. (31 minutes), at which time her plate was placed on the table in front of her. The staff member walked away after placing the food on the table and did not return to feed the resident until 12:28 p.m. (5 minutes). Resident #3's meal sat on the table in front of her for 5 minutes before she was assisted to eat.</p> <p>Resident #169 sat facing the table waiting for her meal from 11:54 a.m. to 12:33 p.m. (39 minutes), at which time her meal was served. For 11 minutes Resident #169 watched her table mates eat. At 12:21 p.m., Resident #169 asked her tablemate "Is it good?" Resident</p>		<p>meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service 2). The Therapy Program Director will re-educate the therapy department staff on the following expectation in regards to the staff promote care and services in a manner to protect dignity when encouraging therapy participation: Resident Rights</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> 1). The following observations of 1 meal service in the Restorative Dining Room will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: a) plates placed in front of residents b)trays set up for meals c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service. Throughout the audit / observation period, all 3 meal services will be observed. 2). The following audits/interviews will be conducted by the DHS or</p>		

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	<p>#169 was served her meal at 12:33 p.m. She immediately began to feed herself.</p> <p>During a 4/16/15, 8:25 a.m. to 9:00 a.m., Rehab Dining Room breakfast observation the following occurred:</p> <p>Resident #3 was served her meal at 8:35 a.m. The staff member placed her food on the table, indicated it was breakfast and walked away. Resident #3 was not cued or assisted to eat. Resident #3 did not begin to feed herself. Resident #3 was offered feeding assistance at 8:38 a.m., which was 3 minutes after her meal was placed on the table.</p> <p>Resident #69 was served her meal at 8:36 a.m. The staff member placed the tray in front of her and asked for her to wake up. Resident #69 did not open her eyes or respond to the verbal prompt to wake. Resident #69 sat with her eyes closed and her meal tray in front of her for 7 minutes at which time a staff member assisted her to eat.</p> <p>Resident #141 was served his meal at 8:42 a.m. He was assisted to eat within 1 minute of his meal being placed on the table. At 8:45 a.m. the staff member, who was feeding Resident #141, stopped feeding the resident and left the table. She did not offer Resident #141, who had</p>		<p>designee for 5 residents 2 times per week 8 weeks, then monthly times 4 months to ensure compliance: Resident interview to ensure the therapy staff is promoting care and services in a manner to protect dignity when encouraging therapy participation. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>been eating when fed, any explanation or apology. The staff member returned to the table in 1 minute and began to feed Resident #141 again. She did not return to the table with any item to assist with the resident's meal. The staff member fed Resident #141 until 8:51 a.m. Resident #141 ate his meal when fed by the staff member. At 8:51 a.m., the staff member left the dining room. Resident #141 had not completed his meal and no other staff member assisted him. The staff member did not offer Resident #141 any explanation or apology as she left the room. The staff member returned to the room at 8:54 a.m. and had a meal for another resident. She served the meal to the other resident and then returned to assist Resident #141 with eating his meal.</p> <p>During a 4/16/15, 11:50 a.m. to 12:40 p.m., lunch observation in the Rehab Dining room the following occurred:</p> <p>Resident #141 was served his meal at 12:19 p.m. The staff member placed his plate in front of the resident on the table and walked away. Resident #141 who must be fed to eat, sat with his meal in front of him without assistance to eat for 2 minutes.</p> <p>3. Resident #3's clinical record was reviewed on 4/17/15 at 12:15 p.m.</p>			

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	<p>Resident #3's current diagnoses included, but were not limited to, blindness, depression and dementia.</p> <p>Resident #3 had a current, 3/1/15, quarterly, Minimum Data Set assessment (MDS) which indicated the resident had minimum difficulty in hearing in some environments, usually understood others, was usually understood by others, had severely impaired vision, had impaired cognition and required curing and assistance for decision making, was dependent on staff for mobility and required staff assistance for eating.</p> <p>Resident #3 had a current, 3/1/15, care plan need related to needing to be fed due to blindness. An approach to this problem included was "encourage me to eat and drink."</p> <p>4. Resident #169's clinical record was reviewed on 4/17/15 at 12:18 p.m. Resident #169's current diagnoses included, but were not limited to, history of right hip and elbow fracture, confusion and history of stroke.</p> <p>Resident #169 was a new admission and had been in the facility for less than 30 days. Resident had a current 4/8/15, "Diet Order &amp; Communication" form which indicated the resident needed to eat</p>			

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	<p>in the "restorative dining room" [rehab dining room] due to a decline in food/fluids intake.</p> <p>5. Resident #141's clinical record was reviewed on 4/17/15 at 12:19 p.m. Resident #141's current diagnoses included, but were not limited to, anxiety with depression and dementia with behaviors.</p> <p>Resident #141's had a current, 2/6/15, quarterly, Minimum Data Set assessment (MDS) which indicated the resident sometimes understood by others, sometimes understands others, was severely cognitively impaired and rarely or never made decisions, required staff assistance for mobility and required staff assistance for eating.</p> <p>Resident #141 had a current, 2/6/15, care plan problem/need regarding the need for assistance with activities of daily living, such as eating.</p> <p>6. Resident #69's clinical record was reviewed on 4/17/15 at 12:11 p.m. Resident #69's current diagnoses included, but were not limited to, dementia and hearing loss.</p> <p>Resident #69 had a current, 2/28/15, quarterly, Minimum Data Set assessment</p>			

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	<p>(MDS) which indicated the resident had moderate difficulty in hearing and needed the speaker to increase his volume to be understood, was severely cognitively impaired and rarely or never make decisions, required staff assistance for mobility and required staff assistance for eating.</p> <p>Resident #69 had a current, 2/18/15, care plan problem/need regarding having a self care deficit and requiring assistance with activities of daily living.</p> <p>7. During a 4/17/15, 9:10 a.m., family interview, the family member of Resident #64 indicated a Speech Therapist had come into Resident #64's room on a Saturday morning between 6:30 a.m. and 7:00 a.m., awakened the resident and informed her she needed to get up and eat breakfast in order for the Speech Therapist to observe her eating. Resident #64's family member indicated the resident did not want to get up so early and eat, but felt she had no other option so she complied.</p> <p>Resident #64's clinical record was reviewed on 4/20/15 at 10:53 a.m. Resident #64's current diagnoses included, but were not limited to, history of pneumonia, Parkinson's disease and congestive heart failure.</p>			

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	<p>Resident #64 had a, 3/31/15, order to discontinue speech therapy. Resident #64 had a 3/31/15 Speech Therapy note which indicated the therapy was being ended per family and resident request.8. On 4/13/2015 at 2:21 p.m., during an interview Resident #162 indicated recently the therapist came too early to take her to therapy. The resident indicated she informed the therapist she wanted to have her coffee before she went to therapy. The resident indicated this upset her because she had not had her coffee and had felt "bullied" by the therapist.</p> <p>On 4/16/2015 at 12:32 p.m., Occupation Therapist #10 indicated the therapy department, after an initial evaluation, should communicate the resident's choices for therapy on the department's schedule.</p> <p>On 4/16/2015 at 12:32: p.m., Therapy Manager #12 indicated the resident had a choice for the therapy time.</p> <p>The "Residents Rights" policy was provided by the DoN on 4/17/15 at 1:05 p.m.. This current policy indicated "...Quality of Life: 35. Dignity/Self Determination and Participation: You have the right to receive care from the</p>			

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F 244 SS=E Bldg. 00	<p>facility in a manner that is a safe environment and that promotes, maintains, or enhances your dignity and respect in full recognition of your individuality...."</p> <p>3.1-3(t)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to address and further act upon the Resident Council's continued grievance in regards to call light response for 10 of 10 months Resident's Council minutes reviewed. (June-December, 2014; January-March, 2015).</p> <p>Findings include:</p> <p>On 4/13/15 At 11:27 a.m., during an interview Resident #85 indicated he had to wait 30-45 minutes for a call light to be answered sometimes.</p> <p>Of 4/13/15 at 11:30 a.m., during an</p>	F 244	<p><b>F 244</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The resident council minutes for the last meeting will be reviewed. Each concerns listed will have a documented response / resolution and those responses / resolutions will be presented at the next resident council meeting to ensure the concern was completely addressed or need to be further acted upon, including concerns regarding call light response time.</p>	05/20/2015	

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	<p>interview Resident #29 indicated last weekend she had timed her call light and it took on average an hour to answer it.</p> <p>On 4/13/15 at 3:57 p.m., during an interview Resident #165 indicated she had to wait a long time to use the bathroom. She also indicated it was painful to sit on the toilet with a broken hip and wait for them to help her.</p> <p>On 4/13/15 at 4:26 p.m., during an interview Resident #50 indicated it had taken almost an hour to answer his call light.</p> <p>On 4/16/15 at 10:14 a.m., during Resident Council President interview, Resident #7 indicated call light response was still a problem.</p> <p>The Resident Council meeting minutes were reviewed on 10/16/15 at 10:45 a.m., and indicated the following:</p> <p>The 6/20/2014 meeting minutes indicated new business was call lights were not being answered on second shift;</p> <p>The 7/15/14 meeting minutes indicated in the old business the Director of Nursing was made aware of call lights. The new business indicated the call lights still had longer wait times;</p> <p>The 8/14/14 meeting minutes indicated in</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Executive Director or designee will re-educate the Leadership Team members on the standard of documented follow up to concerns identified in resident council and presenting the responses / resolutions to those concerns during the next resident council meeting, or sooner if necessary to ensure the concern was completely addressed or need to be further acted upon, including concerns regarding call light response time.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Executive Director or designee will review the minutes</p>	

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	<p>the old business minutes call lights were still an issue;</p> <p>The 9/18/14 meeting minutes call lights seemed better;</p> <p>The 10/17/14 meeting minutes indicated in the old business included still waiting for lights to be answered; during discussion of new business "Nursing: Not enough help! waiting longer; [sic]"</p> <p>The 11/21/14 meeting minutes indicated in the old business of call light response was better in the daytime and "bad" on evenings; during discussion of new business "Nursing: Call lights [sic] bad of an evening."</p> <p>The 12/19/14 meeting minutes indicated "Call lights are not answered very good after dinner."</p> <p>The 1/16/15 meeting minutes old business indicated call lights were better;</p> <p>The 2/20/15 meeting minutes the new business indicated "Nursing: OK - still thinks we need more help, girls work to [sic] hard."</p> <p>The 3/27/15 meeting minutes indicated in the old business call lights seemed to be getting better and answered faster.</p> <p>On 4/16/15 at 11:55 a.m., the Director of Nursing (DON) provided her response to the Resident Council concerns related to call lights. The DON had entered a memo in the kiosk (CNA's computer communication) with her concern of call</p>		<p>from each resident council meeting and the documents listing the concerns identified and the responses / resolutions noted. Also, will review the documented date of when the responses / resolutions were presented to the resident council to ensure the concern was completely addressed or need to be further acted upon, including concerns regarding call light response time. This review will be on going.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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F 282 SS=E Bldg. 00	<p>light response time. This memo was entered in the kiosk from 6/20/14 through 6/27/14, from 7/15/15 through 7/22/15, from 8/15/15 through 8/22/15, and from 12/19/15 through 12/26/15.</p> <p>On 4/17/15 at 1:27 p.m., the DON provided "Call Light Response Time Audit" as follows: Day shift on 12/09/14, on 12/17/14, on 12/22/14, and on 12/30/14; Evening shift on 12/08/14, on 12/16/14, on 12/22/14, and on 12/30/14; Night shift on 12/10/14, on 12/17/14, on 12/24/14, and on 12/31/14. No further auditing of call lights information was indicated/provided.</p> <p>3.1-3(l)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow care plans regarding obtaining a lab as ordered (Resident # 7), following facility policy for neurochecks after a fall (Resident # 7), administering insulin within appropriate interval prior to meal per</p>	F 282	<b>F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Resident #7 - MD contacted and BMP has been drawn. Resident has had no falls requiring neurochecks since	05/20/2015

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	<p>manufacture guidelines (Resident # 85 &amp; 50), providing/receiving between dialysis provider and facility (Resident # 35), and failed to ensure orders were clarified after a medication change (Resident # 165) for 5 of 36 residents whose care plans were reviewed.</p> <p>Findings include:</p> <p>1.a. Resident #7's clinical record was reviewed on 4/15/2015 at 8:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, confusion, stage III renal failure, dementia, diabetes mellitus, and anxiety/depression.</p> <p>The resident had a 2/26/15, physician's telephone order for a BMP (Basic Metabolic Panel) laboratory (lab) test to be drawn on 3/2/15.</p> <p>The results of the test were requested from the Medical Records Nurse on 4/15/2015 at 10:20 a.m.</p> <p>During an interview with the Director of Nursing on 4/17/15 at 9:54 a.m., she indicated the BMP lab test had not been completed. She indicated the facility was not aware of the order.</p> <p>The "Lab Tracking Guidelines" policy was provided by the RN Consultant on</p>		<p>3/27/15. 2). Resident #35 - has been discharged. 3). Resident #85 - resident is receiving ordered insulin at appropriate time before/after receiving his meal. 4). Resident #50 - has been discharged 5). Resident #165 - Ativan orders have been clarified <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review the following to ensure care plans are being followed regarding: 1). All resident recent lab orders to ensure they were obtained as ordered. 2). All residents with a fall occurring in the past 3 days to ensure neurochecks were completed if applicable per facility policy. 3). All residents with weight monitoring in place to ensure the MD was notified of any weight changes in accordance with the MD orders and / or significant loss/gain parameters. 4). All residents receiving dialysis to ensure the Facility/Dialysis communication form is being completed before/after each visit 5). All residents receiving ordered insulin to ensure it is being administered at appropriate time before/after receiving their meal 6). All residents current orders will be reviewed to ensure any orders needing clarified after a medication change has been completed <b>Measures put in</b></p>	

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	<p>4/20/15 at 2:06 p.m. The purpose was to facilitate a method of tracking laboratory tests ordered and monitor if a test had been completed in a timely manner to identify and treat infections and/or make medication adjustments.</p> <p>1.b. Review of a "Fall Circumstance Assessment and Intervention" form indicated Resident #7 fell in her room and hit her forehead on 3/27/15 at 12:15 p.m.</p> <p>Review of the "Neurological Assessment" indicated Resident #7's vital signs were obtained at 12:15 p.m. The blood pressure was 200/74, temperature 98.7, pulse 76, respirations 20, right pupil reactive 0.2 and left pupil reactive 0.2. The form indicated vital signs should have been obtained every 15 minutes for 2 hours. The next set of vital signs were obtained at 3:45 p.m. The record was missing 7 sets of vital signs.</p> <p>During an interview with the Director of Nursing on 4/17/15 at 9:54 a.m., she indicated she thought neuro (neurological) checks were to be performed every 15 minutes for the first 4 hours when a resident had a head injury but she needed to check the policy.</p> <p>The, undated, "Neuro Check Procedure</p>		<p><b>place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Lab Tracking 2). Neurological Checks 3). Physician Notification of Diagnostic Testing and Change in Condition 4). Insulin Administration 5). Dialysis Provider Communication 6). Medication Order Policy <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Resident recent lab orders to ensure they were obtained as ordered. 2). Residents with a fall to ensure neurochecks were completed if applicable per facility policy. 3). Residents with weight monitoring in place to ensure the MD was notified of any weight changes in accordance with the MD orders and / or significant loss/gain parameters. 4). Residents receiving dialysis to ensure the Facility/Dialysis communication form is being completed before/after each visit 5). Residents receiving ordered insulin to ensure it is being administered at appropriate time before/after receiving their meal</p>	

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	<p>Time Frame" policy was provided by the Director of Nursing on 4/17/15 at 10:35 a.m. The procedure indicated vital signs should have been obtained every 15 minutes for the first hour and every 30 minutes for the next 2 hours, then every 4 hours times 4 followed by every 8 hours for 48 hours.</p> <p>2. The clinical record for Resident #35 was reviewed on April 14, 2015 at 4:13 p.m. Diagnoses for Resident #35 included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure. anemia, congestive heart failure and distal tibia/fibula fracture with cast.</p> <p>A physician's order, dated March 2, 2015, indicated Resident #35 was to be weighed daily. The physician was to be notified if the resident had a weight gain of two pounds in one day.</p> <p>A physician's order, dated December 31, 2014, indicated Resident #35 was to have dialysis on Tuesdays, Thursdays and Saturdays. Resident #35's pick up time was 10:00 a.m. by ambulance transportation.</p> <p>An Acute Care Plan for Resident #35 stated: "I have ESRD [end stage renal disease] and I attend dialysis 3X [three times] weekly. Please send a sack lunch</p>		<p>6). Residents current orders will be reviewed to ensure any orders needing clarified after a medication change has been completed The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>with me on dialysis days. Please obtain my weight as ordered and report any significant changes to my physician. I have a shunt to my left antecube that is used during dialysis. Please check this for a bruit/thrill daily. Do not use my left arm to obtain a blood pressure. My goal is to attend my dialysis per my schedule, for my weight to remain stable, and for there to be no complications related to my shunt throughout this review period...."</p> <p>Review of the March 2015 and April 2015 daily weights, indicated Resident #35 weights on the following dates: March 4, 2015 weight 168.2 pounds and on March 5, 2015 Resident #35 weighed 170.2 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>March 6, 2015 Resident #35 weighed 169.4 pounds and on March 7, 2015 Resident #35 weighed 172.2 pounds, a weight gain of 2.8 pounds. No physician documentation was noted in the clinical record.</p> <p>March 9, 2015 Resident #35 weighed 172.2 pounds and on March 10, 2015 Resident #35 weighed 175.8 pounds, a weight gain of 3.6 pounds. No physician</p>			

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	<p>documentation was noted in the clinical record.</p> <p>March 11, 2015 Resident #35 weighed 172 pounds and on March 12, 2015 Resident #35 weighed 174.4 pounds, a weight gain of 2.4 pounds. No physician documentation was noted in the clinical record.</p> <p>March 13, 2015 Resident #35 weighed 169.2 pounds and on March 14, 2015 Resident #35 weighed 172.4 pounds, a weight gain of 3.2 pounds. No physician documentation was noted in the clinical record.</p> <p>March 15, 2015 Resident #35 weighed 167.2 pounds and on March 16, 2015 Resident #35 weighed 173.2 pounds, a weight gain of 6 pounds. No physician documentation was noted in the clinical record.</p> <p>March 16, 2015 Resident #35 weighed 173.2 pounds and on March 17, 2015 Resident #35 weighed 175.8 pounds, a weight gain of 2.6 pounds. No physician documentation was noted in the clinical record.</p> <p>No weights for the following dates were available: March 20, 21, 22, 25, 28, and 29, 30, and 31 2015.</p>			

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	<p>April 3, 2015 Resident #35 weighed 170.2 pounds and on April 4, 2015 Resident #35 weighed 172.2 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>April 6, 2015 Resident #35 weighed 168.4 pounds and on April 7, 2015 Resident #35 weighed 173.8 pounds, a weight gain of 5.4 pounds. No physician documentation was noted in the clinical record.</p> <p>April 13, 2015 Resident #35 weighed 168.3 pounds and on April 14, 2015 Resident #35 weighed 170.3 pounds, a weight gain of 2 pounds. No physician documentation was noted in the clinical record.</p> <p>April 14, 2015 Resident #35 weighed 170.3 pounds and on April 15, 2015 Resident #35 weighed 173.8 pounds, a weight gain of 3.5 pounds. No physician documentation was noted in the clinical record.</p> <p>Review of the Facility/Dialysis Communication forms for March and April 2015 indicated the following:</p> <p>Dated April 14, 2015 No communication</p>			

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	<p>from dialysis center.</p> <p>Resident complained of shortness of breath during dialysis and was sent to the hospital for evaluation.</p> <p>Dated April 14, 2015 form not complete, no communication from the dialysis center.</p> <p>Dated March 31, 2015 form not complete, no communication from the dialysis center.</p> <p>Dated March 26, 2015 form not complete, no communication from the facility.</p> <p>Dated March 24, 2015 form not complete, no communication from the dialysis center.</p> <p>Dated March 19, 2015 form missing.</p> <p>Dated March 14, 2015 form missing.</p> <p>Dated March 5, 2015 form not complete, no communication from the dialysis center.</p> <p>During an interview on April 15, 2015 at 1:18 p.m., LPN #11 indicated the communication forms should have been filled out and sent with the resident to the dialysis center. LPN #11 further</p>			

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	<p>indicated there might have been a binder for the missing forms and she would look for it. LPN #11 reviewed the resident's clinical record and no further documentation was found.</p> <p>During an interview on April 15, 2015 at 2:20 p.m., LPN #9 indicated no further information regarding the dialysis communication forms was available.</p> <p>A contract, dated October 2008, titled "SNF Outpatient Dialysis Services Agreement" was provided by the Administrator on April 15, 2015 at 3:22 p.m.</p> <p>The contract indicated the following: "SNF Outpatient Dialysis Services Agreement...</p> <p>A. Obligations of Nursing Facility and/or Owner...</p> <p>2. Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD [end stage renal disease] Residents,...."</p> <p>3. The clinical record for Resident #85 was reviewed on April 16, 2015 at 3:00 p.m. Diagnoses for Resident #85 included, but were not limited to, hepatic encephalopathy, uncontrolled insulin dependent diabetes mellitus, obstructive sleep apnea and stage 2 diastolic</p>			

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	<p>dysfunction.</p> <p>During an interview on April 14, 2015 at 5:00 p.m., LPN #13 indicated Resident #85 was given 20 units of Novolog and 34 units of Levemir at 4:55 p.m.</p> <p>During an observation on April 14, 2015 at 5:30 p.m., Resident #85 received his evening meal tray approximately 35 minutes after receiving his insulin.</p> <p>During an interview on April 15, 2015 at 1:37 p.m., the Director of Nursing indicated the following: "Whatever the guidelines for the medication it depends on the insulin. They need to give it closer to the meal. The nurses have access to drug handbooks while working on the units."</p> <p>Review of "Nursing 2015 Drug Handbook 35th Anniversary", provided by the Director of Nursing on 4/20/15 at 3:45 p.m., indicated Novolog should be given 5 to 10 minutes before the start of a meal.</p> <p>4. The clinical record for Resident #50 was reviewed on April 16, 2015 at 2:53 p.m. Diagnoses for Resident #50 included, but were not limited to, congestive heart failure, wounds on legs bilateral, severe lower extremity venous</p>				

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	<p>dependent edema, liver cirrhosis and ascites with severe penoscrotal edema.</p> <p>During an interview on April 14, 2015 at 5:00 p.m., LPN #13 indicated Resident #50 was given 10 units of Humalog at 4:50 p.m.</p> <p>During an observation on April 14, 2015, Resident #50 received his evening meal tray at 5:21 p.m., approximately 31 minutes after receiving his insulin.</p> <p>During an interview on April 15, 2015 at 1:37 p.m., the Director of Nursing indicated the following: "Whatever the guidelines for the medication it depends on the insulin. They need to give it closer to the meal. The nurses have access to drug handbooks while working on the units."</p> <p>Review of "Nursing 2015 Drug Handbook 35th Anniversary" provided by the Director of Nursing on 4/20/15 at 3:45 p.m., indicated Humalog should be given 15 minutes before or after a meal."</p> <p>5. Resident #165's clinical record was reviewed on 4/17/15 at 9:30 a.m., the resident's diagnoses included, but were not limited to, aftercare right hip hemiarthroplasty, insomnia, osteoarthritis, end stage renal disease.</p>			

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	<p>The physician's orders were as follows:</p> <p>On 3/30/15, Ativan 0.5 mg 1 tablet orally every bedtime for anxiety with depression;</p> <p>On 3/31/15, Ativan 0.5 mg 1 tablet orally three times a day as needed;</p> <p>On 4/7//15, scheduled Ativan 0.5 mg three times a day.</p> <p>No information was indicated for a discontinued physician order for the 3/30/15, and 3/31/15 orders.</p> <p>The resident had the potential to receive the as needed and bedtime Ativan as well as the scheduled Ativan. No additional Ativan had been given after the 04/07/15 scheduled Ativan order was received.</p> <p>On 4/17/15 at 2:00 p.m., during an interview RN #18 indicated the Ativan prn (as needed) and hs (at bedtime) physician's orders should have been discontinued on 4/7/15/ when the scheduled Ativan was ordered.</p> <p>The, undated, "Guidelines for Medication Order" policy was provided by the Director of Nursing on 4/20/15 at 9:40 a.m. The purpose of the policy was to establish uniform guidelines in the receiving and recording of medication orders. The policy indicated a current written list of orders would be</p>			

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F 323 SS=D Bldg. 00	<p>maintained in the clinical record of each resident. The orders would be maintained in chronological order. Telephone/verbal orders shall be recorded on the Physician Order Sheet when received by the nurse receiving the order. The policy indicated an order should not just be "dropped" and a discontinue order should be written.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a secured storage of portable oxygen tanks when not in use 2 of 4 residents utilizing portable oxygen for 1 of 3 halls observed. (Residents #28 and #162; 600 hall)</p> <p>Findings include:</p> <p>On 4/13/15 at 11:50 a.m., a portable oxygen tank was observed sitting on the floor in the hallway outside Resident</p>	F 323	<p><b>F 323</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #162 has been discharged. Resident #28 and 600 hall - portable oxygen tanks are in secured storage when not in use.</p> <p><b>Identification of other residents</b></p>	05/20/2015

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	<p>#28's room.</p> <p>On 4/13/2015 at 2:03 p.m., 2 portable oxygen tanks were observed sitting on the floor in the hallway outside Resident #162's room.</p> <p>On 4/13/15 at 2:55 p.m., as a visitor was observed coming out of Resident 162's room, she knocked over an oxygen tank as her foot got caught in the strap. The oxygen tank began to whistle until it was upright again.</p> <p>On 4/16/15 at 8:48: a.m., 2 portable oxygen tank were observed outside Resident #162's room.</p> <p>On 4/16/2015 at 10:51 a.m., RN #17 indicated the portable oxygen tanks were filled everyday and left outside resident's rooms in the hallway as extras. The 2 present hallway portable oxygen tanks for Resident #162 were checked at this time by RN #17. One of these tanks was indicated as full, and the other tank was half full. At the same time RN #17 also indicated they shouldn't be stored in the hallway. She was observed to remove the tanks from the hallway.</p> <p>On 4/16/2015 at 10:57 a.m., during an interview the DoN indicated portable oxygen tanks should not be stored in the</p>		<p><b>having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee observed all hallways to ensure portable oxygen tanks are in secured storage when not in use.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Oxygen Storage</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for all hallways will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Portable oxygen tanks are in secured storage when not in use.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>		

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F 325 SS=D Bldg. 00	<p>hallway.</p> <p>3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to consistently monitor meal consumptions and weights for a resident with fluctuating weights for 1 of 4 residents reviewed for nutrition. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7's clinical record was reviewed on 4/15/2015 at 8:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, confusion, stage III renal failure, dementia, diabetes mellitus, and anxiety/depression.</p>	F 325	<p>randomly thereafter for further recommendation.</p> <p><b>F 325</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #7 - Re-weight was obtained per the Registered Dietician (RD) recommendation and all weights have been recorded in the medical record. In addition, meal consumptions were reviewed to ensure % of food consumed for each meal is documented</p> <p><b>Identification of other residents</b></p>	05/20/2015	

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	<p>The resident had physician's order for a regular textured controlled carbohydrate diet.</p> <p>The resident had a 11/3/14 weight of 206 pounds and a 11/15/14, readmission assessment with a weight of 194 pounds, after a 10 day hospital stay. A 9 pound weight loss.</p> <p>Resident #7's "Monthly Record of V/S [Vital Signs] and Weights" indicated the following weights: 186 pounds on 2/2/15 188 pounds on 3/9/15 167.6 pounds on 4/3/15 The clinical record lacked a weight for December, 2014 and January, 2015.</p> <p>Review of the "Meal Intake Detail Report" lacked a percentage of food consumed for the lunch meal on January 4, 11, 28, February 6, 7, 8, 20, 21, 22, March 20, 21, 22, and April 9, 2015.</p> <p>Review of the "Meal Intake Detail Report" lacked a percentage of food consumed for the dinner meal on January 19, February 9, 11, 20, 23, 24, 25, 28, March 1, 3, 6, 9, 12, 15, 23, 24, April 5, 7, 9 and 10, 2015.</p> <p>Review of the Nutrition Progress Notes indicated, on 2/9/15, the resident had a</p>		<p><b>having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents to ensure re-weights requested by RD have been obtained, all weights have been recorded in the medical record and meal consumption % for each meal is documented.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: 1. Weight Tracking 2. Nutritional Recommendations</p> <p>In addition, the DHS will review with the nursing staff the expectation that food consumption % will be documented after each meal.</p> <p>DHS will request that RD place all recommendations for re-weights on the RD recommendation summary log after each visit and provide DHS with a copy.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does</b></p>				

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	<p>significant weight change in the last 90 days. A 4/13/15, Nutrition Progress Note indicated the resident's April 2014, weight was 167 pounds and was a 21.4 pound loss. A reweight was requested.</p> <p>During an interview on 4/14/2015 at 9:06 a.m., Unit Manager # 3 indicated she had no additional weights for the resident.</p> <p>During an interview on 4/17/2015 at 9:54 a.m., the Director of Nursing indicated the following weights that had been recorded on the kiosk, but were not in the clinical record: 192.2 pounds on 12/10/14 186.2 pounds on 1/9/15 186 pounds on 2/6/15 188.2 pounds on 3/2/15.</p> <p>The Director of Nursing indicated she was not aware of the, 4/13/15, Nutrition Progress Note requesting a reweight for the or the documented April weight of 167.6 pounds. The Director of Nursing indicated the the Registered Dietician gave her recommendations to the Unit Managers.</p> <p>3.1-46(a)(1)</p>		<p><b>not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1. Review residents to ensure re-weights have been obtained and documented. 2. Review residents to ensure weights are documented in the medical record. 3. Review residents to ensure food consumption % is documented in the medical record. 4. RD recommendations for re-weights are listed on the RD recommendation summary log after each visit</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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F 329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on clinical record review and interview, the facility failed to provide a medication as ordered and to monitor for the possible side effects of the medication for 1 of 5 residents reviewed for unnecessary medications (Resident #7), and failed to assess the effectiveness of the administered pain medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #30)</p> <p>Findings include:</p>	F 329	<p><b>F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #7 - timed Lasix order has been discontinued. Resident #30 - the PRN Medication Tracking log has been reviewed to ensure the effectiveness of administered pain medication is being assessed / documented. <b>Identification of other residents having the potential to be affected by the same alleged</b></p>	05/20/2015

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	<p>1. Resident #7's clinical record was reviewed on 4/15/2015 at 8:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, confusion, stage III renal failure, dementia, diabetes mellitus, and anxiety/depression.</p> <p>The resident had current physician's orders for valsartan 80 mg tablet one daily for high blood pressure, verapamil 80 mg one tablet orally three times a day for high blood pressure, and furosemide (a diuretic) 40 mg tablet one orally daily for high blood pressure. These orders originated 11/16/14.</p> <p>The resident had a 2/24/15, "Change in Condition Form" indicating the resident had increased 1+ to 2+ pitting edema in both legs. The form indicated Resident #7's legs were red and warm to touch and she had a history of cellulitis.</p> <p>Review of a 2/26/15, 7:10 p.m., Nurse's Note indicated new orders were received in response to the 2/25/15, faxed "Change in Condition Form" for Bactroban (antibiotic ointment) to bilateral lower extremities three times a day for seven days. Lasix (furosemide) 20 mg IM (intramuscular injection) daily for three days, and to continue 40 mg Lasix orally in addition to the IM order. Also, a BMP (Basic Metabolic Panel) laboratory test</p>		<p><b>deficient practice and corrective actions taken:</b> DHS or designee will review the following: 1). All resident Medication Administration Record (MAR) to ensure meds are being administered/documented as ordered 2). All residents have the potential to be affected by the alleged deficient practice on failure to monitor for possible side effects of medications. 3). All resident PRN Medication Tracking log has been reviewed to ensure the effectiveness of administered pain medication is being assessed / documented.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guidelines: 1). Medication Administration General Guideline 2). Medication Monitoring and Management 3). Administration of PRN Medication 4). Medication Side Effects and Adverse Effects Reference Form now available in the front of each medication book to use as a guide when monitoring / documenting possible side effects of a medication. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per</p>		

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	<p>was to be done on 2/27/15 and on 3/2/15.</p> <p>The 35th Edition of the "Nursing 2015 Drug Handbook" indicated as nursing considerations for valsartan: "Watch for hypotension. Excessive hypotension can occur when drug is given with high doses of diuretics...Monitor serum BUN, creatinine, and potassium levels..."</p> <p>The clinical record indicated the Lasix 20 mg IM injection was given on 2/26 and 2/27/15. The record lacked an indication of the Lasix IM injection being given on 2/28/15.</p> <p>Review of the drug disposal log indicated three vials of Lasix 10 mg/ml [6 ml] had been discontinued and returned to pharmacy on 3/27/15.</p> <p>The clinical record lacked any further assessments of the edema of the legs or of any monitoring of the blood pressure during the time the additional Lasix was given.</p> <p>During an interview with the Director of Nursing on 4/17/2015 at 9:54 a.m., she indicated the third dose of Lasix IM injection had not been given on 2/28/15. She indicated the pharmacy had delivered three vials and they were returned to the pharmacy. She indicated the two vials</p>		<p>week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Residents Medication Administration Record (MAR) to ensure meds are being administered/documented as ordered 2). Residents are monitored for possible side effects of medications. 3). Resident PRN Medication Tracking log reviewed to ensure the effectiveness of administered pain medication is being assessed / documented. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>given came from the emergency drug kit.</p> <p>During an interview with Unit Manager #3 on 4/20/15 at 10:20 a.m., she indicated the blood pressure or edema had not been monitored while the resident was receiving the additional Lasix.</p> <p>2. Resident #30's clinical record was reviewed 4/15/2015 9:39 a.m. The resident's diagnoses included, but not limited to, fall, left suprachondlylar hip fracture-s/p orif (status post open reduction internal fixation), atrial fibrillation, diastolic heart failure, coronary artery disease. The Significant Change Minimum Data Set assessment, dated 3/14/15, indicated she had moderate cognitive impairment.</p> <p>The signed physician's orders, dated 3/12/15, indicated the following; Fentanyl 25 micrograms per hour patch (narcotic pain medication), originally dated 2/19/15, apply 1 patch to skin every 72 hours for pain; APAP (Tylenol)(mild analgesic) 325 milligrams (mg) every 4 hours as needed (prn); Tramadol 50mg (pain medication); originally dated 3/07/15, 1 tablet by mouth (po) every 6 hours prn moderate pain;</p>			

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	<p>Norco 5/325mg (narcotic pain medication), originally dated 3/07/15, 1 tablet po every 6 hours prn severe pain.</p> <p>The "PRN MEDICATION TRACKING" indicated the following ; "Pain Scale: Verbal: 1-2 Mild, 3-5 Moderate, 6-8 Severe, 9-10 Excruiating [sic]"</p> <p>On 4/01/15 at 9:20 a.m., Norco 5/325 1 tablet was given; verbal pain scale was 5 with no information related to its effectiveness; On 4/01/15 at 8:00 p.m., Tylenol 325 mg 2 tablets was given; verbal pain scale was 5 with no information related to its effectiveness; On 4/03/15 at 9:50 a.m., Norco 5/325 1 tablet was given; verbal pain scale was 6; On 4/04/15 at 12:45 p.m., Norco 5/325 1 tablet was given; verbal pain scale was 5; On 4/06/15 at 1:00 a.m., Tylenol 325 mg 2 tablets was given; verbal pain scale was 5 with no information related to its effectiveness.</p> <p>No further information was indicated in the nurse's notes related to the resident's pain/pain medication.</p> <p>4/20/2015 11:03 a.m., during an interview with Unit Manager #1, she</p>			

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F 356 SS=C Bldg. 00	<p>indicated the pain scale for moderate pain was rated 4 to 6. She indicated she did not know why the Tramadol was not used for Resident #30's complaint of moderate pain.</p> <p>The "ADMINISTRATION OF PRN MEDICATIONS GUIDELINE" was provided by the DoN on 4/20/15 at 9:40 a.m. This current policy indicated the following:</p> <p>"Purpose: To provide guidelines for the administration of non-routine (PRN) medication administration.</p> <p>1. Procedure: 1. Prior to administration of PRN medication the nurse shall review the physician orders and note any parimeters (sic) for administration...</p> <p>5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects."</p> <p>3.1-48(a)(3)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours</p>			

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	<p>worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure timely staff posting information for 4 of 6 days observed. (April 13, 14, 15, 16, 2015)</p> <p>Findings include:</p> <p>On 4/13/15 at 9:50 a.m., the staff posting information was observed dated for Friday April 10, 2015</p>	F 356	<p><b>F 356</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The nurse staffing information is posted timely.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged</b></p>	05/20/2015

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	<p>On 4/14/15 at 9:04 a.m., the staff posting information was observed dated for Monday April 13, 2015.</p> <p>On 4/15/15 at 8:40 a.m., the staff posting information was observed dated for Tuesday April 14, 2015.</p> <p>On 4/15/15 at 11:00 a.m., the staff posting information was observed dated for Wednesday April 15, 2015.</p> <p>On 4/16/15 at 8:51 a.m., the staff posting information was observed dated for Wednesday April 15, 2015.</p> <p>On 4/16/15 at 11:19 a.m., Staff Scheduler #21 indicated she did the staff posting by 10:00 am after the morning meeting to enter the facility's census.</p> <p>3.1-17(a)</p>		<p><b>deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing leadership team on the following: Guideline for Staff Posting</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audit will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The nurse staffing information is posted timely.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure safe and sanitary handling of food for 5 of 33 residents scheduled to eat in the main dining room and for 2 of 2 dining observations in the main dining room. (Residents' #8, #32, #45, #53, and #170; observations on 4/13/15 and 4/16/15)</p> <p>Findings include:</p> <p>On 4/13/15 at 11:56 a.m., lunch in the main dining room was observed. Social Service Assistant (SSA) #19 was observed with a hairnet on. Her neck length hair was not contained by the hairnet. SSA#19 was observed entering the kitchen, and upon her return from the kitchen, she began serving Residents #32, #170, and #45 drinks (coffee and juice).</p> <p>On 4/16/15 from 11:56 a.m. to 12:30 p.m. during lunch in the main dining room, Dietary Aide #6 with gloved hands was observed to pick up the dinner plate. His thumb was observed touching the inside of the dinner plate beyond the rim.</p>	F 371	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Resident #8-Observed meal was consumed with no adverse outcome noted. 2). Resident #32- Observed meal was consumed with no adverse outcome noted. 3). Resident #45-has discharged from the facility. 4). Resident #53- Observed meal was consumed with no adverse outcome noted. 5). Resident #170- Observed meal was consumed with no adverse outcome noted.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice.</p>	05/20/2015			

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	<p>Resident #128 received the food served on this plate and was observed eating from the plate. Next, Dietary Aide #6 with the same gloved hands was observed touching two more dinner plates with his thumb on the food surfaces. He also touched the frame of his glasses with the same gloved hands. No change of gloves or hand washing was observed. Resident #53 and Resident #8 received the dinner plates of food and were observed eating the food. The Activity Director #7 was observed with her long hair hanging out loose from under the hair net. She was observed to enter the kitchen, past the food preparation area, and return to the dining room. At this same time Dietary Aide #6 demonstrated picking up the plates by the rim of the dinner plate.</p> <p>On 4/16/15 at 12:30 p.m., Activity Director #7 indicated one's hair should be completely covered by a hairnet when entering the kitchen.</p> <p>On 4/17/15 at 2:15 p.m., the Administrator indicated a total of 33 residents could eat in the main dining room.</p> <p>Review of the current facility policy, revised 2009, titled "Food Production Guidelines-Sanitation &amp; Safety", provided by the Director of Nursing on 4/17/15 at 10:40 a.m., included, but was</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Social Services Assistant #19, Dietary aide #6, and Activity Director #7 will be directly reeducated on the proper policies and procedures of safe food handling, and use of hair restraints.</p> <p>Staff who participate in dining services will be inserviced on policies and procedures for safe and sanitary handling of food.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Audits and/or observations on proper food handling and proper use of hair restraints and /or observations for 3 residents and 3 staff members will be conducted by the DFS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further</p>	

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F 387 SS=D Bldg. 00	<p>not limited to, the following:</p> <p>"...3. Approved hairnets, caps or other effective hair restraints shall be used by employees who engage in the preparation and service of food...</p> <p>...22. Plates, silverware, glasses, etc., are handled so hands do not touch the areas where the food or mouth will be placed..."</p> <p>3.1-21(i)(3) 3.1-21(i)(2)</p> <p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure a resident had timely physician visits for 1 of 5 residents reviewed for unnecessary medications. (Resident #7)</p> <p>Findings include:</p>	F 387	<p>recommendation.</p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #7 - timely</b></p>	05/20/2015

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	<p>Resident #7's clinical record was reviewed on 4/15/2015 at 8:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, confusion, stage III renal failure, dementia, diabetes mellitus, and anxiety/depression.</p> <p>Resident #7 had signed physician's orders and a physician's progress note dated 12/23/14. These orders were the most current signed orders in the resident's record.</p> <p>During an interview with the Medical Records Nurse on 4/15/15 at 10:20 a.m., she indicated the resident's most current signed orders were on the chart. She indicated the more current orders were flagged and that indicated they needed to be signed by the physician.</p> <p>During a 4/17/15, 9:54 a.m., interview with the Director of Nursing, she indicated the last signed orders for the resident were 12/23/14.</p> <p>The undated, "Guidelines For Physician Services" was provided by the Director of Nursing on 4/15/15 at 2:20 p.m. The policy indicated the resident's attending physician "is responsible for conducting required routine visits...to ensure resident receives quality care and medical treatments."</p>		<p>physician visit has been completed.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all resident's medical records to ensure a timely physician visit has been completed.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: 1). Physician Services 2). State Regulation for Physician Services related to physician visits</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: A timely physician visit has been completed.</p>		

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F 441 SS=D Bldg. 00	<p>3.1-22(d)(1)</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.</p>		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	<p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</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 ensure current standards of practice and facility policy were followed to ensure residents were protected from potential exposure to infection. This practice had the potential to affect 4 of the 46 residents who resided on the 100 Hall. (Resident # 29, 126,</p> <p>Findings include:</p> <p>1. The clinical record for Resident #29 was reviewed on April 16, 2015 at 10:08 a.m. Diagnoses for Resident #29 included, but were not limited to, chronic bilateral ischial non-healing surgical wound, diabetes mellitus, edema, hypertension, hypothyroidism, diabetic neuropathy of extremity, and osteoarthritis.</p> <p>During an interview with Resident #29 on April 13, 2015 at 11:30 a.m., the</p>	F 441	<p><b>F 441</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #29 - an isolation/precaution sign is on the door. Resident #85 - C-PAP breathing mask is stored in a plastic bag.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will observe the following: 1). all residents in isolation to ensure a isolation/precaution sign is on the door. 2). all residents with respiratory equipment to ensure the respiratory circuit (i.e.: mouth piece / masks / nasal canulas)</p>	05/20/2015

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	<p>resident indicated she was on isolation for Clostridium Difficile. Observation of the Resident #29's room indicated there was no isolation sign on the door. An isolation cart was noted near the bathroom covered with bags of linen and not readily noticeable. The room lacked any indication the resident was on isolation precautions. Resident #29 was also indicated she believed her roommate also had Clostridium Difficile.</p> <p>During an interview on April 14, 2015 at 8:23 a.m., LPN #8 indicated she did not believe Resident #29 was in isolation precautions, but she wasn't sure.</p> <p>During an interview on April 14, 2015 at 8:29 a.m., LPN #3 indicated Resident #29 was still in isolation precautions. LPN #1 also indicated the facility was waiting for results of a stool sample ordered April 10, 2015.</p> <p>During an observation on April 14, 2015 at 8:37 a.m., LPN #3 was observed placing an isolation sign on Resident #29's door and removing the bagged linen from on top of the isolation cart.</p> <p>The clinical record for Resident # 29 was reviewed on April 14, 2015 at 8:30 a.m. It indicated the clinical record lacked the results of the stool sample ordered on</p>		<p>are stored in a plastic bag</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: 1). Contact Precautions 2). Respiratory Equipment Infection Control</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Residents in isolation to ensure a isolation/precaution sign is on the door. 2). Residents with respiratory equipment to ensure the respiratory circuit (i.e.: mouth piece / masks / nasal canulas) are stored in a plastic bag</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>	

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NAME OF PROVIDER OR SUPPLIER  BETHANY POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012			
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	<p>April 10, 2015.</p> <p>2. Resident # 126 was identified as the roommate for Resident # 29. The clinical record review for Resident # 126 was completed on April 13, 2015 at 11:55 a.m., The resident's test results were negative for Clostridium Difficile.</p> <p>A policy, dated January 2015, titled "Guidelines for Contact Precautions" was provided by the Nurse Consultant on April 14, 2015 at 4:50 p.m. The policy indicated the following: "...6. Precaution Sign: a. Post a sign at the resident's door to advise the visitors to report to nurses station before entering the room."</p> <p>Review of the "Resident Listing Report" indicated 46 residents, including Resident #29, resided on the 100 Hall.</p> <p>3. On 4/13/2015 at 2:10 p.m. and on 4/14/2015 at 8:39 a.m., Resident #162's nebulizer mouthpiece was observed not in use and not covered.</p> <p>On 4/15/2015 at 12:42 p.m., Resident #162's nebulizer mouthpiece was observed not in use and uncovered in the tray of the nebulizer machine, which was located on the room floor.</p> <p>4. On 4/14/2015 at 9:02 a.m., Resident</p>		randomly thereafter for further recommendation.				

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R 000 Bldg. 00	<p>#85's continuous positive air pressure (C-PAP) breathing mask was observed on bedside table not in use and not covered.</p> <p>The undated, "Guidelines For Respiratory Infection Control" policy was provided by the Nurse Consultant on 4/20/15 at 2:04 p.m. The policy indicated the purpose was to provide infection control guidelines to help prevent infections associated with respiratory therapy equipment, including ventilators, and to prevent transmission of infections to residents and staff. The policy indicated, after the completion of medication, administration of nebulizer therapy, the circuit should be stored in a plastic bag, marked with the date and the resident's name, between uses.</p> <p>3.1-18(2)</p> <p>This survey was for a State Residential Licensure Survey.</p> <p>Survey date: April 13, 14, 15, 16, 17, and 20, 2015.</p> <p>Facility number: 011045</p>	R 000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

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R 406 Bldg. 00	<p>Provider number: 155698 AIM number: 200380790</p> <p>Census bed type: SNF: 41 SNF/NF: 26 Residential: 63 Total: 130</p> <p>Census payor type: Medicare: 34 Medicaid: 16 Other: 80 Total: 130</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation and interview, the facility failed to ensure the disinfecting wipes for cleaning the glucometers were not expired on 1 of 2 medication carts and 1 of 2 medication rooms observed during the medication storage</p>	R 406	<p>required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on April 20, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p><b>R 406</b></p> <p><b>Corrective actions accomplished for those</b></p>	05/20/2015

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	<p>observation on the Assisted Living and Legacy Units. This deficient practice had the potential to effect 7 of 7 residents with physician orders for blood sugar monitoring. (Resident #R9, #R12, #R42, #R23, #R17, #R15, and #R52)</p> <p>Findings include:</p> <p>During an observation of the medication room on the Assisted Living Unit on 4/20/15 at 2:34 p.m., LPN #14 retrieved a bag of sanitizing wipes. LPN #14 indicated the wipes in the bag were the wipes used to clean the glucometers. The bag contained 16 single use Sani-Cloth bleach germicidal disposable wipes with an expiration date of 11/2014. LPN #14 indicated she had no other wipes in the medication room or on the medication cart. LPN #14 indicated each resident with a physician order for blood glucose monitoring had their own glucometer.</p> <p>During an observation of the medication cart on the Legacy Unit on 4/20/15 at 3:10 p.m., Unit Manager #15 retrieved one open box of sanitizing wipes from the bottom drawer of the cart. The box contained 39 single use Sani-Cloth bleach germicidal disposable wipes with an expiration date of 11/2014. Unit Manager #15 indicated each resident with a physician order for blood glucose</p>		<p><b>residents found to be affected by the alleged deficient practice:</b> The expired disinfecting wipes used for cleaning the glucometers were discarded and a new stock of un-expired wipes was placed on each medication cart.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review each medication cart and over flow stock of disinfecting wipes used for cleaning the glucometers to ensure they are not expired.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Glucometer Cleaning</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for each med cart and over flow stock will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: disinfecting wipes used for cleaning the glucometers to</p>	

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	<p>monitoring had their own glucometer.</p> <p>Unit Manager #16 was informed of the expired single use Sani-Cloth wipes on 4/20/15 at 3:13 p.m. She indicated she did not know when the single use Sani-Cloth wipes were received.</p> <p>On 4/20/15 at 3:20 p.m., Unit Manager #16 brought 5 boxes, with 40 single use Sani-Cloth wipes per box, from the storage closet. The wipes had an expiration date of 11/2014. She indicated those were the only other single use Sani-Cloth wipes on the Legacy Unit.</p> <p>Unit Manager #16 provided a list of the 7 residents (Residents # R9, #R12, #R42, #R23, #R17, #R15, and #R52), who had a physician order for blood glucose monitoring that could potentially be affected on the Assisted Living and Legacy Units on 4/20/15 at 3:24 p.m. She also indicated all of the expired single use Sani-Cloth wipes from the Assisted Living and Legacy Units had been discarded.</p> <p>Review of the current, undated facility policy, titled "Glucometer Cleaning Guidelines", provided by the Director of Nursing on 4/20/15 at 3:35 p.m., included, but was not limited to, the following:</p>		<p>ensure they are not expired.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>"...3. After cleaning visible blood or body fluids or if not visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions...</p> <p>...4. Single use glucometers should be cleaned when soiled and disinfected periodically...."</p>				