

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155683	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/13/2014
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NAME OF PROVIDER OR SUPPLIER  B & B CHRISTIAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3208 N SHERMAN DR INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Dates of Survey: June 9, 10, 11, 12 &amp; 13, 2014</p> <p>Facility number: 011032 Provider number: 155683 AIM number: 200262860</p> <p>Survey team: Courtney Mujic, RN-TC Karina Gates, BHS Tom Stauss, RN Beth Walsh, RN (June 9, 10, 11, 12, 2014)</p> <p>Census bed type: NF: 23 SNF/NF: 6 Total: 29</p> <p>Census payor type: Medicaid: 28 Other: 1 Total: 29</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 23,</p>	F000000	Please accept this as my credible allegation of compliance.	

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

TITLE

(X6) DATE

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

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F000250 SS=D	<p>2014 by Cheryl Fielden, RN.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received a follow up mental status assessment as planned for 1 of 5 residents reviewed for social services. (Residents #1)</p> <p>Findings include:</p> <p>1) The clinical record for Resident #1 was reviewed on 6/11/14 at 1:30 p.m. The diagnoses for Resident #1 included, but were not limited to, schizophrenia and delusions.</p> <p>The June, 2014 Medication Record for Resident #1 indicated she received 1 mg of Haloperidol (antipsychotic medication) daily effective 1/14/14 and 5 mg of Saphris (antipsychotic medication) twice daily effective 1/30/14.</p>	F000250	<p>A mental health assessment was completed for resident #1 on June 12, 2014. All residents with mental health issues were identified. They all could have potentially been affected by this deficient practice. No others were actually found to be affected. The Social Services Director met with the supervisor of Midtown Mental Health on June 16, 2014. A new tracking system was discussed and put in place. There will now be a sign in book kept at the nurse's station with dates that the residents will be seen and the name of the case manager. The next follow up appointment will be noted for each Midtown Mental Health resident. A copy will also be kept by the Social Services Director. A short note will be placed in the resident's chart following each visit. Following the visits, Midtown Mental Health will give the hard copy to the facility within one to two weeks. If a visit is</p>	06/30/2014

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	<p>The 2/25/14 care plan, updated 3/19/14, indicated the problem was, "Delusional behaviors ie. stating she's been taking care of a baby &amp; someone stole it!" The goal was, "(Name of mental health center) will provide case mgmt (management) services for 60 min (minutes), 1-3 x (times) monthly for 90 d (days)." An intervention was, "Staff along (symbol for "with") NH (nursing home) will monitor progress."</p> <p>The 4/29/14 mental health center progress note indicated the plan was, "Writer will follow up with (name of Resident #1) in two weeks for an assessment of her mental status." No further mental health center progress notes were found after the 4/29/14 note.</p> <p>An interview was conducted with the SSD (Social Services Director) on 6/11/14 at 12:00 p.m., regarding the 4/29/14 plan for an assessment of Resident #1's mental status. She indicated, "I don't have anything past 4/29 (4/29/14). I will contact him (Resident #1's case manager from mental health center), and ask for them."</p> <p>A telephone interview was conducted with Resident #1's case manager from the mental health center on 6/11/14 at 2:35</p>		<p>missed, Midtown Mental Health will be notified by the Social Services Director or the charge nurse. This will be monitored weekly by the Social Services Director and nursing department. It will also be monitored quarterly by the QA committee in conjunction with the Midtown Mental Health case managers. Written notification will be given to the Midtown Mental Health case managers three weeks prior to the QA meeting.</p>	

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	<p>p.m. regarding the plan to follow up with a mental status assessment of Resident #1. He indicated, "Unfortunately, it was not done. It was supposed to be done." Regarding whether he'd seen Resident #1 since her 4/29/14 visit, he indicated he had seen her 3 times, and "The nature of our conversation was 'hello, how are you?', not an assessment of her mental health." Regarding why an assessment was not done, he indicated, "To be honest, I forgot." Regarding whether any staff at the facility contacted him about the assessment, he indicated, "I usually talk to the SSD or one of the nurses. (Name of the SSD) spoke to me in general, but not about (name of Resident #1). No one at the facility contacted me about the mental health assessment before today. Moving forward, I'm going to amend her plan to less frequent visits, once a month maybe."</p> <p>Another interview was conducted with Resident #1's case manger in the presence of the SSD on 6/12/14 at 10:11 a.m. He indicated, "I plan to see her today, and do an assessment of her mental status. I still plan to decrease the frequency of her visits. 4/29 (4/29/14) is the last time I saw her for an assessment of her mental status. I did not do an assessment of her mental status after 4/29 like the note says I would. I saw her after 4/29, but only for</p>			

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F000253 SS=E	<p>hello type conversation, like I said yesterday."</p> <p>3.1-34(a)</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide a clean and homelike environment for 6 resident's rooms/bathrooms of 6 rooms/bathrooms reviewed during an environmental tour. This affected 14 of 15 residents residing in the rooms reviewed. (Resident #s 5, 6, 8, 10, 12, 13, 14, 21, 22, 23, 24, 26, 27, 29)</p> <p>Findings include:</p> <p>1. During a random observation of</p>	F000253	<p>All bathroom floors were cleaned. The affected wall was repaired and painted. The dresser drawers and nightstands were also repaired. All residents were affected by this deficient practice. All of the bathroom fixtures were replaced with new ones. All of the bathrooms were painted. All of the bathroom floors were stripped and cleaned. All of the toilets were thoroughly cleaned. The walls in rooms 1 and 23 were re-drywalled and painted. All of the affected dressers and nightstands were either repaired</p>	07/11/2014

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	<p>Resident # 22's room, on 6/10/14 at 10:33 a.m., the wall near the window appeared to be stripped of paint in several locations near the bed.</p> <p>During an environmental tour with the Maintenance Director/Housekeeping Supervisor, on 6/12/14 at 11:30 a.m., he indicated the facility cleaned the wall with some cleaner to remove some markings and it stripped the paint off of the wall. The Maintenance Director/Housekeeping Supervisor further indicated the wall needed to be buffed and repainted and the stripped wall did not provide a homelike environment for Resident #22.</p> <p>2. During a random observation of Resident #s 8, 24, 26 &amp; 29's bathroom, on 6/10/14 at 11:53 a.m., there was a white/greenish film all over the bathroom's fixture, a large hand length/width black mark on the bathroom door, several light brown hand length/width size marks between the handrail and door, and a dark brown ring around the base of the toilet.</p> <p>During an environmental tour with the Maintenance Director/Housekeeping Supervisor (MD/HS), on 6/12/14 at 11:30 a.m., the above Resident's bathroom was noted with the same concerns. The</p>		<p>or replaced. A new environmental monitoring sheet was created by the Administrator. The Maintenance Supervisor will check each room and bathroom weekly. The Administrator and Maintenance Supervisor together will also do monthly environmental rounds. The QA Committee will monitor this on a quarterly basis.</p>	

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	<p>Maintenance Director/Housekeeping Supervisor indicated he had plans to strip and wax the bathroom floor, paint the bathroom door, and clean the sink fixture, within the next couple of weeks. He further indicated the bathroom did not provide a homelike environment for the Residents. The MD/HS indicated the bathroom needed to be a cleaned a little further than it was.</p> <p>3. During a random observation of Resident #s 6, 12, 14, &amp; 27's bathroom, on 6/10/14 at 12:05 p.m., there was white/greenish film all over the bathroom's sink fixture, light gray spots throughout the bathroom floor, and a dark brown ring around the base of the toilet. The wall in Resident #s 6 and 12's room was noted to have water damage near the bed and door. The wall was warped in several locations.</p> <p>During an environmental tour with the Maintenance Director/Housekeeping Supervisor (MD/HS), on 6/12/14 at 11:30 a.m., the above Resident's bathroom was noted with the same concerns. The Maintenance Director/Housekeeping Supervisor indicated he had plans to strip and wax the bathroom floor and clean the sink fixture, within the next couple of weeks. He further indicated the bathroom did not provide a homelike</p>			

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	<p>environment for the Residents. The MD/HS indicated the bathroom needed to be a cleaned a little further than it was. The MD/HS also indicated a sprinkler started to leak in Resident #s 6 &amp; 12's room about 30 days ago and the wall needed to be repaired.</p> <p>4. During a random observation of Resident #s 10, 13, &amp; 23's bathroom, on 6/10/14 at 2:11 p.m., there was white/greenish film noted on the bathroom fixture.</p> <p>During an environmental tour with the Maintenance Director/Housekeeping Supervisor (MD/HS), on 6/12/14 at 11:30 a.m., the above Resident's bathroom was noted with the same concern. The Maintenance Director/Housekeeping Supervisor indicated he had plans to clean the sink fixture, within the next couple of weeks. The MD/HS indicated the bathroom needed to be a cleaned a little further than it was.</p> <p>5. During a random observation of Resident #s 2 &amp; 5 's room, on 6/11/14 at 9:52 a.m., a dresser containing Resident #5's clothing appeared to have lopsided drawers and was not able to close properly.</p> <p>During an environmental tour with the</p>			

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	<p>MD/HS, on 6/12/14 at 11:30 a.m., he indicated he received a work order to fix the dresser a couple of days prior. The MD/HS further indicated other staff members put so many clothing items in the dresser that it throws the dresser drawers off track and the tracks need to be replaced. He indicated the dresser should be fixed by the end of the week.</p> <p>6. During a random observation of Resident #21's bathroom, on 6/11/14 at 9:57 a.m., several brown streaks were noted under the bathroom sink, white/greenish film was noted on the sink fixture, and a dark brown ring was noted around the base of the toilet.</p> <p>During an environmental tour with MD/HS, on 6/12/14 at 11:30 a.m. he indicated he planned on stripping and waxing the bathroom floor and cleaning the sink fixture within the next couple of weeks. The MD/HS further indicated the bathroom did not provide a homelike environment for the Resident.</p> <p>3.1-19(f)(5)</p>				

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F000278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure accuracy of a</p>	F000278	The MDS for resident #1 will be corrected on July 8, 2014. The	07/08/2014	

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	<p>resident's Quarterly MDS (minimum data set) assessment regarding a diagnosis for 1 of 3 residents whose MDS assessments were reviewed. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record for Resident #1 was reviewed on 6/11/14 at 1:30 p.m. The diagnoses for Resident #1 included, but were not limited to, schizophrenia.</p> <p>The 3/6/14 Quarterly MDS indicated Resident #1 did not have schizophrenia.</p> <p>The March, 2014 Physician's Orders for Resident #1 indicated a diagnosis of schizophrenia.</p> <p>An interview was conducted with the SSD (Social Services Director) on 6/11/14 at 12:00 p.m. She indicated Resident #1 had a diagnosis of schizophrenia.</p> <p>An interview was conducted with the BOM (Business Office Manager) on 6/11/14 at 2:30 p.m. She indicated she was responsible for entering information from MDS assessments into the computer, and Resident #1's 3/6/14 Quarterly MDS should have indicated she had schizophrenia.</p>		<p>mistake was an incorrect data entry error. All other residents could have been affected by this deficient practice. However, no others were affected. All MDS' were audited for data entry errors. None were found by the MDS Coordinator. All MDS' will be double checked by the MDS Coordinator and the Social Services Director to see if there are any data omissions or errors. If any are found, they will be corrected immediately. This will be monitored, each time an MDS is input, by the MDS Coordinator and the Social Services Director. The Interdisciplinary Team will monitor this on a quarterly basis.</p>	

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F000279 SS=D	<p>3.1-31(i)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based interview and record review, the facility failed to ensure a resident with a developmental disability had a facility care plan to address his diagnosis for 1 of #21 residents reviewed for care plans. (Residents #23)</p> <p>Findings include:</p>	F000279	A developmental disability care plan was put in place for resident #23.No other were affected by this deficient practice. Only one resident had a diagnosis of developmental disability.The Social Services Director met with Tammy Tungett to discuss developmentally disabled residents. Specific incites were gained concerning their care and care planning. A care plan is now	06/20/2014	

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F000280 SS=D	<p>The clinical record for Resident #23 was reviewed on 6/12/14 at 2:00 p.m. The diagnoses for Resident #23 included, but were not limited to, developmental disability.</p> <p>The 2/10/14 Pre-Admission Screening/Annual Review Certification for Resident #23 indicated he had a developmental disability and "does meet PASRR Level II criteria for: continued residence in a nursing facility."</p> <p>The care plans for Resident #23 were reviewed. No care plan addressing his developmental disability was found.</p> <p>An interview was conducted with the SSD (Social Services Director) on 6/12/14 at 2:36 p.m. She indicated Resident #23 did not have a care plan specific to his developmental disability. She stated, "I didn't think I needed one, because he didn't have any specialized activities recommended. I would have, if he needed specialized activities."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p>		<p>in place. It is specifically written for resident #23. This will be revised as needed. This will be monitored daily by the nursing staff. They will report any changes to the Social Services Director. This will be updated quarterly by the interdisciplinary team.</p>	

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	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise a pain care plan with the appropriate pain medications ordered. This affected 1 of 15 residents reviewed for care plans. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 6/11/14 at 1:05 p.m. The diagnoses for Resident #21 included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dementia. The resident was admitted on 11/12/12.</p> <p>A review of a pain care plan, dated 4/16/14, indicated an intervention for</p>	F000280	<p>A pain assessment was immediately put in place for resident #21. All residents were identified to have the potential to be affected by this deficient practice. A pain assessment plan was put in place by the MDS Coordinator. A daily pain assessment plan for all residents was put in place by the Director of Nursing. A new policy was written to support the new pain assessment schedule. This will be monitored daily by the nurses, monthly by the Director of Nursing, and quarterly by the QA Committee.</p>	06/30/2014

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F000309 SS=D	<p>Tramadol (pain medication).</p> <p>A phoned Physician's Order, dated 3/29/14, indicated to discontinue the order for Tramadol related to non-use.</p> <p>A review of the April, May, and June Physician's Orders indicated an order for ibuprofen 400 mg (milligram) tablet by mouth every 6 hours as needed for pain. The order was initiated on 9/5/13. The Physician's Orders also indicated an allergy to ibuprofen on them. No other pain medications were ordered for Resident #21.</p> <p>During an interview with the Director of Nursing (DoN), on 6/12/14 at 11:51 a.m., she indicated the facility does not always update the care plans with new Physician's Orders. The DoN further indicated the facility sometimes just wait until the quarterly review of care plans to update them.</p> <p>3.1-35(b)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>			

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	<p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to recognize a medication allergy that could have had an adverse consequence and failed to routinely assess a resident who had a history of pain for 1 of 3 residents reviewed for pain, and the facility failed to ensure a medication was passed as directed by a physician's order which resulted in a wrong medication dose being administered to a resident. This affected 1 out of 9 residents observed for medication administration and had the potential to affect all 29 residents who lived in the facility. (Resident #3 &amp; Resident #21)</p> <p>Finding include:</p> <p>1. The clinical record for Resident #21 was reviewed on 6/11/14 at 1:05 p.m. The diagnoses for Resident #21 included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dementia. The resident was admitted on 11/12/12.</p> <p>A review of the Admission Physician's Orders indicated an allergy to ibuprofen.</p>	F000309	<p>A daily pain assessment sheet is now in place for all residents. A medication incident report was generated for the wrong amount of medication given to resident #3. He was monitored for adverse affects. The resident showed no adverse affects. All residents had the potential to be affected by this deficient practice. No others were affected. No other medication errors were found. All resident charts were checked for medication allergies. No problems were found. A four hour inservice was given to all nurses and qma's reviewing policies and procedures. It covered medication errors, the proper way to pass medication, checking for drug allergies, proper drug administration, pain assessment, and patient medication rights. Each nurse and qma did a med pass with the Director of Nursing. This will be monitored monthly by the Director of Nursing. The Director of Nursing will randomly select a nurse or qma and monitor their med pass.</p>	07/09/2014

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	<p>A review of the April, May, and June Physician's Orders indicated an order for ibuprofen 400 mg (milligram) tablet by mouth every 6 hours as needed for pain. The order was initiated on 9/5/13. The Physician's Orders also indicated an allergy to ibuprofen. The Physician's Orders further indicated they were reviewed by LPN #1.</p> <p>During an interview with LPN #1, on 6/11/14 at 2:35 p.m., she indicated she was the one to review the Physician's Orders/Rewrites, but she typically didn't look at the Resident's allergies when reviewing the Orders, but she will start to do so now.</p> <p>On 6/11/14, at 2:40 p.m., the Director of Nursing (DoN) indicated its a problem when a medication was ordered and the Resident was allergic to it. The DoN indicated she will further look into the order for the ibuprofen.</p> <p>At 9:40 a.m., on 6/12/14, the DoN indicated the ibuprofen was ordered on 9/4/13 and was discontinued on 1/30/14, but the order was never removed from the Physician's Orders/Rewrites. The DoN indicated she was unsure why the medication was ordered in the first place when Resident #21 was allergic to it and she also indicated she was unsure why</p>			

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	<p>the ibuprofen was never removed from the Physician's Orders/Rewrites when it was discontinued several months prior.</p> <p>1b. The clinical record for Resident #21 was reviewed on 6/11/14 at 1:05 p.m. The diagnoses for Resident #21 included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dementia. The resident was admitted on 11/12/12.</p> <p>A review of Resident #21's Admission Physician's Orders indicated an order for Tramadol 50 mg (milligrams) twice a day as needed for pain in the right shoulder.</p> <p>A pain care plan, dated 4/16/14, indicated a problem of, "States he has moderate amount of pain daily/occasionally."</p> <p>The Annual MDS (Minimum Data Set) Assessment, dated 10/17/13, indicated Resident #21 does have frequent pain.</p> <p>The Quarterly MDS Assessments, dated 1/9/14 &amp; 4/3/14, indicated Resident #21 does have moderate pain occasionally.</p> <p>A Pain Assessment, dated 4/2/14, indicated Resident #21 had moderate pain, in his chest and head. The choices for frequency of pain were; "no pain, pain (symbol for less than) daily, and pain</p>			

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	<p>daily." Pain less than daily was checked.</p> <p>During an interview with Resident #21, on 6/11/14 at 9:45 a.m., Resident #21 indicated he had pain all over and he thought he was getting pain medication, but the medication wasn't working.</p> <p>On 6/12/14 at 11:10 a.m., during a pain assessment with LPN #1 of Resident #21, Resident #21 indicated he had pain of an "8" on a scale of 1-10. Resident #21 then indicated he had this pain for quite awhile. LPN #1 then asked Resident #21 why Resident #21 didn't tell her sooner about the pain and Resident #21 indicated no one asked.</p> <p>During an interview with LPN #1, on 6/12/14 at 11:15 a.m., LPN #1 indicated she doesn't specifically assess pain often. LPN #1 indicated she would ask a Resident, "how are you [the Resident] doing?" and would expect the resident to tell her if they were in pain at that point.</p> <p>At 12:22 p.m., on 6/12/14, LPN #2 indicated the Pain Assessment, on 4/2/14, was the last documentation, of when a pain assessment was done on Resident #21. LPN #2 further indicated the facility was working on a program to assess pain more frequently. LPN #2 further indicated Resident #21 should've</p>						

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	<p>been assessed for pain since 4/2/14, since Resident #21 had pain in the past and a care plan for pain.</p> <p>2) During a med pass observation of QMA #3 on 6/11/14 at 9:37 a.m., the QMA administered 2 puffs of the medication Flovent 110 mcg to Resident #3. An MD order for the Medication indicated the medication was to be administered "1 puff two times daily."</p> <p>On 6/11/14 at 9:39 a.m., QMA #3 indicated regarding Resident #3's Flovent, "only 1 puff should have been given." She indicated the medication administration record for Resident #3's Flovent medication indicated "1 puff twice a day."</p> <p>Physician's orders, dated 11/21/13, indicated Fluticasone (Flovent) 110 mcg (micrograms) 1 puff inhalation 2 times daily at 9 a.m., and 5 p.m.</p> <p>On 6/12/14 at 10:06 a.m., the DoN indicated all licensed staff who pass medications should administer all medications as ordered by the physician for all residents at all times. She also indicated it would not be appropriate for a licensed nursing staff member to administer 2 puffs of a medication if the resident was only to receive 1 puff per</p>			

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F000329 SS=D	<p>MD orders.</p> <p>A facility policy titled "Licensed Nurse And QMA (Qualified Medication Aide) Procedure" indicated the following "...Always adhere to the five rights of medication administration, right drug, right resident, right dose..."</p> <p>3.1-37(a) 3.1-35(g)(1)</p> <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</p>			

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	<p>contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a to ensure follow through of a pharmacy recommendation for a decrease in a hypnotic medication for 1 of 5 residents reviewed for unnecessary medications. (Residents #12)</p> <p>Findings include:</p> <p>The clinical record for Resident #12 was reviewed on 6/12/14 at 10:00 a.m. The diagnoses for Resident #12 included, but were not limited to, insomnia.</p> <p>The June, 2014 Medication Record for Resident #12 indicated he received 5 mg of Zolpidem Tartate, generic Ambien (hypnotic medication), once daily at bedtime effective 8/23/13.</p> <p>The 5/20/14 Monthly Medication Regimen Review for Resident #12 indicated, "Physician Recommendation: (symbol for "decrease") AMB."</p> <p>The 5/20/14 Executive Summary Of Consultant Pharmacist's Medication Regimen Review report, prepared by Pharmacist #6, indicated, "This visit, 14 recommendations were forwarded to the</p>	F000329	<p>The two missing/missed pharmacy reports were reviewed. The medication reduction for resident #12 was reported to the physician. However, he declined the recommendation due to the resident's behavior. All previous pharmacy reports were checked. No others were missing any pages. All pharmacy consulting reports will be checked by the charge nurse and the Director of Nursing. The face sheet with the number of pages and all recommendations will be completed by the nurse and the D.O.N. Both will sign each recommendation. The completed face sheet and recommendations will be monitored monthly by the Administrator. The QA Committee will review any findings on a quarterly basis.</p>	06/16/2014

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	<p>following disciplines: 7 written to MD, 7 written to Nursing. Please refer to the Consultant Pharmacist's Medication Regimen Review for specifics."</p> <p>Attached to the above mentioned report were 5 Notes To Attending Physician/Prescriber, not 7. No note was attached for a decrease in Ambien for Resident #12.</p> <p>A telephone interview was conducted with Pharmacist #6 on 6/12/14 at 11:28 a.m., regarding the down arrow AMB on the 5/20/14 Monthly Medication Regimen Review for Resident #12 and the 5/20/14 Executive Summary report he prepared. He indicated, "It means I recommended it be reduced to Ambien 5 mg prn (as needed)...There should be a Note To Attending Physician/Prescriber. I sent it to the facility on the evening of 5/22 (5/22/14)....It looks like I sent 26 pages of reports. I don't know why she (LPN #7) doesn't have 26 pages.....She says she only has 5 recommendations....I'm resending the entire 26 pages today. I've never had an issue with anyone not receiving their entire report....His (Resident #12) was the first recommendation, so it was strange for her not to get it. This is an unusual situation. This report was sent on 5/22/14. The first method to catch this</p>			

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F000386 SS=D	<p>error is to compare the number of recommendations on the summary to the number of recommendations (Notes to Attending Physician/Prescriber) actually received."</p> <p>An interview was conducted with LPN #7 on 6/12/14 at 11:35 a.m. She indicated, "I don't compare the number of recommendations on the summary to actual notes to attending physician. I'm going to start covering myself, counting pages, comparing the number of recommendations...."</p> <p>On 6/12/14 at 12:03 p.m., the 5/20/14 Note To Attending Physician/ Prescriber for Resident #12 was faxed to the facility from Pharmacist #6. It indicated, "This resident has been receiving the following sedative/hypnotic order: Ambien 5 mg QHS (every night). In an effort to achieve the minimal effective dose, may I suggest: a trial reduction of Ambien to 5 mg QHS PRN insomnia. Thank you."</p> <p>3.1-48(b)(2)</p>				
	483.40(b) PHYSICIAN VISITS - REVIEW				

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	<p><b>CARE/NOTES/ORDERS</b></p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>Based on interview and record review, the facility failed to ensure monthly physician's orders were signed and dated by a physician for 3 of 8 residents reviewed for pain and unnecessary medications. (Residents #1 &amp; #21)</p> <p>1) The clinical record for Resident #1 was reviewed on 6/11/14 at 1:30 p.m. The April, May, and June, 2014 physician's orders were not signed by the physician.</p> <p>On 6/11/14 at 2:00 p.m., the most recent signed physician's orders for Resident #1 were requested. No signed physician's orders for Resident #1 were provided on 6/11/14. On 6/12/14 at 9:30 a.m., the DON (Director of Nursing) provided a copy of the March, 2014 monthly physician's orders for Resident #1 with Physician #5's signature dated 6/12/14.</p> <p>An interview was conducted with Physician #5 on 6/13/14 at 11:44 a.m.</p>	F000386	<p>The Physician was in the facility on June 13 and 14 of 2014. All records were brought current. All residents had the potential to be affected by this deficient practice. The records that were out of compliance were updated by the Physician on June 13 and 14, 2014. A meeting was held with the Physician and his nurse. The Physician or his nurse practitioner will visit the facility monthly to update records. He will see all new residents according to state regulations. His office nurse will fax a schedule with the monthly visits. The charge nurse will notify the physician's office of all new residents. This will be monitored by the charge nurse and the Director of Nursing monthly. All missed scheduled appointments will be reported to the Administrator. The Administrator will be responsible for contacting the Physician.</p>	07/06/2014	

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	<p>He indicated it was his signature on the March, 2014 orders. He indicated, "I just signed them yesterday. The rotation got messed up. I was in here in May (2014), but I know hers is one that got missed....It's our fault."</p> <p>2) The clinical record for Resident #21 was reviewed on 6/11/14 at 1:05 p.m. The diagnoses for Resident #21 included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dementia. The resident was admitted on 11/12/12.</p> <p>A review of the April, May, and June 2014 Physician's Orders for Resident #21 did not indicate a Physician Signature on them.</p> <p>A review of the Physician Progress Notes, indicated a Physician visit on 1/25/14. No other Physician/Nurse Practitioner Progress Notes were located in the clinical record.</p> <p>During an interview with the Director of Nursing (DoN), on 6/11/14 at 2:00 p.m., she indicated the above Physician's Orders did not have the Physician's Signature, but the facility just accepted the Orders as the current Physician's Orders. The DoN indicated she will continue to look for the last signed</p>			

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F000387 SS=D	<p>Physician's Orders.</p> <p>On 6/12/14 at 10:30 a.m., LPN #2, indicated the facility was unable to locate any signed Physician Orders for Resident #21, since January 2014, including in the closed/overflow clinical record, but she will check again.</p> <p>The DoN indicated, on 6/12/14 at 11:51 a.m., the facility was not able to locate any other signed Physician's Orders/Progress Notes for Resident #21 and the facility even looked in the overflow/closed clinical records. She further indicated the Nurse Practitioner for the Medical Doctor, quit some time ago, so maybe that was why there were no other Progress Notes located in the clinical record or any signed Physician's Orders, as they should've been.</p> <p>3.1-22(c)(3)</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</p>						

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	<p>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 interview and record review, the facility failed to ensure a resident was seen by a Physician at least every 60 days. This affected 1 of 8 residents reviewed for unnecessary medications and pain. (Resident #21)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #21 was reviewed on 6/11/14 at 1:05 p.m. The diagnoses for Resident #21 included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dementia. The resident was admitted on 11/12/12.</p> <p>A review of the Physician Progress Notes, indicated a Physician visit on 1/25/14. No other Physician Progress Notes were located in the clinical record.</p> <p>A review of the April, May, and June 2014 Physician's Orders for Resident #21 did not indicate a Physician Signature on them.</p> <p>During an interview with LPN #2, on 6/12/14 at 10:30 a.m., she indicated she</p>	F000387	<p>The Physician was in the facility on June 13 and 14 of 2014. All records were brought current. All residents had the potential to be affected by this deficient practice. The records that were out of compliance were updated by the Physician on June 13 and 14, 2014. A meeting was held with the Physician and his nurse. The Physician or his nurse practitioner will visit the facility monthly to update records. He will see all new residents according to state regulations. His office nurse will fax a schedule with the monthly visits. The charge nurse will notify the Physician's office of all new residents. This will be monitored by the charge nurse and the Director of Nursing monthly. All missed scheduled appointments will be reported to the Administrator. The Administrator will be responsible for contacting the Physician.</p>	07/06/2014

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F000431	<p>was unable to locate any other signed Progress Notes for Resident #21, since January 2014, including in the closed/overflow clinical record, but she will check again.</p> <p>The Director of Nursing (DoN) indicated on 6/12/14 at 10:40 a.m., the facility was unable to locate any other Physician Progress Notes or signed Physician's Orders since 1/25/14, but the facility will look again.</p> <p>To further clarify, the DoN was asked again on 6/12/14 at 11:51 a.m., if the facility was able to locate any other signed Physician's Orders or Progress Notes for Resident #21 since 1/25/14, to indicate the Resident was seen by the Medical Doctor since 1/25/14. The DoN indicated the facility was not able to locate any other signed Physican's Orders/Progress Notes for Resident #21 and the facility even looked in the overflow/closed clinical records again. The DoN also indicated she was unsure of when the last time Resident #21 was seen by their MD. She further indicated the MD was supposed to see a Resident at least every 60 days.</p> <p>3.1-22(d)(1)</p> <p>483.60(b), (d), (e)</p>			

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SS=D	<p><b>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an unlabeled medication was properly labeled for resident administration and</p>	F000431	The medication was immediately destroyed because it was in an unlabeled cup. All residents had the potential to be affected by this deficient practice. No others were affected. No other	07/09/2014

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	<p>secured in a double locked medication cart. This had the potential to affect 9 out of 29 residents who received medication from the North unit medication cart.</p> <p>Findings include:</p> <p>On 6/13/14 at 9:32 a.m., during a medication cart storage observation of the North unit medication cart, a small orange pill was observed in an unlabeled medication cup, with no markings on the cup, on the top drawer of a medication cart including medications for Resident #21 and other residents for the North hall including, but not limited to, Resident #'s 14 and 22. QMA #3 was near the cart performing a routine medication pass for the residents of North hall.</p> <p>On 6/13/14 at 9:34 a.m., QMA #3 indicated she "thought" the pill was for Resident #21, who had apparently refused the medication earlier. She also indicated the pill was "Xanax" for Resident #21.</p> <p>The medication administration record for Resident #21, dated 6/1/14 through 6/30/14, indicated the resident received "...Alprazolam (Xanax) 0.5 mg tablet three times daily..."</p>		<p>unlabeled medication was found. An inservice was given on proper medication administration, storage, and labeling. The Director of Nursing also did a medication pass with all nurses and qma's. This will be monitored by the Director of Nursing, who will complete a random medication pass with one nurse or qma on a monthly basis.</p>				

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	<p>On 6/13/14 at 9:37 a.m., during an observation, Resident #21's Alprazolam medication packet indicated the tablets were small, orange tablets. The tablets in the Alprazolam package was identical in appearance to the pill observed in the unlabeled medication cup in the top drawer of the North unit medication cart as described above.</p> <p>On 6/13/14 at 9:39 am, the Director of Nursing (DoN) indicated no pills should be left unlabeled and open in a medication cart.</p> <p>On 6/13/14 at 1:14 p.m., the DoN indicated alprazolam should be kept "double locked" in the medication cart. She indicated the alprazolam tablet left in the top drawer of the medication cart in an unlabeled medication cup was not considered "double locked."</p> <p>A facility policy for the "Purpose" of "...safe storage of medication..." indicated the following, "...Narcotics should always be double locked..."</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(m) 3.1-25(n)</p>				

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

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