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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155267 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>02/25/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>SCOTT VILLA NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>545 W MOONGLO ROAD<br>SCOTTSBURG, IN47170 |
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| F0000              | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 22, 23, 24, 25, 2011</p> <p>Facility number: 000168<br/>Provider number: 155267<br/>AIM number: 100267020</p> <p>Survey Team:<br/>Avona Connell, RN, TC,<br/>Donna Groan RN.<br/>Gloria J. Reisert, MSW</p> <p>Census bed type:<br/>SNF/NF: 51<br/>Total: 51</p> <p>Census payor Type:<br/>Medicare: 08<br/>Medicaid: 36<br/>Other: 07<br/>Total: 51</p> <p>Sample: 13<br/>Supplemental sample: 03</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review 3/02/11 by Suzanne Williams, RN</p> | F0000         | Attached is the Addendum for the Plan of Correction for Survey Event D1LL11 exit date 2/25/2011 Scott Villa Nursing Rehab is respectfully requesting a desk review for the Annual Recertification Survey of 2011. |                      |

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

TITLE

(X6) DATE

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

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| F0157<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure the physician was notified of a resident need for an intravenous flush for 1 of 1 resident reviewed with a PICC (Peripherally Inserted Central Catheter) line in a sample of 13.</p> <p>Findings include:</p> <p>The clinical record for Resident #39 was reviewed on 2/22/11 at 12:45 p.m. The resident's diagnoses included, but were not limited to pressure ulcer and chronic airway obstruction. The resident was sent out to a hospital for the placement of a PICC line. Nurses Note included, but was not limited to: 2/15/11 "[Named] County EMS (Emergency Medical Service) here to transport to [named] hospital for placement of PICC line..." 2/15/11 5:30 P "Res returned from [named] hospital. Arrived via ambulance with 3 EMTs [Emergency Medical Technicians]...Late entry: 6:30 PM When res arrive/returned from [named] hospital, No paperwork or progress note from PICC line placement came with res or EMTs." Documentation was lacking the physician was notified of the need for orders for the care of the PICC line.</p> <p>The TAR (Treatment Administration</p> | F0157   | Resident #39's order for the PICC line flush was obtained 2/21/11.A one time audit of all PICC line orders was conducted by DON/designee on 2/21/11.All Nursing staff will be educated on the PICC line flush protocol. On 3/2/11 licensed staff were in-serviced on the Protocol Any new admit or re-admit to the facility with a PICC line will be reviewed by the IDT with in 24 hours to assure that the protocol has been implemented. On 3/2/11 the protocol for PICC line care was placed in nurse's MAR and info. binder located at each nurses station.DON/designee will audit all PICC line orders daily for 2 weeks then weekly x 12 weeks then. All new admits/re-admits will be reviewed by the Intra-disciplinary team to assure orders have been obtained and implemented. Any issues identified the MD and family will be notified and corrections will be made as indicated. Result of this process will be reviewed by the Quality Assurance Committee for review and update as indicated 3/27/2011 | 03/27/2011           |   |

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|   | <p>Record) for Feb. (February) 2011 included, but was not limited to "Monitor PICC site Q. (every) Shift" beginning 2/15/11 2- 10 p.m. through 2/22/11, 6-2 shift.</p> <p>On 2/23/11 at 3 p.m., the Consultant Nurse provided the Policy and Procedure for "Physician Notification" dated revised June 2009, which included, but was not limited to: "Policy: The Physician Notification form may be used for non-emergency update to the physician. It will accurately describe the resident's condition. Procedure: 1. Complete the Physician Notification for physician update: Use for non-emergency update, call physician with change of condition, 2. Notify/Update the physician..."</p> <p>In interview with the Director of Nursing, she provided a Physician's telephone Order obtained on 2/21/11 which indicated "PICC Line Flush PICC line with 5 cc (cubic centimeters) N/S (normal saline) and 5 cc Heparin (blood thinner) before and after each use and q. shift to maintain patency."</p> <p>3.1-5(a)(3)</p> |  |   |                      |  |

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| F0225<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported immediately to the Administrator and to other officials in accordance with state law and thoroughly investigated for 1 of 13 residents reviewed for abuse in a sample of 13 and 1 of 1 resident reporting misappropriation of property in a supplemental sample of 3. (Resident #11, 41)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 2/23/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, morbid obesity and arthritis. The Nurse Progress Note for 2/23/11 indicated at 8:15 a.m., "Res. states he will not go to appt. (appointment) @ (at) Wound Clinic today, because 'they hurt my left leg, last week and I'm not going this wk.(week).'" On 2/23/11 at 12:30 p.m. the Director of Nursing was queried as to the Progress Note. She nor the Administrator had been made aware of the allegation.</p> <p>In interview with LPN #1 on 2/23/11 at 12:55 p.m., she indicated Resident #11 indicated "they hurt his leg when they transferred him from the stretcher to the treatment table." She went on to indicate</p> | F0225   | <p>F-225</p> <p>Concerning Resident #11, an investigation was started immediately after the surveyors notified the HFA of the nurse's note. Protocol was followed for any abuse allegation and reportable faxed to registry on 2/23/11. Staff were in-serviced on 2/23/11 and 2/24/11 on the abuse policy including importance of reporting allegations of abuse immediately. SSD/HFA will randomly ask 3 Residents a week for 6 weeks and then 1 Resident once a week for 6 weeks regarding treatment and care received in and outside the facility. SSD will have a 1x special Resident Council and review Resident's Rights and the types of abuse and reporting to staff any time they feel uneasy/unsafe or if they feel they have been mistreated. Random audits will be completed by HFA/Designee for 12 weeks then weekly x 12 weeks. This process will be an on-going process reviewed through monthly resident council meetings. Any concerns will be addressed immediately by the HFA/Designee. Results will be given to HFA on the days questioned and audits will be discussed at monthly QA meetings. Any non-compliance will be addressed by the HFA/DON through re-education and/or disciplinary action.</p> <p>3/27/2011</p> | 03/27/2011           |   |

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|   | <p>the EMTs (Emergency Medical Technicians) hurt him. She indicated what she had written wasn't clear enough. When queried as to reporting abuse, she indicated she would report it to the Director of Nursing and Administrator.</p> <p>2. On 2/25/11 at 11:40 a.m., a family member for Resident #41 asked to speak with surveyors. During the interview, he was queried if any personal items had been taken. At this time, he indicated a bottle of white shoulder perfume came up missing 3 months ago. He reported it to the nurses and to the CNAs' (Certified Nursing Assistant) and nothing was done. At 12 p.m., the Social Worker was asked if anyone reported perfume missing from a resident. She indicated "No".</p> <p>3.1-28(c)<br/>3.1-28(d)<br/>3.1-28(e)</p> |  |   |                      |  |

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| F0226<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure its abuse prevention policy and procedure was implemented, by failing to ensure an allegation of abuse was reported immediately to the Administrator and to other officials in accordance with state law and thoroughly investigated for 1 of 13 residents reviewed for abuse in a sample of 13 and 1 of 1 resident reporting misappropriation of property in a supplemental sample of 3. (Resident #11, 41)</p> <p>Findings include:</p> <p>On 2/22/11 at 10:30 a.m., the Administrator provided the Policy and Procedure for "Prevention and Reporting: Resident Mistreatment, neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property revised January 2007. The Procedure included but was not limited to:"Identification 3. Instruct staff, resident, family, visitor, etc. to report immediately, without fear of reprisal, any knowledge of abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property...Reporting 2. Report the incident immediately to the Director of Nursing and/or Administrator."</p> | F0226  | <p>F-226</p> <p>Resident #41 reported a bottle of perfume was missing and not followed through. Bottle of perfume was replaced 3/7/11. An audit will be conducted randomly on 3 Residents weekly x 6 weeks and then 1 Resident per week for 6 weeks to see if they have any items missing. The audit will be done by SSD/HFA. Resident # 11 an investigation was initiated immediately once survey team notified the HFA of the nurses note related to resident's allegation of having been hurt while out of facility. Licensed staff were re-educated on reporting any resident's concern of having been mistreated or hurt while outside of facility or in facility. Any concern identified will be addressed immediately and investigated and reported as indicated.</p> <p>All staff will be re-educated on completing resident concern/grievance forms for any resident concerns and follow up on any concern that resident may voice.</p> <p>At daily stand up meetings any grievances will continue to be reviewed and given to appropriate department for investigation. This process will be followed up on Monday-Friday until issue is resolved. Follow up with the family/resident will be completed by the HFA/SSD with in 72 hours to</p> | 03/27/2011           |  |

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|   | <p>1. The clinical record for Resident #11 was reviewed on 2/23/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, morbid obesity and arthritis. The Nurse Progress Note for 2/23/11 indicated at 8:15 a.m., "Res. states he will not go to appt. (appointment) @ (at) Wound Clinic today, because 'they hurt my left leg, last week and I'm not going this wk.(week).'" On 2/23/11 at 12:30 p.m. the Director of Nursing was queried as to the Progress Note. She nor the Administrator had been made aware of the allegation.</p> <p>In interview with LPN #1 on 2/23/11 at 12:55 p.m., she indicated Resident #11 indicated "they hurt his leg when they transferred him from the stretcher to the treatment table." She went on to indicate the EMTs (Emergency Medical Technicians) hurt him. She indicated what she had written wasn't clear enough. When queried as to reporting abuse, she indicated she would report it to the Director of Nursing and Administrator.</p> <p>2. On 2/25/11 at 11:40 a.m., a family member for Resident #41 asked to speak with surveyors. During the interview, he was queried if any personal items had been taken. At this time, he indicated a</p> |  | <p>assure there has been a resolution. The grievance log will be maintained by the SSD and reviewed by HFA weekly to assure all concerns have had resolution. The audit and logs will be reviewed at monthly QA meetings for review and up-date as indicated. Any non compliance will be addressed by the HFA/DON through re-education and or disciplinary action.</p> <p>3/27/2011</p> |                      |  |

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|   | bottle of white shoulder perfume came up missing 3 months ago. He reported it to the nurses and to the CNAs' (Certified Nursing Assistant) and nothing was done. At 12 p.m., the Social Worker was asked if anyone reported perfume missing from a resident. She indicated "No".<br><br>3.1-28(a) |  |   |                      |  |

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| F0272<br>SS=D   | <p>Based on record review, observation and interview, the facility failed to assess a resident after each return from dialysis treatment to check for thrill/bruit [how well blood was flowing through shunt], vital signs, and shunt site condition. This deficient practice affected 1 of 1 dialysis resident reviewed for dialysis care in a sample of 13 residents. (Resident #1)</p> <p>Finding includes:</p> <p>The clinical record for Resident #1 was reviewed on 2/24/11 at 7:25 a.m. The resident's diagnoses included, but were not limited to end stage renal disease and diabetes mellitus type II. The resident was admitted to the facility on 2/12/11.</p> <p>Current Physician's Orders for Admission included, but were not limited to, "Dialysis M.(Monday), W. (Wednesday), F. (Friday)."</p> <p>The Treatment Administration Record (TAR) for February 2011 indicated "Monitor daily shunt L upper chest s/s (signs/symptoms) infection."</p> <p>On 2/24/11 at 8:50 a.m., with the Director of Nursing, Resident #1 was observed to have a shunt, for dialysis access, in the left upper arm.</p> | F0272   | <p>F-272 The assessment of Resident #1's shunt was done on 2/24/11 resident did not have a negative outcome as a result of this alleged deficient practice. All Residents receiving dialysis were assessed for thrill and bruit and assessment was placed on TAR to be monitored by nursing. All nurse's were in-serviced on 2/24/11 regarding assessing residents with dialysis shunts for thrill and bruit. Any new admission or re-admission with a dialysis shunt will be assessed by the nurse in charge and reviewed by the IDT 5 days a week Monday --Friday to assure any identified resident(s) have been adequately assessed. MD/family will be notified if any changes are identified. DON/designee will audit TAR daily times 4 weeks, then weekly times 4 weeks then monthly times 6 months and then as indicated. Results will be reviewed monthly at the monthly QA meetings for review and up-date as indicated. Any non compliance will be addressed by the HFA/DON through re-education and/or disciplinary action. 3/27/2011</p> | 03/27/2011           |   |

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|   | <p>Review of the Policy and Procedure for "Dialysis Management (Hemodialysis)" revised July 2008 included, but was not limited to "Clinical responsibilities will include, but are not limited to, the following: "13. Assure daily assessment and documentation of fistula or graft site...18. Check AV fistula/graft site function by palpating thrill and listening for bruit daily and upon return post-dialysis and document on TAR. Documentation was lacking of an assessment of the shunt site in the Progress Notes or on the TAR.</p> <p>In interview with the Assistant Director of Nursing on 2/22/11 at 9:05 a.m., she was unable to find documentation of the shunt care.</p> <p>3.1-31(c)(2)<br/>3.1-31(c)(3)<br/>3.1-31(c)(6)<br/>3.1-31(c)(7)<br/>3.1-31(c)(12)</p> |   |   |                      |   |

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| F0285<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure an annual Level II screening [PASRR - pre-admission screening and resident review] was completed in a timely manner for 1 of 3 residents reviewed for annual Level II assessments in a sample of 13 residents. (Resident #47)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #47 on 2/22/2011 at 1:15 p.m., indicated the resident had diagnoses which included, but were not limited to, alcohol dependence, alcohol-induced dementia, and bi-polar disorder.</p> <p>On 3/3/2009, an initial Level II was completed which indicated the resident was to have a "Yearly Resident Review". Documentation was lacking of any further Level IIs having been completed after the initial one on 3/3/2009.</p> <p>During an interview with the social worker on 2/22/2011 at 1:55 p.m., she indicated [name of agency] was behind in completing the annual Level IIs by quite some time. When queried, she indicated it could be a year or more as that was what she had been told.</p> | F0285  | <p>F-285 Resident #47 had annual PASRR review on 2/22/11. A one time review will be completed to assure that all Level II are in place and are up to date per regulatory guidelines. Any concerns identified will be addressed timely. SSD will be re-educated on her role and responsibility in obtaining annual PASRR reviews. SSD will maintain a schedule of when PASRR and Level II are due. HFA will conduct audits weekly times 6 months and then at random to assure this process is being followed. Any discrepancies will be addressed immediately. Result of audits will be reviewed at monthly QA meetings for review and up-date as indicated. Any further incidents will result in re-education and/or disciplinary action by HFA/DON. 3/27/2011</p> | 03/27/2011           |  |

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|   | <p>During an interview with the representative from [name of agency] on 2/22/2011 at 4:30 p.m., he indicated that the office had received a call from the facility that morning indicating that in addition to the one Level II assessment he planned on doing, Resident #47 and another resident needed a Yearly Resident Review. He indicated that up until recently, if the facility did not send the agency a list of people who needed Level II annual reviews, then they did not get done and people were missed. He also indicated that the agency was slightly behind by a week or so in doing the annual resident reviews, but not a year or two.</p> <p>During a second interview with the social worker on 2/25/2011 at 8:05 a.m., she indicated she only notifies the agency who conducts the Level IIs after the initial one so they can put them on the schedule for the annuals, but makes no further contact with the agency to follow-up to ensure they get completed timely. She indicated she did not know she was responsible to do this as she had never done it before. `</p> <p>On 2/25/2011 at 9:40 a.m., the business office manager presented a copy of the social worker's signed "Job Description" dated 2/15/2005. Review of Essential</p> |  |   |                      |  |

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|   | <p>Functions" included:...13. Ensures that assessments are initiated and completed according to the resident's/patient Level of Care, as required...15. Monitors and collaborates with outside agencies to ensure quality interventions and communicates these interventions and outcomes to the team through IPOC meetings and as required..."</p> <p>3.1-29(a)</p> |  |   |                      |  |

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| F0323<br>SS=D   | <p>Based on record review, observation and interview, the facility failed to ensure interventions to prevent falls were implemented, by failing to ensure a personal alarm was turned to the "on" position to prevent a resident from rising, for 1 of 2 residents reviewed for falls in a sample of 13 and 1 of 1 resident reviewed for falls in a supplemental sample of 3. (Resident #26, #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #26 was reviewed on 2/23/11 at 9:45 a.m. The resident's diagnoses included, but were not limited to dementia and cerebral vascular accident (CVA). In the record was an Accident/Incident Report dated 11/6/10 at 7 a.m., which included, but was not limited to "Describe Injury and Exactly What Occurred Heard: noise from resident room. CNAs (Certified Nursing Assistant) found res sitting on floor next to bed. Res denied pain, hitting head. ROM (Range of Motion) WNL (Within Normal Limits). Assessed before assisted x ii (2) back to bed. Res alarm in bed but not turned on." Documentation of a fall was lacking in the nurse Progress Notes.</p> <p>Review of the Initial 14 day Minimum</p> | F0323   | <p>F-323 Resident #26's need for personal alarm was reviewed on 2/24/11 and his alarm was discontinued on 2/24/11. All Resident's with alarms will be reviewed by the IDT team to assess for need and will be discontinued if warranted. All Resident's with alarms that have been discontinued will be monitored for 72 hours to assure effectiveness of removal of alarms. The DON conducted an in-service on 2/24/11 on alarms, checking for placement, alarm functioning, and daily checks. Alarms audits will be done daily for the 4 weeks then 3 times a week for the 4 weeks and 1 time a week and randomly thereafter by DON/designee. EDT will in-service staff on alarms and proper functioning. Audits will be reviewed on-going at monthly QA meetings for review and updates as indicated. Any noncompliance will be addressed by the HFA/DON through re-education and disciplinary action. 3/27/2011</p> | 03/27/2011           |   |

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|   | <p>Data Set Assessment, dated 9/23/10, indicated the resident had a fall on 9/17/10. The Fall/Injury Assessment: Prevention and Management Plan of Care, dated 10/18/10, indicated the resident was to ambulate and transfer with the assist of two with a gait belt. The bed and chair alarm interventions were checked with no date of application.</p> <p>Review of the Treatment Administration Record for November 2011, at this time, indicated the "Bed/Chair alarm at all times D/T (due to) decreased safety awareness" was checked on 11/6, 10 - 6 and 6 - 2 shifts.</p> <p>On 2/24/11 between 1:45 p.m. and 2:05 p.m., the Assistant Director of Nursing was asked to do an alarm check on all residents utilizing personal safety alarms with and without an "on" and "off" switch. Of the 11 alarms checked, Resident #28's alarm box was in the off position. Resident #28 was seated near the north lounge in a wheel chair. At this time, the ADON indicated the alarm was off and turned the alarm on.</p> <p>On 2/22/11 between 10:30 a.m. and 11:30 a.m., the Director of Nursing provided the current resident roster which indicated Resident #28 was incontinent, had falls,</p> |  |   |                      |  |

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|   | <p>and used assistive devices.</p> <p>On 2/23/11 at 3 p.m., the Corporate Nurse Consultant provided the Policy and Procedure for Fall/Injury Assessment: Prevention and Management Plan of Care Revised January 2009 which included, but was not limited to "Procedure cognitive and Sensory Factors a. Utilize bed/chair alarms and other types of alarms, as appropriate. Check function according to manufacturer recommendation...."</p> <p>On 2/25/11 at 3:50 p.m., the Director of Nursing brought in a faxed instruction for the Universal Alarm from the manufacturer. Revised 10/18/10 which included, but was not limited to "Instructions: 7. On/Off Switch Resets Monitor. Alarm will allow for normal movement. However, if resident gets off pad the alarm will sound to alert staff. when resident gets pack (sic) on pad the alarm will automatically reset...9. The alarm must be checked prior to each use for proper functioning. The On/Off Switch also functions as a battery tester...."</p> <p>3.1-45(a)(2)</p> |  |   |                      |  |

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| F0356<br>SS=B   | <p>Based on record review and interview, the facility failed to ensure the posted daily nurse staffing data was maintained for a minimum of 18 months and available on request, for 7 of 12 months reviewed.</p> <p>Findings include:</p> <p>On 2/23/11 at 1:45 p.m., the Assistant Director of Nursing (ADN) was asked to provide the daily nurse staffing data for the past 18 months. At 2 p.m., she returned with the daily nurse staffing data, dated from 12/10/10 through 2/23/11. When queried as to where the remainder were, she indicated it was possible that a person who had left employment may have taken the staffing forms, or they were misplaced.</p> <p>3.1-13(a)</p> | F0356   | Beginning 2/26/11 a copy of the daily staffing sheets will be kept in the EDT office. HFA will review daily staffing logs to assure they are being completed, posted and stored properly. Logs will be reviewed at monthly QA meetings. Any issues will be addressed through education. | 03/27/2011           |   |

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| F0425<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist followed-up on pharmacy recommendations previously made for gradual dose reductions [GDR] for 1 of 13 residents reviewed for pharmacy recommendations in a sample of 13 residents. (Resident #10)</p> <p>Finding includes:</p> <p>1. Review of the clinical record for Resident #10 on 2/24/2011 at 7:46 a.m., indicated the resident had diagnoses which included, but were not limited to, schizophrenia, depressive disorder, and Alzheimer disease.</p> <p>On 9/17/2010, the consultant pharmacist made a request for gradual dose reductions [GDR] on:</p> <p>a. Abilify [an anti-psychotic] 30 milligrams [mg] - 1 tablet at night</p> <p>b. Celexa [an anti-depressant] 20 mg - 1 tablet daily</p> <p>c. Diazepam [a sedative] 1 mg - 1 tablet at night</p> <p>d. Divalprox [a mood stabilizer] 250 mg - 3 tablets twice daily</p> <p>e. Seroquel [an anti-psychotic] 300 mg - 1 tablet every morning</p> <p>f. Seroquel [an anti-psychotic] 600 mg - 1 tablet every night</p> | F0425  | <p>F-425 Resident #10's drug regimen was reviewed by the psychiatrist on 9/27/10 and 3/8/11 and recommended to continue all medications as ordered. A one time audit of all Resident's receiving psychoactive meds will be reviewed by SSD to assure all recommendations have been addressed. All pharmacy recommendations will be reviewed by DON/designee monthly for any changes. SS will be re-educated on review of psychoactive medications and follow up for pharmacy recommendations. A one time review of pharmacy recommendations for the past 60 days will be reviewed by SSD to assure all recommendations have been followed up on timely. Any concerns identified will be addressed immediately by notification of MD. All pharmacy recommendations will be reviewed monthly by SSD, DON/Designee/HFA to assure follow up has been addressed. This will be reviewed on-going by QA monthly for review and up-dates as indicated. Any concerns identified will be addressed immediately and any non compliance will be addressed by the HFA/DON through re-education and disciplinary action. 3/27/2011</p> | 03/27/2011           |  |

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|   | <p>On 10/1/2010, the primary physician responded and indicated that he did not wish to implement a GDR at the time due to wanting the psychiatrist to make the recommendation. Documentation on the monthly consultant pharmacist report between October 2010 and February 2011 was lacking of any further follow-up by the consultant pharmacist.</p> <p>During an interview with the Assistant Director of Nursing [ADoN] on 2/24/2011 at 9:00 a.m., she indicated nursing should have followed-up on the recommendations with the pharmacist or primary physician.</p> <p>3.1-25(a)</p> |  |   |                      |  |

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| F0428<br>SS=D   | <p>Based on record review and interview, the facility failed to ensure consultant pharmacy recommendations for gradual dose reductions were acted upon for 1 of 13 residents reviewed for gradual dose reductions (Resident #10) in a sample of 13 residents and for re-evaluation of duplicate medications for muscle spasms for 1 of 1 residents reviewed for anti-spasmodic medications (Resident #46) in a sample of 13 residents.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #10 on 2/24/2011 at 7:46 a.m., indicated the resident had diagnoses which included, but were not limited to, schizophrenia, depressive disorder, and Alzheimer disease.</p> <p>On 9/17/2010, the consultant pharmacist made a request for gradual dose reductions [GDR] on:</p> <ul style="list-style-type: none"> <li>a. Abilify [an anti-psychotic] 30 milligrams [mg] - 1 tablet at night</li> <li>b. Celexa [an anti-depressant] 20 mg - 1 tablet daily</li> <li>c. Diazepam [a sedative] 1 mg - 1 tablet at night</li> <li>d. Divalprox [a mood stabilizer] 250 mg - 3 tablets twice daily</li> <li>e. Seroquel [an anti-psychotic] 300 mg - 1</li> </ul> | F0428   | Resident #10's drug regimen was reviewed by the psychiatrist on 9/27/10 and recommended to continue all medications as ordered. Resident number #46 has been assessed by Primary Care Physician and has an appointment with Dr. Gary Gettelfinger, MD on 3/31/11 at the Bloomington Pain Clinic to review meds and evaluate continued use. All Resident's receiving psychoactive meds will be reviewed by SSD to assure all recommendations have been addressed. All Licensed staff will be educated on following up on Pharmacy Recommendations in a timely manner. DON/designee will audit all GDRs monthly hereafter to assure recommendations are addressed in a timely manner. Audits will be ongoing and any discrepancies will be addressed in monthly QA meetings. Results will be addressed in monthly QA for review of concerns as indicated. Any further incidents will result in re-education and/or disciplinary action by HFA/DON. | 03/27/2011   |  |   |  |

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|   | <p>tablet every morning</p> <p>f. Seroquel [an anti-psychotic] 600 mg - 1 tablet every night</p> <p>On 10/1/2010, the primary physician responded and indicated that he did not wish to implement a GDR at the time due to wanting the psychiatrist to make the recommendation. Documentation was lacking of any further follow-up by the facility and/or the psychiatrist.</p> <p>During an interview with the Assistant Director of Nursing [ADoN] on 2/24/2011 at 9:00 a.m., she indicated nursing should have followed-up on the recommendations with the psychiatrist.</p> <p>The ADoN also presented a copy of the facility's current policy on "Medication Regimen Review". Review of the policy included, but was not limited to, "...6. Facility should ensure that Facility Physicians/Prescribers are provided with copies of the MRR [Medication Regimen Review] 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to</p> |  |   |                      |  |

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| SS=D  | <p>either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected...."</p> <p>2. Resident #46's clinical record was reviewed on 02/23/11, at 9:40 a.m. The resident had diagnoses including, but not limited to, traumatic brain injury, paraplegia, anxiety, neurogenic bladder, depression, and gastroesophageal reflux disease.</p> <p>The pharmacy consultant report dated May 6, 2010, indicated the following:<br/>"(Resident name) takes duplicate therapy of Cyclobenzaprine 10 milligrams daily (autonomic nervous system drug) (skeletal muscle relaxant centrally acting).and Zanaflex 4 milligram twice daily (skeletal muscle relaxant) and Baclofen Pump (skeletal muscle relaxant/antispasmodic)."</p> <p>"Please consider re-evaluating the need for these agents. If dual therapy is to continue, it is recommended that a) prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential</p> |   | <p>Resident #10's drug regimen was reviewed by the psychiatrist on 9/27/10 and recommended to continue all medications as ordered. Resident number #46 has been assessed by Primary Care Physician and has an appointment with Dr. Gary Gettelfinger, MD on 3/31/11 at the Bloomington Pain Clinic to review meds and evaluate continued use. All Resident's receiving psychoactive meds will be reviewed by SSD to assure all recommendations have been addressed. All Licensed staff will be educated on following up on Pharmacy Recommendations in a timely manner. DON/designee will audit all GDRs monthly hereafter to assure recommendations are addressed in a timely manner. Audits will be ongoing and any discrepancies will be addressed in monthly QA meetings. Results will be addressed in monthly QA for review of concerns as indicated. Any further incidents will result in re-education and/or disciplinary action by HFA/DON.</p> | 03/27/2011           |   |

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|   | <p>adverse consequences."</p> <p>The physician indicated the following: "I decline the recommending(s) above and do not wish to implement any changes due to the reasons below."<br/>"Pt. (patient) is seen by specialist for spasms related to paraplegia. Specialist must address this."</p> <p>A yellow sticky note was attached to the recommendation and indicated the following: "Nurses please send to specialist to have them address. Then place under progress section in chart."</p> <p>In interview with the Assistant Director of Nursing on 02/25/11 at 2:33 p.m., she indicated documentation was lacking the specialist had been made aware of the recommendations.</p> <p>3.1-25(i)</p> |  |   |                      |  |

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| F0514<br>SS=D   | <p>A. Based on record review and interview, the facility failed to ensure the intravenous flushes were documented for 1 of 1 resident reviewed with a PICC (Peripherally Inserted Central Catheter) line requiring flushes in a sample of 13. (Resident #39)</p> <p>B. Based on record review and interview, the facility failed to ensure a residents failure to use a breathing machine was documented for 1 of 1 resident using a CPAP (Continuous Positive Airway Pressure) device in a sample of 13. (Resident #42)</p> <p>Findings include;</p> <p>A. The clinical record for Resident #39 was reviewed on 2/22/11 at 12:45 p.m. The resident's diagnoses included, but were not limited to Pressure Ulcer and Chronic Airway Obstruction. The resident was sent out to a hospital for the placement of a PICC line. Nurses Note included, but was not limited to: 2/15/11 "[Named] County EMS (Emergency Medical Service) here to transport to [named] hospital for placement of PICC line..." 2/15/11 5:30 P "Res returned from [named] hospital. Arrived via ambulance with 3 EMTs [Emergency Medical Technician's]...Late entry: 6:30</p> | F0514   | <p>F-514 Resident #39's order for the PICC line flush was obtained 2/21/11. A one time audit of all PICC line orders was conducted by DON/designee on 2/21/11. All Licensed staff will be educated on the PICC line flush protocol. On 3/2/11 licensed staff were in-serviced on the Protocol Any new admit or re-admit to the facility with a PICC line will be reviewed by the IDT with in 24 hours to assure that the protocol has been implemented. On 3/2/11 the protocol for PICC line care was placed in nurse's MAR and info. binder located at each nurses station. DON/designee will audit all PICC line orders daily for 2 weeks then weekly x 12 weeks then. All new admits/re-admits will be reviewed by the Intra-disciplinary team to assure orders have been obtained and implemented. Any issues identified the MD and family will be notified and corrections will be made as indicated. Resident #42 is alert and oriented and was provided education of why C-PAP is indicated encouraged to use the CPAP without removing after application. Nurses were educated on 3/2/11 on medication refusal policy and procedure and notifying the MD/DON/Designee of refusal of medications or treatment per P/P. Any admission/re-admission with a C-PAP will reviewed by the IDT with in 24-72 hours to assure that</p> | 03/27/2011           |   |

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|   | <p>PM When res arrive/returned from [named] hospital, No paperwork or progress note from PICC line placement came with res or EMTs."</p> <p>Review of the Medication and Treatment Administration Record for February 2011 lacked any reference to the flushing of the PICC line until February 21 at which time the following was transcribed "Flush PICC line with 5 cc (cubic centimeters) N/S (normal saline) and 3 cc Heparin (blood thinner) before and after each use and q. (every) shift."</p> <p>In interview with the Director of Nursing on 2/23/11 at 8:50 a.m., she indicated "if not documented it wasn't done. I know personally it was flushed."</p> <p>Review of the Plan of Care for "Actual/Potential for Infection," reviewed on 2/22/11 at 12:45 p.m., included but was not limited to, "2/16/11 Problem: IV (intravenous) access PICC; (Place date of intervention to initiate) IV site/tubing care per protocol."</p> <p>On 2/23/11 at 9:10 a.m., the Assistant Director of Nursing provided the Policy and Procedure for "Peripherally Inserted Central Catheter (PICC) Flushing revised August 15, 2008. Considerations: 1.</p> |  | <p>compliance is being monitored by nursing.MARS will be audited daily x 4 weeks then weekly x 4 weeks, then monthly x 6 months. This process will be reviewed monthly x 6 months and then as indicated by the QA committee for review and up-date as indicated 3/27/2011</p> |  |  |  |  |

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|   | <p>Specific flush orders must be documented...3. flushing is performed to ensure and maintain catheter patency and to prevent mixing of incompatible medications/solutions..15.</p> <p>Documentation in the medical record includes, but is not limited to: 15.1 Date and time; 15.2 Prescribed flushing agent(s); 15.2 Site assessment; 15.3 Resident response to procedure and/or medication; 15.4 Resident/significant other teaching."</p> <p>B. The clinical record for Resident #42 was reviewed on 2/24/11 at 6:15 a.m. The resident's diagnoses included, but were not limited to Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The resident was admitted to the facility on 2/17/11. A Physician's Telephone Order dated 2/21/11 included, but was not limited to: "CPAP machine q. (every) HS (Hour of Sleep)."</p> <p>In interview with Resident #42 on 2/24/11 at 11 a.m., she indicated she had not been using the CPAP machine as the nurse didn't know how to put it on." In interview with the Assistant Director of Nursing (ADON) at this time, she indicated she would check into this problem. On 2/25/11 at 11:25 a.m., the Corporate Nurse Consultant provided the</p> |  |   |                      |  |

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|   | <p>following: The ADON talked with the resident and she indicated she had not been wearing the CPAP at night. LPN #2 has charted on the Treatment Administration Record that the CPAP had been worn since the order was received on 2/21/11. The TAR for February 2011 included, but was not limited to "CPAP Machine q. HS 10 - 6 shift."</p> <p>The 10 - 6 nurse Progress Notes for 2/22/11 at 2:30 a.m. indicated "Rs (resident) resting abed. rsp even and unlabored no acute distress. No verbal complaint. Abd (abdomen) soft non-distended. Speech clear. Able to make need known..." 2/23/11 2 Res. in bed with eyes closed..." 2/24/11 2A " No verbal complaints..."</p> <p>On 2/25/11 at 4:05 p.m., the ADON provided the Policy and Procedure for the use of "Non-Invasive Ventilation (Continuous Positive Airway Pressure [CPAP/Bilevel Positive Airway Pressure[BiPAP])" revised January 2007 which included, but was not limited to: Procedure #26. "Document procedure in the medical record to include: Date and time; Complications and the nursing action taken, Mask type and size, resident or family teaching and their comprehension and progress, Resident's</p> |  |   |                      |  |

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|   | <p>tolerance of the procedure, Respiratory assessment, and Type and amount of pressure.</p> <p>Documentation was lacking the resident was removing the CPAP machine nor if the resident was tolerating the procedure.</p> <p>3.1-50(a)(1)<br/>3.1-50(a)(2)</p> |  |   |                      |  |