

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD VILLAGE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN 46143
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 3, 4, 5, 6, 7, 10, 11, and 12, 2014</p> <p>Facility number: 000010 Provider number: 155026 AIM number: 100453660</p> <p>Survey team: Patti Allen, SW-TC (March 3, 4, 5, 6, 10, 11, and 12, 2014) Marcy Smith, RN Dorothy Plummer, RN (March 3, 4, 5, 6, 7, 11, and 12, 2014) Karyn Homan, RN</p> <p>Census bed type: SNF: 17 SNF/NF: 93 Residential: 39 Total: 149</p> <p>Census payor source: Medicare: 17 Medicaid: 52 Other: 80 Total: 149</p> <p>Residential sample: 08</p> <p>These deficiencies reflect state</p>	F000000	<p>Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. In fact, Greenwood Village South reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance by April 11, 2014.</p>	
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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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on March 24, 2014; by Kimberly Perigo, RN.			
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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <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 care plan treatment of an identified deterioration of a pressure ulcer. (Resident #102)</p> <p>Findings include:</p> <p>The clinical record of Resident #102 was reviewed on 3/6/14 at 10:15 a.m. Diagnoses included, but were not limited to, dementia with delusions, hyperlipidemia, hypothyroidism, hypertension, osteoporosis, and degenerative joint disease.</p> <p>The significant change Minimum Data</p>	F000280	<p>1. Resident # 102's nurse practitioner treatment orders were clarified and received on 3/08/14.</p> <p>2. Residents who have the potential to be affected by the alleged deficient practice have had progress notes and current treatment orders reviewed. 3. An in-service was conducted with nursing staff to review clinical wound care treatment and associated assessment and professional communication mechanisms and standards associated with wound care treatment. A meeting was held with Wound Care Specialists' nurse practitioner outlining new order completion and communication. 4. Clinical</p>	04/11/2014			

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	<p>Set assessment (MDS) dated 12/14/13, indicated Resident #102 required extensive assistance of two persons for bed mobility, transfers, dressing, and toileting and required total assistance of two persons for bathing.</p> <p>A review of the wound sheets in the clinical record indicated a wound to the left buttocks was first observed on 9/6/2013. The wound was evaluated by the wound specialist nurse practitioner (NP) on 9/11/2013, and measurements were recorded as 1.7 cm (length) x 2.3 cm (width) x 0.1 cm (depth), and the wound was coded as a Stage 3 pressure ulcer, a full thickness skin loss involving damage to the underlying tissue.</p> <p>The recapitulation of physician's orders for Resident #102, dated 3/1/2014 through 3/31/2014, indicated the treatment order for the left buttocks wound had an origination date of 2/11/2014. The order indicated the treatment to the left buttocks wound was, "Sod Chloride 0.9% [Sodium chloride] Cleanse coccyx [left buttocks] wound, pat dry, apply calmoseptine [a cream used to treat minor skin irritations], apply Iodosorb [an antimicrobial agent used to promote a clean wound</p>		<p>Leaders (or designee) will visualize wounds on a daily basis for the next thirty (30) days; then weekly thereafter for the next six (6) months. The Director of Nursing and/or designee will meet with Wound Care Specialist nurse practitioner during each visit to compare the accuracy of written/signed orders with progress notes. A weekly audit will be completed to review wound care treatment orders, progress notes, clinical documentation, and plan of care X six (6) months. A summary of results of the audits will be discussed during the community's Quality Assurance Process Improvement committee meeting.</p>				

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	<p>healing environment], change daily- -may leave open to air."</p> <p>A Visit Report, electronically signed by the NP specializing in wound care, dated 2/25/2014 at 1:58 p.m., indicated the wound to the left buttock of Resident #102 was deteriorating. "...Location: left buttock...Severity: now unstageable pressure...previous tx [treatment] hydrogel [treatment used to create a moist wound healing environment] with no improvement; changed to Iodosorb however wound is now deteriorating...Associated Signs and Symptoms: no s/sx [sign/symptom] of infection..." On the second page of the Visit Report, a section titled "Integumentary (Hair, Skin)..." indicated, "Wound #4 Left Superior Buttock is a Necrotic [dead] Tissue (unstageable) Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2.5 cm [centimeter] length x [by] 2.6 cm width x 0.8 cm depth...There is a small amount of serous [watery] drainage noted which has no odor...Wound bed is 76-100% [percent] slough [dead tissue], 1-25% granulation [outgrowth of new tissue]. The wound is deteriorating...Discussed plan with</p>			
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	<p>nurse at bedside: Yes...Wound Orders: Wound #4 Left Superior Buttock Santyl [treatment for pressure ulcers to remove nonliving tissue from a wound to promote optimal healing environment] cleanse wound bed with NS [Normal Saline]. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN [as needed], soiled...."</p> <p>A form titled "RESIDENT RISK MEETING", indicated Resident #102 was reviewed for "Wound, Weight, Hydration, Pain, and Falls" on 2/27/2014. The form indicated Resident #102 had a Stage 3 wound to the left superior buttocks, and included measurements dated 2/25/2014. No documentation was noted in the column titled "IDT [Interdisciplinary Team] Risk Team Interventions/Recommendations/Plan ."</p> <p>During an interview with RN #2 on 3/6/2014 at 11:15 a.m., RN #2 indicated indicated the current treatment order for the left buttocks wound was "Cleanse with NS, apply the calmoseptine around the wound, and then apply the Iodosorb and</p>			
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	<p>cover with a dry dressing."</p> <p>On 3/8/2014, a telephone order was received from the wound specialist NP, "D/C [Discontinue] current tx [treatment] to (L) [Left] Superior Buttock. Cleanse (L) superior buttock wound /c [with] NS. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze then cover /c dry gauze. Secure daily & [and] prn soilage," as indicated by report dated 2/25/2014.</p> <p>During an interview with the Director of Nursing (DoN) on 3/11/2014 at 10:25 a.m., the DoN indicated the wound specialist NP had been contacted regarding the wound orders in the Visit Note from 2/25/2014. The DoN indicated the NP had failed to write the new treatment orders in the physician's orders and the nursing staff, "Do not have enough time to read all of the progress notes to verify the accuracy of the notes and orders."</p> <p>During an interview with the NP on 3/11/2014 at 1:30 p.m., the NP indicated she had assessed Resident #102 on 2/25/2014, and had failed to write a new treatment order in the physician's orders. The NP indicated</p>			

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	<p>the left buttocks wound had deteriorated with the treatment of Iodosorb and as noted in the Visit Note the treatment should have been changed to Santyl.</p> <p>During an interview with the NP on 3/11/2014 at 1:50 p.m., the NP indicated the expectation was for the facility staff to review the Visit Notes and to notify the NP if the Visit Note indicated a treatment was to be changed and the NP had failed to write an order to change the treatment.</p> <p>On 3/12/2014 at 1:05 p.m., the Administrator provided an undated policy titled, "<u>PRESSURE ULCER PREVENTION AND MANAGEMENT POLICY AND PROCEDURE</u>," and indicated the policy was the policy currently used by the facility. "...<u>For an Actual Pressure Ulcer...</u> 8. Daily monitoring is to be in place to assess the effectiveness of the plan of care and to ensure the care plan is followed i.e.: wound status pain, s/s infection or change and the need to notify the physician. 9. Weekly progress will be documented by in [sig] nurse to assess to [sig] location, stage, size, shape, depth size and depth of sinus track, surrounding tissue, and drainage (type, color,</p>			
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	odor, and amount), wound bed, wound edges, and related pain. PUSH scale may be used for clinical validation of healing. 10. If progress is not noted in 3 weeks or deterioration is present, Physician is notified for treatment order review...." 3.1-35(d)2(B)				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure plans of care were followed for the administration of antipsychotic and antianxiety medications, (Residents #106 and #25) and correct application of a self-release seat belt (Resident #58) for 3 of 30 residents whose plans of care were reviewed in a Stage 2 sample of 30.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #106 was reviewed on 3/7/14 at 10:05 a.m. Diagnoses included, but were not limited to, depression, dementia, agitation, and insomnia.</p> <p>A care plan for Resident #106, created 5/28/13, and current through 4/24/14, indicated she, "has a history of falls [due to] unsteady gait, trouble maneuvering walker, rolls out of bed, has poor safety awareness and impulsive movements." The goal was she would have no fall related injury.</p> <p>Interventions included:</p>	F000282	(1.) 1. A therapy screening/evaluation was completed for Resident # 106 on 3/10/14. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted with nursing staff and rehabilitation staff to outline specific procedures for distribution/communication of therapy screens to therapy provider. An action plan was developed with Rehab Care, therapy provider regarding therapy screening requests. A therapy screening spreadsheet was developed to track screening processes and completion. 4. A weekly audit will be completed to review that therapy screens were completed within seventy-two (72) hours and associated follow up for the next six (6) months. A summary of the results of the weekly audit will be reviewed with rehabilitation staff and clinical leadership and discussed during the community's Quality Assurance Process Improvement committee meetings. (2)(a) 1. The order for Resident's # 25's Abilify was discontinued per physician order 3/06/14. The	04/11/2014			

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	<p>"Effective 8/23/13 - Present, "Therapy as ordered." "Effective 2/25/14 - Present PT [Physical Therapy]/OT consult."</p> <p>Fall Risk Evaluations for Resident #106, dated 1/22/14, 2/14/14, and 2/25/14, indicated she was a high risk for falls.</p> <p>A Fall/Event Investigation, dated 1/22/14, indicated Resident #106 fell in the bathroom. In addition to the current safety interventions already in place, a new intervention added after this fall was for a PT consult.</p> <p>A Fall/Investigation, dated 2/25/14, indicated Resident #106 had an un-witnessed fall in the dining room. The report indicated, "Resident fell when lost balance due to way walks." In addition to current safety interventions already in place, a new intervention of PT/OT consult was added. After this fall, the resident was sent to a hospital to be evaluated, due to complaints of headache and nausea. She returned to the facility that evening, with no new orders, "all results negative."</p> <p>No information was found in Resident #106's record, which indicated a PT consult had been done after her fall</p>		<p>nurse who transcribed the Abilify Physician's order on 2/24/14 has been re-educated. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted with nursing staff to outline the procedure for transcription of orders specifically during the timeframe of monthly physician re-write review. 4. The Clinical Leadership team, in addition to licensed nurse staff, will complete monthly physician re-write verification checks for the next three (3) months. A weekly audit will be completed to review transcription of physician orders for the next six (6) months. A summary of the results of the weekly audit will be reviewed with the clinical leadership team and discussed during the community's Quality Assurance Process Improvement Committee. (2) (b)</p> <p>1. Licensed nurse staff who administered p.r.n. Ativan as noted in the 2567 have been re-educated. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted to review nursing staff regarding the procedure to introduce, attempt, and document a non-drug approach prior to the administration of a p.r.n. medication. 4. A weekly audit</p>		

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	<p>on 1/22/14. During an interview with the Unit Manager and the Administrator on 3/7/14 at 3:54 p.m., they indicated a PT consult had not been done after this fall. They indicated they didn't know why it hadn't been done.</p> <p>No information was found in Resident #106's record, which indicated a PT consult had been done after her fall on 2/25/14. During an interview with Physical Therapy Assistant #3 on 3/7/14 at 3:50 p.m., she indicated the resident was not screened by physical therapy after her falls on 1/22/14 and 2/25/14. She indicated she was not able to find any referrals for PT screens after those falls.</p> <p>2. The clinical record of Resident #25 was reviewed on 3/6/14 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety.</p> <p>a. A physician's order dated 1/13/14, indicated Resident #25 was to receive Abilify 2.5 mg. (milligrams) daily. Abilify is an antipsychotic medication used to treat the symptoms of schizophrenia and bipolar disorder. A physician's order dated 2/24/14, indicated Abilify 2.5 mg. was to be discontinued.</p>		<p>will be completed for the next six (6) months to review p.r.n. administration of medications. The results of the weekly audit will be discussed during the community's Quality Assurance Process Improvement meetings.</p> <p>(3) 1. Resident # 58's self-releasing Velcro belt positioning was corrected on 3/07/14. Resident # 58's C.N.A. caregiver who applied resident # 58's Velcro belt has been re-educated. 2. Current resident (1) has the potential to be affected by the alleged deficient practice were observed with proper positioning of belt noted. 3. An in-service was conducted to review the procedure for application of the Velcro belt for resident # 58. 4. Licensed nurses will verify proper placement of the Velcro belt each shift. A daily observation audit will be conducted for the next thirty (30) days and weekly thereafter for the next six (6) months per clinical leadership. A summary of the results of the observation audits will be discussed during the community's Quality Assurance Process Improvement committee meeting.</p>				

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	<p>The Medication Administration Record for Resident #25 for February, 2014, indicated she did not receive Abilify after the order to discontinue it on 2/24/14.</p> <p>The Medication Administration Record for Resident #25 for March, 2014, indicated she received Abilify, 2.5 mg. on March 1, 2, 3, 4, and 5, 2014. An order was not found in the resident's clinical record to restart the Abilify.</p> <p>During an interview with the Director of Nursing on 3/6/14 at 2:40 p.m., she indicated a "transcription error" had occurred. She indicated Resident #25 had received Abilify on March 1-5, 2014, in error. She indicated notification of the error to the physician was being done at that time.</p> <p>b. A recapitulated physician's order for February, 2014, with an original date of 1/14/14, indicated Resident #25 could receive Ativan, 0.25 mg. twice a day as needed. Ativan is an antianxiety medication.</p> <p>A care plan for Resident #25, dated 7/27/11 and current through 5/3/14, indicated a problem of, "[resident's</p>			
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	<p>name] is receiving an antianxiety drug on a regular basis as needed for anxiety. She has anxiety related to oxygen levels, staff, schedule, [bowel movements] and lab work. During periods of anxiety she becomes short-tempered, seeks extra attention from staff (i.e. calls the nurse on the phone, requests additional time for care), she becomes verbally abusive toward staff at times, is accusatory of staff at times, refuses care from specific staff members.... "</p> <p>Interventions for this problem included:</p> <p>"Engage [resident name] in group/individual activities that reduce periods of anxiety and promote socialization"</p> <p>"Administer antianxiety meds as ordered. Monitor for side effects of medication..."</p> <p>"Provide quiet atmosphere with one-on-one support during periods of increased anxiety. Allow [resident's name] to talk about event and causes, if known."</p> <p>"Record behavior in the Lifestyle Support Log..."</p>			
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	<p>"Encourage [resident's name] to breathe deeply, through the nose, during periods of anxiety."</p> <p>"Encourage [resident's name] to speak slowly and calm down prior to speaking during periods of anxiety as rapid speech hinders her breathing and increases anxiety levels."</p> <p>"Encourage [resident's name] to use her call light to request assistance with care and to use the phone for non-care related assistance. Reassure her that staff will respond to the call light."</p> <p>"Explain how much time is available to provide her care prior to giving it. Ask her if this amount of time is acceptable and reschedule care or proceed with care per her preference."</p> <p>"Encourage [resident's name] to collaborate with staff to create a care/activity schedule that will meet her needs and preferences. Refer to her care schedule during periods of anxiety and explain that staff does not have an unlimited amount of time to spend with her. Reassure her that her schedule can be modified as needed to accommodate her preferences or medical state."</p>			
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	<p>"If [resident's name] is upset, give her time to calm down. Encourage relaxation techniques for anxiety...Reapproach her at a later time to provide care if needed."</p> <p>A Medication Administration Record for Resident #25 for February, 2014, indicated she received Ativan, 0.25 mg., on 2/10, 2/13, and 2/28, 2014.</p> <p>A nurse's note dated 2/10/14 at 1:28 a.m., indicated, "Resident has been on call light for several times and doesn't remember or know what she wants. Prn [as needed] Ativan given with positive results." The nurse's note did not indicate any alternative non-pharmacological interventions from the resident's anxiety care plan were attempted by staff prior to giving the prn Ativan.</p> <p>A nurse's note dated 2/13/14 at 1:16 a.m. indicated, "Prn Ativan given...resident request. No behavior noted..." The nurse's note did not indicate any alternative, non-pharmacological interventions from the resident's anxiety care plan were attempted by staff prior to giving the prn Ativan.</p> <p>A nurse's note dated 2/28/14 at 10:42</p>			
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	<p>p.m. indicated, "At change of shift, resident [complained of] increased anxiety. Res[ident] assessed and asked to describe how she felt. Res[ident] stated she felt like she had a lot of anxious energy. Res[ident] administered prn [Ativan]. Res[ident] reassessed half hour later and resident stated she felt a lot better..."</p> <p>The nurse's note did not indicate any alternative, non-pharmacological interventions from the resident's care plan were attempted prior to giving the prn Ativan.</p> <p>A review of the Behavior Tracking Log for Resident #25 for February, 2014, did not indicate any behaviors during the month.</p> <p>During an interview with the Director of Nursing on 3/7/14 at 8:45 a.m., she indicated she was not able to find any other documentation in Resident #25's record, regarding assessments and interventions provided to the resident prior to giving the prn Ativan on 2/10, 2/13, and 2/28, 2014.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>3. The clinical record of Resident #58 was reviewed on 3/7/2014 at 2:45 p.m. Diagnoses included but were not limited to, seizure disorder, hypertension, anxiety, blind in right eye, TIA (transient ischemic attack) with right sided weakness, restless leg syndrome, and neuropathy.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 1/4/2014, indicated Resident #58 required extensive assistance of 2 persons for bed mobility, dressing, and toileting and required total assistance of 2 persons for transfers and bathing.</p> <p>A careplan dated 9/11/2011, indicated Resident #58 was at risk for falls related to weakness and poor safety awareness. Interventions included, but were not limited to, "...Resident prefers to have a self release seat belt on her broda chair (not a restraint is able to release upon command 100% [percent] of the time) prefers it because it makes her feel safe...."</p>	F000282	<p>(1.) 1. A therapy screening/evaluation was completed for Resident # 106 on 3/10/14. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted with nursing staff and rehabilitation staff to outline specific procedures for distribution/communication of therapy screens to therapy provider. An action plan was developed with Rehab Care, therapy provider regarding therapy screening requests. A therapy screening spreadsheet was developed to track screening processes and completion. 4. A weekly audit will be completed to review that therapy screens were completed within seventy-two (72) hours and associated follow up for the next six (6) months. A summary of the results of the weekly audit will be reviewed with rehabilitation staff and clinical leadership and discussed during the community's Quality Assurance Process Improvement committee meetings. (2)(a) 1. The order for Resident's # 25's Abilify was discontinued per physician order 3/06/14. The</p>	04/11/2014			

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	<p>Resident #58 was observed sitting up in the hallway by the nurse's station on 3/7/2014 at 10:30 a.m. Resident #58 was asked to release the self releasing seat belt. Resident #58 indicated she was unable to release the belt. Resident #58 indicated she leans forward in her chair and the belt helped her to feel more secure. Resident #58 indicated she did not want to remove the belt.</p> <p>During an interview with CNA #8 on 3/7/2014 at 10:45 a.m., CNA #8 indicated Resident # 58, "Some days she can release her belt and some days she cannot release it. I have seen her pop it right off."</p> <p>On 3/7/2014 at 3:15 p.m., Resident #58 was taken to her room by RN #2. RN #2 asked Resident #58 to release her self releasing belt. Resident #58 attempted to release the belt, but indicated she wasn't able to release it. RN #2 indicated Resident #58 can usually release the belt but, "The belt is on backwards, which is why she cannot release it. If the belt is not properly applied, she will not be able to release it." The seat belt had a typed note taped to the buckle, which read, "Velcro to the front, buckle to the back." The buckle was resting on the right lower abdomen of Resident</p>		<p>nurse who transcribed the Abilify Physician's order on 2/24/14 has been re-educated. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted with nursing staff to outline the procedure for transcription of orders specifically during the timeframe of monthly physician re-write review. 4. The Clinical Leadership team, in addition to licensed nurse staff, will complete monthly physician re-write verification checks for the next three (3) months. A weekly audit will be completed to review transcription of physician orders for the next six (6) months. A summary of the results of the weekly audit will be reviewed with the clinical leadership team and discussed during the community's Quality Assurance Process Improvement Committee. (2) (b)</p> <p>1. Licensed nurse staff who administered p.r.n. Ativan as noted in the 2567 have been re-educated. 2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit. 3. An in-service was conducted to review nursing staff regarding the procedure to introduce, attempt, and document a non-drug approach prior to the administration of a p.r.n. medication. 4. A weekly audit</p>				

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	<p>#58 (applied backwards).</p> <p>Resident #58 was taken to the bathroom and upon return to the hallway, was asked by RN #2 to release the seat belt. Resident #58 pulled on the velcro strap and was able to release the belt.</p> <p>An untitled and undated document was provided by the DoN on 3/12/2014 at 1:05 p.m. The heading at the top of the document read, "4.10 BRODA Unpadded Seat Belt...Properly attached this accessory securely holds a resident in a chair with a minimum of risk from the belt...."</p> <p>3.1-35(g)(2)</p>		<p>will be completed for the next six (6) months to review p.r.n. administration of medications. The results of the weekly audit will be discussed during the community's Quality Assurance Process Improvement meetings.</p> <p>(3) 1. Resident # 58's self-releasing Velcro belt positioning was corrected on 3/07/14. Resident # 58's C.N.A. caregiver who applied resident # 58's Velcro belt has been re-educated. 2. Current resident (1) has the potential to be affected by the alleged deficient practice were observed with proper positioning of belt noted. 3. An in-service was conducted to review the procedure for application of the Velcro belt for resident # 58. 4. Licensed nurses will verify proper placement of the Velcro belt each shift. A daily observation audit will be conducted for the next thirty (30) days and weekly thereafter for the next six (6) months per clinical leadership. A summary of the results of the observation audits will be discussed during the community's Quality Assurance Process Improvement committee meeting.</p>		

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to provide services to promote the healing of an unstageable pressure ulcer and failed to revise interventions for 1 of 1 residents reviewed for pressure ulcers in a sample of 1 who met the criteria for review of pressure ulcers. (Resident #102) Resident #102 experienced deterioration of a Stage 3 pressure ulcer; the facility failed to implement recommended changes to the plan of care of a treatment to promote healing. Resident #102 experienced further deterioration of the pressure ulcer and an oral antibiotic was prescribed as an addition to the wound care.</p> <p>Findings include:</p> <p>The clinical record of Resident #102</p>	F000314	We respectfully request that this citation be reviewed and deleted based upon the following: F 314 regulations reads "based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters a facility without pressure sores does not develop pressure sores unless the clinical condition demonstrates they were unavoidable and a resident having pressure sores receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Our community contends that we have met the intention of the regulation, in that, the community evaluated the resident's condition Please see uploaded documents on this plan of correction for the full rationale of the request for IDR. 1. Resident # 102's nurse practitioner orders were clarified and received on 3/08/14. 2. Residents who have	04/11/2014			

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	<p>was reviewed on 3/6/14 at 10:15 a.m. Diagnoses included, but were not limited to, dementia with delusions, hyperlipidemia, hypothyroidism, hypertension, osteoporosis, and degenerative joint disease.</p> <p>The significant change Minimum Data Set assessment (MDS) dated 12/14/13, indicated Resident #102 required extensive assistance of two persons for bed mobility, transfers, dressing, and toileting and required total assistance of two persons for bathing.</p> <p>A review of the wound sheets in the clinical record indicated the wound to the left buttocks was first observed on 9/6/2013. The wound was evaluated by the wound specialist nurse practitioner (NP) on 9/11/2013, and measurements were recorded as 1.7 cm (length) x 2.3 cm (width) x 0.1 (depth) cm and was a Stage 3 pressure ulcer, defined as full thickness skin loss with damage to the underlying tissue.</p> <p>The wound sheet indicated the wound type as "2". The scoring code for the wound type indicated, "1 = Pressure 2 = Stasis". The measurements for 2/18/2014 were 1.6 cm (length) x 1.9 cm (width) x 0.5</p>		<p>the potential to be affected by the alleged deficient practice have had progress notes and current treatment orders reviewed. 3. An in-service was conducted with nursing staff to review clinical wound care treatment and associated assessment and professional communication mechanisms and standards associated with wound care treatment. A meeting was held with Wound Care Specialists nurse practitioner outlining new order completion and communication. 4. Clinical Leaders (or designee) will visualize wounds on a daily basis X thirty (30) days; then weekly thereafter. The Director of Nursing and/or designee will meet with Wound Care Specialist nurse practitioner during each visit to compare the accuracy of written/signed orders with progress notes. A weekly audit will be completed to review wound care treatment orders with progress notes. A weekly audit will be completed to review wound care treatment orders, progress notes, clinical documentation, and plan of care X six (6) months. A summary of the results of the audits will be discussed during the community's Quality Assurance Process Improvement committee meetings.</p>		

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	<p>cm (depth); for 2/25/2014 measurements were 2.5 cm (length) x 2.6 cm (width) x 0.8 cm (depth). The measurements for 3/4/2014 were 3.0 cm (length) x 2.5 cm (width) x 0.8 cm (depth), indicating the wound had increased in size and depth. Exudate (fluid that has been forced out of the tissues because of inflammation or injury) was coded as "1." The scoring code for exudate indicated, "...1 = Clear...." In the section titled, "Wound Tissue," the granulization (a term used to describe pink-red moist tissue that fills an open wound, when it starts to heal), was documented as 100% granulation on 2/18/2014, 25% granulation and 75% slough [dead tissue] on 2/25/2014, and 100% slough on 3/4/2014, which indicated the wound was not healing. The actual clinical stage of the wound was coded as "3" on the wound sheet for 2/18/2014, 2/25/2014, and 3/4/2014. The scoring code for clinical stage indicated, "...3 = Stage Three...."</p> <p>A Visit Report, electronically signed by a NP specializing in wound care, dated 2/25/2014 at 1:58 p.m., indicated the wound to the left buttock of Resident #102 was deteriorating. "...Location: left buttock...Severity: now unstageable pressure...previous tx [treatment]</p>			
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	<p>hydrogel [a treatment of pressure ulcers used to create a moist wound healing environment] with no improvement; changed to Iodosorb [an antimicrobial used to promote clean wound healing environment] however wound is now deteriorating...Associated Signs and Symptoms: no s/sx [sign/symptom] of infection..." On the second page of the Visit Report, a section titled "Integumentary (Hair, Skin)..." indicated, "Wound #4 Left Superior Buttock is a Necrotic [dead] Tissue (unstageable) Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2.5 cm [centimeter] length x [by] 2.6 cm width x 0.8 cm depth...There is a small amount of serous [watery] drainage noted which has no odor...Wound bed is 76-100% [percent] slough, 1-25% granulation. The wound is deteriorating...Discussed plan with nurse at bedside: Yes...Wound Orders: Wound #4 Left Superior Buttock Santyl [treatment for removal of non healing tissue from a wound] cleanse wound bed with NS [Normal Saline]. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze, then cover</p>			
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	<p>with dry gauze and secure daily and PRN [as needed], soiled...."</p> <p>A form titled "RESIDENT RISK MEETING" indicated Resident #102 was reviewed for "Wounds, Weight, Hydration, Pain, and Falls" on 2/27/2014. The form indicated Resident #102 had a Stage 3 wound to the left superior buttocks and included measurements dated 2/25/2014. No documentation was noted in the column titled "IDT [Interdisciplinary Team] Risk Team Interventions/Recommendations/Plan ."</p> <p>The recapitulation of physician's orders for Resident #102, dated 3/1/2014 through 3/31/2014, indicated the treatment order for the left buttocks wound had an origination date of 2/11/2014. The order indicated the treatment to the left buttocks wound was "Sod Chloride 0.9% [Sodium chloride] Cleanse coccyx [left buttocks] wound, pat dry, apply calmoseptine, apply Iodosorb, change daily--may leave open to air."</p> <p>During an interview with RN #2 on 3/6/2014 at 11:15 a.m., RN #2 indicated the wound on the left buttocks should have been coded on</p>			
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	<p>the wound sheets as a pressure ulcer and not as a stasis ulcer. "It has always been pressure." When asked about the staging of the wound on the wound sheet, RN #2 indicated, "She [NP] changed that after the last visit, on 2/25/2014. I need to update the sheet. It should be unstageable, not a Stage 3." RN #2 indicated the current treatment order for the left buttocks wound was, "Cleanse with NS, apply the calmoseptine around the wound, and then apply the Iodosorb and cover with a dry dressing."</p> <p>During an observation of a dressing change to the left buttocks wound on 3/6/2014 at 2:30 p.m., LPN #1 indicated the dressing was changed daily and as needed if Resident #102 was incontinent of stool. LPN #2 indicated the indwelling catheter was placed soon after the pressure ulcer developed, as Resident #102 was incontinent of urine and the urine was soiling the wound. LPN #1 removed the dressing to the left buttocks wound. The dressing contained a small amount of serosanguinous (watery pinkish yellow fluid) drainage; no odor was noted. The wound bed appeared as 75% yellow slough (dead tissue), and 25 % dark gray/black color, with an open area of</p>			
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	<p>deeper indentation. LPN #1 indicated the wound measurements were done weekly by the clinical leader and the wound specialist. LPN #1 cleansed the area with NS, patted the area with a dry gauze, and then applied calmoseptine to the area around the wound, applied Iodosorb with a cotton tipped applicator to the wound bed, then packed the wound with gauze, and covered with gauze tape. LPN #1 indicated the area, "Seems to be about the same as it was when the treatment was changed to this one." Resident #102 was awake during the changing of the dressing and indicated, "It feels like a Band-Aid would feel if you ripped it off."</p> <p>During an interview with the Director of Nursing (DoN) on 3/7/2014 at 3:15 p.m., the DoN indicated she would need to investigate the current treatment order for Resident #102 to the left buttocks wound.</p> <p>On 3/8/2014, a telephone order was received from the Wound Specialist NP, "D/C [Discontinue] current tx [treatment] to (L) [Left] Superior Buttock. Cleanse (L) superior buttock wound /c [with] NS. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed</p>			
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	<p>followed by hydrogel moistened, fluffed gauze then cover /c dry gauze. Secure daily & [and] prn soilage."</p> <p>A physician's order was written by the NP on 3/11/2014, "D/C Santyl to (L) buttock wound. Cleanse sacral wound w/ns [with normal saline] & pat dry. Apply skin prep to periwound skin. Lightly pack wound w [with] 1/4 strength Dakins [solution used in wound treatment to remove bacteria] and moistened Kerlix. Cover w/ dry gauze, abd [abdominal] pad & secure w/ tape. (Triangle) [change] bid [twice a day] & prn soiling & saturation. Keflex [an antibiotic treatment of infection] 500 mg [milligram] PO [by mouth] tid [three times a day] x 21 days...."</p> <p>On 3/11/2014 at 1:50 p.m., the NP visited Resident #102 for a scheduled wound assessment. The NP removed the dressing from the left buttocks wound. The dressing contained a moderate amount of malodorous (foul smelling) brown drainage. Upon observation of the wound, the NP indicated the wound had deteriorated from the last visit (2/25/2014), and measurements were 4.7 (length) cm x 3.3 (width) cm x 1.7 cm (depth), with undermining (term used to describe an ulcer larger at</p>			
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	<p>the base than at the surface of the skin) at the deepest depth of 2.4 cm, and was 95% necrotic (dead) tissue.</p> <p>During an interview with the Director of Nursing (DoN) on 3/11/2014 at 10:25 a.m., the DoN indicated the wound specialist NP had been contacted regarding the wound orders documented from the Visit Note from 2/25/2014. The DoN indicated the NP had failed to write the new treatment orders in the physician's orders and the nursing staff, "Do not have enough time to read all of the progress notes to verify the accuracy of the notes and orders."</p> <p>During an interview with the NP on 3/11/2014 at 1:30 p.m., the NP indicated she had assessed Resident #102 on 2/25/2014 and had failed to write a new treatment order in the physician's orders. The NP indicated the left buttocks wound had deteriorated with the treatment of Iodosorb and as noted in the Visit Note, the treatment should have been changed to Santyl. The NP indicated she could not remember if she had discussed the change in treatment with the facility nurse at the time of the visit.</p>			
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	<p>During an interview with the NP on 3/11/2014 at 1:50 p.m., the NP indicated the expectation was for the facility staff to review the Visit Notes and to notify the NP if the Visit Note indicated a treatment was to be changed and the NP had failed to write the order.</p> <p>On 3/12/2014 at 1:05 p.m., the Administrator provided an undated policy titled, "<u>PRESSURE ULCER PREVENTION AND MANAGEMENT POLICY AND PROCEDURE</u>," and indicated the policy was the policy currently used by the facility. "...<u>For an Actual Pressure Ulcer...</u> 8. Daily monitoring is to be in place to assess the effectiveness of the plan of care and to ensure the care plan is followed i.e.: wound status pain, s/s infection or change and the need to notify the physician. 9. Weekly progress will be documented by in [sig] nurse to assess to [sig] location, stage, size, shape, depth size and depth of sinus track, surrounding tissue, and drainage (type, color, odor, and amount), wound bed, wound edges, and related pain. PUSH scale may be used for clinical validation of healing. 10. If progress is not noted in 3 weeks or deterioration is present, Physician is notified for treatment order review...."</p>			
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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 record review and interview, the facility failed to ensure antipsychotic and antianxiety medications were given as ordered and necessary for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #25)</p> <p>Findings include:</p> <p>The clinical record of Resident #25</p>	F000329	(a)1. The order for resident # 25's Abilify was discontinued per physician's order on 3/06/14. Licensed nurse staff member who transcribed the Abilify physician order on 2/24/14 has been re-educated.2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit.3. An in-service was conducted with nursing staff to outline the procedures for transcription of orders specifically during the time frame of monthly physician re-write review.4.	04/11/2014			

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	<p>was reviewed on 3/6/14 at 9:55 a.m. Diagnoses for the resident included, but were not limited to, dementia, depression, and anxiety.</p> <p>a. A physician's order dated 1/13/14, indicated Resident #25 was to receive Abilify 2.5 mg. (milligrams) daily. Abilify is an antipsychotic medication used to treat the symptoms of schizophrenia and bipolar disorder. A physician's order dated 2/24/14 indicated Abilify 2.5 mg. was to be discontinued.</p> <p>The Medication Administration Record for Resident #25 for February, 2014, indicated she did not receive Abilify after the order to discontinue it on 2/24/14.</p> <p>The Medication Administration Record for Resident #25 for March, 2014, indicated she received Abilify, 2.5 mg. on March 1, 2, 3, 4, and 5, 2014. An order was not found in the resident's clinical record to restart the Abilify.</p> <p>During an interview with the Director of Nursing on 3/6/14 at 2:40 p.m., she indicated a "transcription error" had occurred. She indicated Resident #25 had received Abilify on March 1-5, 2014, in error. She</p>		<p>Clinical leadership team, in addition to licensed nurse staff, will complete monthly physician re-write verification checks X three (3) months. A weekly audit will be completed to review transcription of physician orders X six (6) months. A summary of the results of the weekly audit will be reviewed with the Clinical Leadership team and discussed during the community's Quality Assurance Process Improvement committee meeting.(b)1. Licensed nurse staff who administered p.r.n. Ativan as noted in 2567 have been re-educated.2. Current residents who have the potential to be affected by the alleged deficient practice were reviewed through chart audit.3. An in-service was conducted to review nursing staff regarding the procedure to introduce, attempts, and document non-drug approaches prior to the administration of a p.r.n. medication.4. A weekly audit X six (6) months will be completed to review p.r.n. medication administration. The results of the weekly audit will be reviewed with the Clinical Leadership team and discussed during the community's Quality Assurance Process Improvement committee meetings.</p>				

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	<p>indicated notification of the error to the physician was being done at that time.</p> <p>b. A recapitulated physician's order for February, 2014, with an original date of 1/14/14, indicated Resident #25 could receive Ativan, 0.25 mg. twice a day as needed. Ativan is an antianxiety medication.</p> <p>A care plan for Resident #25, dated 7/27/11 and current through 5/3/14, indicated a problem of, "[resident's name] is receiving an antianxiety drug on a regular basis as needed for anxiety. She has anxiety related to oxygen levels, staff, schedule, [bowel movements] and lab work. During periods of anxiety she becomes short-tempered, seeks extra attention from staff (i.e. calls the nurse on the phone, requests additional time for care), she becomes verbally abusive toward staff at times, is accusatory of staff at times, refuses care from specific staff members..."</p> <p>Interventions for this problem included:</p> <p>"Engage [resident name] in group/individual activities that reduce periods of anxiety and promote socialization"</p>			
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	<p>"Administer antianxiety meds as ordered. Monitor for side effects of medication..."</p> <p>"Provide quiet atmosphere with one-on-one support during periods of increased anxiety. Allow [resident's name] to talk about event and causes, if known."</p> <p>"Record behavior in the Lifestyle Support Log..."</p> <p>"Encourage [resident's name] to breathe deeply, through the nose, during periods of anxiety."</p> <p>"Encourage [resident's name] to speak slowly and calm down prior to speaking during periods of anxiety as rapid speech hinders her breathing and increases anxiety levels."</p> <p>"Encourage [resident's name] to use her call light to request assistance with care and to use the phone for non-care related assistance. Reassure her that staff will respond to the call light."</p> <p>"Explain how much time is available to provide her care prior to giving it. Ask her if this amount of time is acceptable and reschedule care or</p>			

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	<p>proceed with care per her preference."</p> <p>"Encourage [resident's name] to collaborate with staff to create a care/activity schedule that will meet her needs and preferences. Refer to her care schedule during periods of anxiety and explain that staff does not have an unlimited amount of time to spend with her. Reassure her that her schedule can be modified as needed to accommodate her preferences or medical state."</p> <p>"If [resident's name] is upset, give her time to calm down. Encourage relaxation techniques for anxiety...Reapproach her at a later time to provide care if needed."</p> <p>A Medication Administration Record for Resident #25 for February, 2014, indicated she received Ativan, 0.25 mg. on 2/10, 2/13, and 2/28, 2014.</p> <p>A nurse's note dated 2/10/14 at 1:28 a.m., indicated, "Resident has been on call light for several times and doesn't remember or know what she wants. Prn [as needed] Ativan given with positive results." The nurse's note did not indicate any alternative non-pharmacological interventions from the resident's anxiety care plan</p>			
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	<p>were attempted by staff prior to giving the prn Ativan.</p> <p>A nurse's note dated 2/13/14 at 1:16 a.m. indicated, "Prn Ativan given...resident request. No behavior noted..." The nurse's note did not indicate any alternative, non-pharmacological interventions from the resident's anxiety care plan were attempted by staff prior to giving the prn Ativan.</p> <p>A nurse's note dated 2/28/14 at 10:42 p.m. indicated, "At change of shift, resident [complained of] increased anxiety. Res[ident] assessed and asked to describe how she felt. Res[ident] stated she felt like she had a lot of anxious energy. Res[ident] administered prn [Ativan]. Res[ident] reassessed half hour later and resident stated she felt a lot better..." The nurse's note did not indicate any alternative, non-pharmacological interventions from the resident's care plan were attempted prior to giving the prn Ativan.</p> <p>A review of the Behavior Tracking Log for Resident #25 for February, 2014, did not indicate any behaviors during the month.</p> <p>During an interview with the Director</p>						

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	<p>of Nursing on 3/7/14 at 8:45 a.m., she indicated she was not able to find any other documentation in Resident #25's record, regarding assessments and interventions provided to the resident prior to giving the prn Ativan on 2/10, 2/13, and 2/28, 2014.</p> <p>3.1-48(a)(2) 3.1-48(a)(4)</p>			
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F009999	<p>3.1-14 Personnel</p> <p>(b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual:</p> <p>(2) has completed a training and competency evaluation program approved by the division or a competency evaluation program approved by the division.</p> <p>(s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules.</p> <p>These state rules were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure a non-state certified employee who worked as a nurse aide for greater than 120 days had been certified by the state for 1 of 7 employees reviewed for nurse aide certification. (Employee # 65)</p> <p>Findings include:</p> <p>Employee #65's employee file was</p>	F009999	<p>1. No residents were affected by the alleged deficient practice.2. The community realizes that all residents under the C.N.A.'s care have the potential to be affected by the deficient alleged practice.3. The staffing coordinator has been counseled. The systemic change will be that the staffing coordinator checks the certifications prior to offering a position to any certified candidate. In addition, the Director of Human Resources, or her designee will require all new hires to bring their valid certifications (licensed staff and C.N.A.'s) to the new hire orientation which occurs prior to working in the health center. No one will be allowed to attend new hire orientation without it.4. The Administrator will require the Human Resources department to document any incidents in which there was noncompliance. These findings will be reviewed at the Quality Assurance Process Improvement meetings for the next six (6) months.</p>	04/11/2014			

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	<p>reviewed on 3/7/14 at 10:30 a.m. A CNA certification issued by the state of California indicated an expiration date of 8/22/2014. The file lacked documentation of a Indiana Nurse Aide Certification.</p> <p>Hire date at Greenwood Village South was 9/03/13, as a CNA. As of 1/03/14, the employee had worked 120 days. The employee remained on the schedule and worked full-time as a CNA as follows:</p> <table> <thead> <tr> <th>date:</th> <th>hours worked?</th> </tr> </thead> <tbody> <tr><td>1/4/14</td><td>5.25</td></tr> <tr><td>1/5/14</td><td>8.00</td></tr> <tr><td>1/6/14</td><td>7.75</td></tr> <tr><td>1/7/14</td><td>15.25</td></tr> <tr><td>1/8/14</td><td>8.75</td></tr> <tr><td>1/9/14</td><td>7.50</td></tr> <tr><td>1/10/14</td><td>7.75</td></tr> <tr><td>1/15/14</td><td>7.50</td></tr> <tr><td>1/16/14</td><td>7.75</td></tr> <tr><td>1/17/14</td><td>7.50</td></tr> <tr><td>1/18/14</td><td>7.75</td></tr> <tr><td>1/19/14</td><td>7.47</td></tr> <tr><td>1/20/14</td><td>15.25</td></tr> <tr><td>1/21/14</td><td>7.50</td></tr> <tr><td>1/22/14</td><td>7.75</td></tr> <tr><td>1/23/14</td><td>7.50</td></tr> <tr><td>1/24/14</td><td>15.00</td></tr> <tr><td>1/27/14</td><td>5.00</td></tr> <tr><td>1/29/14</td><td>7.50</td></tr> <tr><td>1/30/14</td><td>15.50</td></tr> </tbody> </table>			date:	hours worked?	1/4/14	5.25	1/5/14	8.00	1/6/14	7.75	1/7/14	15.25	1/8/14	8.75	1/9/14	7.50	1/10/14	7.75	1/15/14	7.50	1/16/14	7.75	1/17/14	7.50	1/18/14	7.75	1/19/14	7.47	1/20/14	15.25	1/21/14	7.50	1/22/14	7.75	1/23/14	7.50	1/24/14	15.00	1/27/14	5.00	1/29/14	7.50	1/30/14	15.50				
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1/9/14	7.50																																																
1/10/14	7.75																																																
1/15/14	7.50																																																
1/16/14	7.75																																																
1/17/14	7.50																																																
1/18/14	7.75																																																
1/19/14	7.47																																																
1/20/14	15.25																																																
1/21/14	7.50																																																
1/22/14	7.75																																																
1/23/14	7.50																																																
1/24/14	15.00																																																
1/27/14	5.00																																																
1/29/14	7.50																																																
1/30/14	15.50																																																

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD VILLAGE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN 46143
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
1/31/14	7.75			
2/1/14	7.50			
2/2/14	7.50			
2/3/14	7.75			
2/4/14	7.75			
2/5/14	7.75			
2/6/14	15.00			
2/7/14	15.00			
2/10/14	7.75			
2/11/14	7.75			
2/12/14	15.00			
2/13/14	12.50			
2/14/14	7.50			
2/15/14	8.50			
2/18/14	15.00			
2/19/14	7.75			
2/20/14	7.75			
2/21/14	7.75			
2/22/14	7.50			
2/24/14	15.25			
2/25/14	7.50			
2/26/14	7.50			
2/27/14	7.50			
2/28/14	7.50			
3/1/14	7.75			
3/2/14	7.75			
3/3/14	15.25			
3/4/14	15.00			
3/5/14	7.50			
3/6/14	15.25			
	Interview 3/7/14 at 12:30 p.m., with Staffing Coordinator indicated			

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	<p>employee #65 was currently working as a C.N.A. Employee has sent money in to pay for her certification (Indiana) test and is waiting for the testing site to give testing date.</p> <p>Interview on 3/7/14 at 1:45 p.m., with Director of Nursing (DON) indicated employee #65 was called and informed she could not work, until she passed her Indiana certification test.</p>			

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R000298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on observation, interview, and record review, the facility failed to document the reconciliation of narcotic medications as indicated by policy and procedure for 2 of 2 medication carts reviewed. (Medication Cart Hall A and B and Medication Cart Hall C and D)</p> <p>Findings include:</p> <p>During a review of the medication cart for Halls C and D on 3/12/2014 at 10:00 a.m., the "Controlled Drugs-Count Record," dated March 2014, lacked signatures for 9 shifts, which indicated narcotic counts were not completed. In the row dated 3/1/2014, signatures were lacking on all 3 shifts. Signatures were lacking</p>	R000298	<p>1. No residents were found to be affected by the alleged deficient practice. 2. The community realizes that all residents with physician's orders for narcotics have the potential to be affected by the alleged deficient practice. All residents with physician's orders for narcotics have had their narcotic counts reviewed, corrected, and are accurate. 3. The licensed nursing personnel have been educated regarding the Management of Controlled Medications. The Controlled Drugs-Count Record form is to be used every shift with signatures below indicating acknowledgement that nursing personnel have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity</p>	04/11/2014			

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	<p>for shifts on 3/2, 3/7, 3/8, and 2 shifts on 3/11/14.</p> <p>During a review of the medication cart for Halls A and B on 3/12/2014 at 10:05 a.m., the "Controlled Drugs--Count Record," dated March 2014, lacked signatures for shifts on 3/1/2014 and 3/11/2014.</p> <p>During an interview with QMA #6 and LPN #4, on 3/12/2014 at 10:00 a.m., QMA #6 indicated the narcotic counts were completed, "They just forgot to sign the sheets." LPN #4 indicated the narcotics were counted every shift and the sheets should have been signed when the counting was completed and was found to be accurate.</p> <p>During an interview with LPN #5 at 10:55 a.m. on 3/12/2014, LPN #5 indicated the facility expectation was, "Narcotic counts are to be done with each shift change and narcotic count sheets are signed when counts are completed."</p> <p>The "Controlled Drugs--Count Record" form was reviewed on 3/12/2014 at 10:45 a.m. "...Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of</p>		<p>stated on the Controlled Drugs-Count Record. 4. The Director of Residential Health Services or her designee will monitor the Controlled Drugs-Count Record form by reviewing it daily for the next thirty (30) days and weekly thereafter for the next six months. Any discrepancies will be reported to the Administrator immediately. Licensed staff will be subject to progressive disciplinary action for noncompliance with this policy.</p>		

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	<p>each medication counted is in agreement with the quantity stated on the Controlled Drugs--Count Record...."</p> <p>On 3/12/2014 at 11:05 a.m., LPN #5 provided a facility policy titled "Managing Controlled Medications," dated 12/1/2006, and indicated the policy was the one currently used by the facility. "...POLICY: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations..."</p> <p>"PROCEDURE:...5. C. The left side of the Narcotic Record Sheet is to be utilized for the shift count. At each shift change the nurse leaving and the nurse arriving check narcotics for accurate count...."</p>				

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R000352	<p>410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on record review and interview, the facility failed to obtain and/or document daily weights as ordered by the physician for 1 of 7 residents reviewed for documentation of weights in a sample of 7. (Resident #169)</p> <p>Findings include:</p> <p>The clinical record of Resident #169 was reviewed on 3/11/14 at 11:20 p.m. Diagnoses included, but were not limited to, congestive heart failure and high blood pressure.</p> <p>A recapitulated physician's order for March, 2014, with an original date of 2/14/14, indicated Resident #169 was to be weighed daily. The physician was to be notified if she gained or lost more than 3 lbs. (pounds) in 24 hours or 5 lbs. in 1 week.</p> <p>A Monthly Vital Signs and Weights form indicated, between 2/14/14 and 3/7/14, Resident #169 was only</p>	R000352	<p>1. Resident # 169 was not affected by the alleged deficient practice. Due to resident's choice in not wanting to be weighed daily and through discussion with her physician, an order was obtained to discontinue the daily weights. The responsible party was notified. 2. No other residents with physician's orders for daily weights were found to be affected by the alleged deficient practice. 3. The nursing staff have been educated regarding the expectation of documentation regarding daily weights on the Monthly Vital Signs and Weights form and on the Medication Administration Record and the procedure to follow in handling resident refusal by choice. 4. The Director of Residential Health Services or her designee will monitor by reviewing the Monthly Vital Signs and Weights form daily for the next thirty days and weekly thereafter for the next six (6) months. Any discrepancies will be reported to the Administrator immediately. Nursing staff will be subject to progressive disciplinary action for noncompliance.</p>	04/11/2014			

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	<p>weighed 2 times, on 3/5/14 and 3/7/14. No other weights for the resident were found in her record.</p> <p>During an interview with the Clinical Director on 3/11/14 at 4:35 p.m., she indicated she was not able to find any other weights taken on Resident #169 since the daily weight physician's order was written on 2/14/14. She indicated the resident frequently refused to be weighed, but the Certified Nursing Assistants (CNA's) had not documented the resident's refusals. She indicated the CNA's were supposed to document all weights and refusals on the Monthly Vital Signs and Weights form and on the Medication Administration Record.</p>				