STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS THE	950 CROSS AVE MADISON, IN 47250

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00132248, IN00133858, IN00134516, IN00140718. Complaint IN00132248 - Substantiated. Federal/state deficiencies related to the allegations are cited at F353. Complaint IN00133858 - Unsubstantiated due to lack of evidence. Complaint IN00134516 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323. Complaint IN00140718 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 22, 23, 24, 27, 28, 29, 30, and 31, 2014 Facility number: 000116 Provider number: 155209 AIM number: 100266330	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Survey team: Diana Sidell RN, TC Sunny Jungclaus RN Jennifer Carr RN (January 22, 23, 24, 27, 29, 30, and 31, 2014) Census bed type: SNF/NF: 101 Total: 101 Census payor type: Medicare: 22 Medicaid: 75 Other 4 Total: 101 Supplemental sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 12, 2014 by Cheryl Fielden RN.			

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F000224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to ensure residents remained free from misappropriation of their medications, in that two residents had missing narcotic pain medications. This affected 2 of 7 residents who met the criteria for abuse. (Resident #60 and #52) Findings include: 1. Resident #60's record was reviewed on 1/30/14 at 4:55 p.m. The record indicated Resident #60 had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic resp failure, chronic pain, peripheral neuropathy, chronic headache, gastro esophageal reflux disease, mood disorder, panic disorder, osteoporosis, and decreased bowel motility.	F000224	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit resident mistreatment, neglect and abuse of residents and misappropriation of resident property. A. ACTIONS TAKEN: 1. Resident #60 and #52 medications were replaced by the facility at the time of the occurrence. B. OTHERS IDENTIFIED: 1. 100% audit completed at the time of the occurrence. No others affected. C. MEASURES TAKEN: 1. An In-service was completed with nursing staff on the Policy and Procedure for Narcotic control. D. HOW MONITORED: 1. The DON/Designee will monitor narcotic counts five (5) times a week for three (3) weeks then three (3) times a week for two (2) weeks then once a week 2. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA	02/27/2014

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	Physician's recapitulation orders dated January 1 through January 31, 2014, indicated an order for Oxycodone (narcotic pain reliever) 10/325 milligrams. An "Incident Report Form" was provided by the Administrator on 1/29/13 at 9:30 a.m. The incident included, but was not limited to: Date of incident: 7/29/13 at 12:00 a.m. "Brief description of incident: QMA (Qualified Medication Aide) #16 noted during routine medication pass that the Oxycodone that was due to the above resident was taped in the bubble card and upon removal of the medication it appeared to look like to her a Tylenol. QMA #16 notified LPN #17 and upon review the next medication in that bingo card also appeared to look like a Tylenol as well. Nursing failed to save the medication in question or promptly notify nursing for immediate action. Type of Injury/Injuries: none Immediate action taken: Resident assessed and denies any unusual complaints of pain. A pain assessment was completed. A 100% cart audit was complete on all narcotics and no additional issues identified. All nurses/QMA's involved from time the card was delivered and the		Meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	discrepancies were interviewed and given a drug test. Drug tests were negative for Opiates. Preventative measures taken: In-service initiated and will continue prior to the nurse working to include: No tampering with the bubble packs and to report any suspected tampering immediately. Importance of reporting immediately to nursing management. Nurse management to audit narcotic cards q (every) shift for 1 week and include the results in the QA (quality assurance) process and/or need for any further auditing. During this investigation, LPN #17 was relieved of her employment within her 90 days d/t (due to) failure to follow our policy and procedures. The facility will pay the pharmacy directly for the two missing tablets. Reported to local police authority on 7/29/13." The investigation indicated: "On 7-29-13 at 12 am reported from [LPN #17] and [QMA #16] that when the QMA went to give her the 12am dose of Oxycodone, she realized it was taped and the actual medication appeared to be Tylenol. The nurse [LPN #17] was alerted and they noted the next medication in the bubble pack was also taped and appeared to be Tylenol. They			

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	disposed of both pills in the sharps container. During investigation it was discovered that approximately 1130pm on 7-28-13 [QMA #16] had left her keys with [LPN #17] and they failed to count the narcotics. DON called in about 6am and was informed of the above on 7/29/13." A written statement from LPN #17, dated 7/28/13 on the 6p - 6a shift, indicated: "While [QMA #16] was getting [name of hallway] 12 AM meds ready to pass, she noted upon removing [Resident #60's] Percocet 10/325 it was not the correct medication. That pill and the next in line had pieces of tape securing the pills into the blister pack. Upon viewing the next pill it was not a percocet 12/325 either. [QMA #16] popped and administered the correct medication and watched me destroy the pills. I discussed with [LPN #23 and LPN #24] what to do next. [LPN #23 advised me to have [QMA #16] and I write a statement and put under [DoN's] door...While QMA #16 went to lunch at approx[imately] 11pm til 11:30 p.m., I had possession of the cart key." During an interview, on 1/31/14 at 9:58 a.m., the DoN indicated they could not find out how the (tylenol)			

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	got there, and the Administrator indicated LPN #17 was dismissed because she didn't immediately report it, it was reported to administration at 6 a.m. the next morning when the count was taken over by the other shift. The DoN also indicated they disposed of the Tylenol at 11:00 p.m., that evening. 2. Resident #52's record was reviewed on 1/30/14 at 11:48 a.m. The record indicated Resident #52 was admitted with diagnoses that included, but were not limited to pneumonia, lung disease, cerebrovascular disease, depression, high blood pressure, anxiety, Parkinson's disease, convulsions, and restless leg syndrome. An annual Minimum Data Set assessment, dated 1/3/14, indicated Resident #52 was alert and oriented, and cognitively intact. The investigation included: "Saturday October 19, 2013, 2 cards of Lortab 7.5/500mg was received from [name of pharmacy] for [Resident #52]. These medications were signed for by [RN #25] and [QMA #16]. The narcotic count			

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	sheet indicates that the medications were logged in on this date and added to the per shift sheet count. On Monday, October 28, 2013, [the DoN] and [ADoN] were notified that the amount of narcotic sheets did not match the amount of cards in the cart. The number circled initially indicated that there were 28 sheets in the narcotic book. The actual number of sheets in the narcotic book was 29. The amount of cards in the narcotic drawer was actually 28. With further investigation, it was discovered that there were 2 narcotic sheets in the narcotic book for [Resident #52] for Lortab 7.5/500mg and there was only one card in the narcotic drawer. Staff present was immediately drug tested. One staff member, [QMA #16] tested positive for Lortab. [QMA #16] stated that she did have a script (prescription) for the Lortab due to a tooth extraction, but could not provide said script at that time. [QMA #16] was immediately suspended pending investigation...The following staff members were drug tested immediately: RN #2, RN #26, RN #15, LPN #27, LPN #28, RN #29, and QMA #16 - positive, immediately suspended pending investigation...."			

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	On 1/31/14, at 10:05 a.m., the DoN indicated: "When they had done the count that night, the count was off, everybody was drug tested, one tested positive, she said she had a script, she brought it in the next day, and drug tested negative that day, inservicing was done on the proper way to count narcotics." A policy and procedure for "Controlled Substances Disposition" was provided by the Administrator on 1/31/14 at 12:12 p.m. The policy indicated, but was not limited to, "Policy: It is the policy of this facility to comply with federal and state requirements for controlled substances. The following procedures will be adhere (sic) to at all times for disposal of Schedule II thru V medications. Procedure...3. The medications and accompanying count sheets will be kept in the medication cart until they are surrendered to the Director of Nursing (DoN) or his/her designee for destruction. Shift-to-shift counts will be done, and endorsed on the appropriate record, for all controlled substances awaiting destruction for which there are count sheets...." A policy and procedure for "Abuse			

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	Prevention Program" was provided by the Social Service Director on 1/22/14 at 12:44 p.m. The policy indicated, but was not limited to, "Policy: It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. The following Procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party...IV. Identification: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator...Procedure: Any alleged violations involving mistreatment, abuse, neglect, misappropriation of resident property and any injuries of an unknown origin MUST be reported to the Administrator and Director of Nursing. The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or			

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	suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or to the individual in charge of the facility during the Administrator's absence...." 3.1-27(a)(3) 3.1-28(a)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to implement their abuse policy and procedure related to	F000226	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit resident mistreatment, neglect and abuse of residents	02/27/2014

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	misappropriation of narcotic pain medications for 1 of 7 residents reviewed for abuse. (Resident #60) Findings include: Resident #60's record was reviewed on 1/30/14 at 4:55 p.m. The record indicated Resident #60 had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic resp failure, chronic pain, peripheral neuropathy, chronic headache, gastro esophageal reflux disease, mood disorder, panic disorder, osteoporosis, and decreased bowel motility. An "Incident Report Form" was provided by the Administrator on 1/29/13 at 9:30 a.m. The incident included, but was not limited to: Date of incident: 7/29/13 at 12:00 a.m. "Brief description of incident: QMA #16 noted during routine medication pass that the Oxycodone (narcotic pain reliever) that was due to the above resident was taped in the bubble card and upon removal of the medication it appeared to look like to her a Tylenol. QMA #16 notified LPN #17 and upon review the next medication in that bingo card also appeared to look like a		and misappropriation of resident property. A. ACTIONS TAKEN: 1. Resident #60 medications were replaced at facility cost B. OTHERS IDENDIFIED: 1. 100% audit was completed at the time of the Occurrence. No other residents were affected. C. MEASURES TAKEN: 1. An in-service was conducted with the nursing and QMA staff reeducating on the Policy and Procedure for tampering and reporting immediately and the Narcotic control administration Policy and Procedure. D. HOW MONITORED: 1. The DON/Designee will monitor narcotic counts five (5) times a week for three (3) weeks then three (3) times a week for two (2) weeks then once a week. 2. The Administrator/Designee will review the audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	Tylenol as well. Nursing failed to save the medication in question or promptly notify nursing for immediate action. Type of Injury/Injuries: none Immediate action taken: Resident assessed and denies any unusual complaints of pain. A pain assessment was completed. A 100% cart audit was complete on all narcotics and no additional issues identified. All nurses/QMA's involved from time the card was delivered and the discrepancies were interviewed and given a drug test. Drug tests were negative for Opiates. Preventative measures taken: In-service initiated and will continue prior to the nurse working to include: No tampering with the bubble packs and to report any suspected tampering immediately. Importance of reporting immediately to nursing management. Nurse management to audit narcotic cards q (every) shift for 1 week and include the results in the QA process and/or need for any further auditing. During this investigation, LPN #17 was relieved of her employment within her 90 days d/t failure to follow our policy and procedures. The facility will pay the pharmacy directly for the two missing tablets. Reported to local police authority on 7/29/13."			

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	The investigation indicated: "On 7-29-13 at 12 am reported from [LPN #17] and [QMA #16] that when the QMA went to give her the 12am dose of Oxycodone, she realized it was taped and the actual medication appeared to be Tylenol. The nurse [LPN #17] was alerted and they noted the next medication in the bubble pack was also taped and appeared to be Tylenol. They disposed of both pills in the sharps container. During investigation it was discovered that approximately 1130pm on 7-28-13 [QMA #16] had left her keys with [LPN #17] and they failed to count the narcotics. DON called in about 6am and was informed of the above on 7/29/13." A written statement from LPN #17, dated 7/28/13 on the 6p - 6a shift, indicated: "While [QMA #16] was getting [name of hallway] 12 AM meds ready to pass, she noted upon removing [Resident #60's] Percocet 10/325 it was not the correct medication. That pill and the next in line had pieces of tape securing the pills into the blister pack. Upon viewing the next pill it was not a percocet 12/325 either. [QMA #16] popped and administered the correct medication and watched me destroy			

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	the pills. I discussed with [LPN #23 and LPN #24] what to do next. [LPN #23 advised me to have [QMA #16] and I write a statement and put under [DoN's] door...While QMA #16 went to lunch at approx[imately] 11pm til 11:30 p.m., I had possession of the cart key." During an interview, on 1/31/14 at 9:58 a.m., the DoN indicated they could not find out how the (Tylenol) got there, and the Administrator indicated LPN #17 was dismissed because she didn't immediately report it, it was reported to administration at 6 a.m. the next morning when the count was taken over by the other shift. The DoN also indicated they disposed of the Tylenol at 11:00 p.m., that evening. A policy and procedure for "Controlled Substances Disposition" was provided by the Administrator on 1/31/14 at 12:12 p.m. The policy indicated, but was not limited to, "Policy: It is the policy of this facility to comply with federal and state requirements for controlled substances. The following procedures will be adhere (sic) to at all times for disposal of Schedule II thru V medications. Procedure...3. The medications and accompanying			

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	count sheets will be kept in the medication cart until they are surrendered to the Director of Nursing (DON) or his/her designee for destruction. Shift-to-shift counts will be done, and endorsed on the appropriate record, for all controlled substances awaiting destruction for which there are count sheets...." A policy and procedure for "Abuse Prevention Program" was provided by the Social Service Director on 1/22/14 at 12:44 p.m. The policy indicated, but was not limited to, "Policy: It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. The following Procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party...IV. Identification: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the			

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	Administrator...Procedure: Any alleged violations involving mistreatment, abuse, neglect, misappropriation of resident property and any injuries of an unknown origin MUST be reported to the Administrator and Director of Nursing. The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or to the individual in charge of the facility during the Administrator's absence...." 3.1-27(a)(3) 3.1-28(a)			

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F000244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to follow up with Resident Council regarding recommendations. This deficiency had the potential to affect all 101 residents in the facility. Findings include: The Resident Council minutes were provided by the Administrator on 1/22/2014 at 12:47 p.m. Only the minutes for the dates 11/22/2013, 12/18/2013, and 1/15/2014 were provided. During an interview with the Administrator, on 1/30/2014 at 12:22 p.m., he indicated that there were no Resident Council minutes available prior to 11/22/2013. Resident #11 has been a resident at the facility since July, 2011 and is the current Resident Council	F000244	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. A. ACTION TAKEN: 1. Resident Council meeting held on 2-19-14. B. OTHERS IDENTIFIED: 1. All residents had the potential to be affected. Those residents were not determined to be negatively affected. C. MEASURES TAKEN: 1. A Resident Council meeting was held 2/19/2014 to introduce the facilities new Policy and Procedure on Resident Council Guidelines, Minutes and Solutions/Resolutions/Complaints . The Resident Council Guidelines, Minutes and Solutions/Resolutions/Complaints were distributed to all resident in attendance and each signed the Guidelines. 2. A Resident Council Meeting will be held every	02/27/2014

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	President. Her most recent Quarterly Minimum Data Set Assessment (MDS) was conducted on 10/2/2013. A Brief Interview for Mental Status (BIMS) at that time indicated that she was cognitively intact. During an interview with the Resident Council President, Resident #11, on 1/31/2014 at 11:10 a.m., she indicated that the facility does not follow up with residents regarding concerns and/or recommendations brought up during Resident Council meetings. She indicated, "All we know is we tell them and that ' s it...we don't get much of an answer. They don't come and talk about anything we talk about (in the meetings). They're supposed to see about it, but...." A copy of the Resident Council Policy and Procedure, last reviewed 10/8/2013, was provided by the Administrator and Corporate Nurse Consultant on 1/31/2014 at 2:31 p.m. It included in part, but was not limited to, the following: 1. "The Resident Council's complaints and recommendations will be brought to the attention of the appropriate department heads for response. Responses will be documented and kept with the		third (3rd) Wednesday of each month 3. The day after the Resident Council's meeting the Solutions/Resolutions/Complaints will be brought to the daily morning meeting and read and assigned to the appropriate department. Responses will be documented and kept with the Resident Council minutes. The Administrator will review the Resident Council minutes and all responses within 1 week of meeting. The facilities responses to Solutions/Resolutions/Complaints will be reported back to the Resident Council at the next month's meeting. 4. The Administrator will sign-off on the resident council meeting minutes within 1 week of meeting to ensure follow-up to concerns are in place. D. HOW MONITORED: 1. The Administrator/Designee will monitor/follow up monthly, or as needed, with all Solutions/Resolutions/Complaints and sign off after each opportunity for improvement has been met. 2. Resident council concerns will be taken to the monthly and Quarterly QA for compliance. Monitoring will be ongoing. E. The plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	Resident Council minutes...The Administrator will review the Resident Council minutes and all responses." 2. "The facility's responses to issues will be reported back to the Resident Council at the next meeting." During an interview with the Director of Nursing, Corporate Nurse Consultant, and the Administrator on 1/31/2014 @ 12:20pm, the Administrator indicated that he does not document or follow up regarding resolution to issues brought up in previous resident council meetings. During an interview with the Corporate Nurse Consultant and Administrator on 1/31/2014 at 2:31 p.m., a copy of the Resident Council Policy and Procedure and a blank form entitled, "Resident Council Report Communication." Both indicated that Administration was not utilizing the "Resident Council Report Communication" form or following the Resident Council policy and procedure. 3.1-3(l)			

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F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on record review and interview, the facility failed to conduct an accurate initial and on-going bowel and bladder assessment for 1 of 2 residents	F000272	The facility's intent is to comply with the federal requirements to develop and implement written policies and procedures that conduct initial and periodic comprehensive, accurate,	02/27/2014

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	reviewed for urinary incontinence. (Resident #142). Resident #142's chart was reviewed on 1/29/14 at 2:05 p.m. Diagnoses included, but were not limited to, congestive heart failure, late Parkinson's affects, diabetes, hypertension, right below the knee amputation (10/24/2013), dementia, severe aortic stenosis with valve repair, generalized muscle weakness, paralysis agitans, and abnormality of gait. A review of Resident #142's Minimum Data Set Admission Assessment, dated 10/7/2013, indicated, "Indwelling cath (catheter): Yes; Urinary toileting program: No; Urinary continence: frequently incontinent; Bowel continence: frequently incontinent; Bowel toileting program? No; Constipation: No." A review of Resident @142's Minimum Data Set Assessment dated 11/4/2013 indicated the following significant changes: "Indwelling catheter: No; Urinary toileting program: No; Urinary continence: Always incontinent; Bowel continence: Always incontinent; Bowel toileting program:		standardized reproducible assessment of each of resident's functional capacities. A. ACTION TAKEN: 1. Resident #142 is not a current resident B. OTHERS IDENTIFIED: 1. 100% audit was completed for an accurate bowel and bladder assessment. No residents with negative findings were found. C. MEASURES TAKEN: 1. A complete (100 %) audit of all resident will be evaluated for bowel and bladder tracking. All residents requiring a current assessment had one completed. 2. Nursing staff will be in-service on our Incontinence Care Policy and Procedure. 3. Policy and assessment was reviewed and updated. D. HOW MONITORED: 1. MDS Coordinator will monitor all bladder and bowel assessments for accuracy and completeness during residents scheduled MDS. 2. DON/Designee will monitor new admissions and significant changes during the daily CQI meeting for accuracy and completeness. 3. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance	

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	No. Constipation present: No." During an interview with the Corporate Nurse Consultant on 1/30/2013 at 4:30 p.m., she indicated that bowel/bladder assessments are done on admission and quarterly; whether or not residents receive bowel/bladder re-training depends on assessments. The Policy and Procedure entitled "Incontinence", last reviewed 10/8/2013, was provided by the Administrator on 1/31/2014 at 2:13 p.m. It included, but was not limited to, the following: 1. "It is the intent of this facility to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible." 2. "Upon admission (if the resident has a history of incontinence) complete the Bowel and Bladder Tracking Tool." 3. "Complete the Bladder Assessment Form and the Bowel Assessment Form..." 4. "Upon completion of this assessment/evaluation as well as		with all regulatory requirements.	

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	the Tracking Tool, the toileting/bladder program can be determined." During an interview with the Director of Nursing and Corporate Nurse Consultant on 1/31/2014 at 4:47 p.m., the Corporate Nurse Consultant indicated that the Bladder Tracking Tool, Bowel Assessment Form, and the Bladder Assessment Form were not completed. Further, the Corporate Nurse Consultant indicated that even though the resident was admitted with a catheter, the Bowel Assessment Form should have been completed. Additionally, the Bladder Assessment Form should have been completed after the catheter was discontinued shortly after admission. No additional care plans related to bowel or bladder were provided. 3.1-31(d)			

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F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on record review, interview, and observation, the facility failed to ensure 1 resident was free of burns related to electrode stimulating (e-stim) therapy treatments. (Resident #33) B. Based on record review, interview, and observation, the facility failed to ensure residents were free from falls for 2 of 5 residents who met the criteria for falls. (Residents #J and #111) Findings include: A. Resident #33's record was reviewed on 1/30/14, at 11:23 p.m. The record indicated resident #33 was admitted with diagnoses that included, but were not limited to, cerebrovascular disease, type 2 diabetes mellitus, high blood pressure, generalized muscle weakness, acute kidney failure, weakness on one side due to stroke, acquired hypothyroidism, malaise, fatigue, and esophageal reflux.	F000323	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. ACTIONS TAKEN: 1. Resident #33 was assessed by nurse and physician and family notified. Therapy was made aware and e-stem machine was removed from use until it was inspected. 2. Resident J seat belt was repaired at time of occurrence. Resident #111 plan of care guide was updated. B. OTHERS IDENTIFIED: 1. 100% audit of all fall interventions and residents on Estim was completed. No other residents were affected. C. MEASURES TAKEN: 1. Resident e-stem treatment was placed on hold. All resident's electrodes were replaced with new ones. E-stem machine was inspected and service before use. Resident was monitored, treated assessed until area(s) were resolved. In-service was	02/27/2014

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	Progress Notes, dated 12/27/13 at 1:14 p.m., indicated: "Therapy presents pt (patient) with report of burn marks from electrodes on front of right shoulder and back of rt shoulder, pt denies any pain or discomfort, areas are white in color, no blistering or redness at this time, spouse informed, md aware, no new orders at this time, cont[inue] to monitor areas, therapy to evaluate equipment. 130/72 (blood pressure) -72 (heart rate) -20 (respirations) T 97." Progress Notes, dated 12/28/13 at 12:07 p.m., indicated: "Upon assessment at this time to areas anterior and posterior right shoulder there is noted blisters from incident yesterday. MD and husband notified resident denies any pain or discomfort will continue to monitor q [every] shift and PRN [as needed]. B/P 178/69 P 86 R 18 T 98.8." Progress Notes, dated 12/28/13 at 2:23 p.m., indicated: "Cont[inue] to monitor blister areas on right post[erior] and front shoulder area no c/o (complaints of)pain no open areas or drainage bp 156/78 r 16 p 88 t 98 oxygen [saturation] 92%."		completed with therapy related to e-stem procedures and precautions. E-stem machine is to be inspected and serviced biannually. 2. Residents with safety seatbelt alarms will be installed and inspected weekly by maintenance. 3. Residents with risk for falls will be care planned with appropriate interventions according to facility policies and procedures. D. HOW MONITORED: 1. Therapy will have e-stem machine inspected and serviced, as needed, and report findings to Administrator. Inspections and findings will be included in QA meeting. 2. DON/Designee will update the cna care guides with information related to residents and supervision. All incidents will be reviewed in the daily CQI meeting with appropriate interventions/reviews. 3. Maintenance Director will install all safety seatbelt alarms and monitor weekly. 4. Fall interventions will be added to IDT daily walking rounds for review. Results will be reviewed in the daily CQI meeting. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring E. This plan of correction constitutes our credible allegation of compliance	

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	Progress notes, dated 12/31/13 at 6:49 a.m., indicated: "Res[ident] rested quietly abed all noc (night) with no c/o voiced. Blisters to right shoulder cont. blisters are intact, edges light pink with scabbing in the center. No s/s (signs or symptoms) infection to area. Res. denies any pain." Progress notes, dated 1/3/14 at 1:02 p.m., indicated: "Blisters on front & back of R shoulder are beginning to crust over, no drainage noted, res continues to have no c/o pain/discomfort at the area, will continue to monitor." A social service progress note, dated 1/6/14 at 4:00 p.m., indicated: "Late Entry: Note Text: Completed quarterly assessment for Martha. BIMS (brief interview for mental status) =15 (resident is cognitively intact)...." A progress note, dated 1/17/14 at 1:31 p.m., indicated: "RD (registered dietitian) note: Res has burn area on shoulder. Area is Scabbed over. Continue with current diet. Intake is 5-100% with refusal of breakfast every morning...."		with all regulatory requirements.	

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	On 1/31/14 at 10:12 a.m., the Director of Nurses (DoN) indicated that after therapy, Resident #33 had white areas on her skin, and the next day they had turned into blistered areas. She indicated the e-stim (electrode stimulating therapy machine) was put out of commission and they started the reportable incident. Therapy did an inservice and they got a new e-stim machine. The Administrator indicated, at that time, they had been doing an annual machine check and now they do it every 6 months. She indicated the calibration was off and the blisters were in the shape of the pad. Physician's telephone orders, dated 1/27/14 at 2:00 p.m., indicated: "OT (Occupational Therapy) clarification order - pt to cont skilled OT services 3X/wk X30 days to include self care, therx (therapeutic exercises) therapeutic activities, NMRED (neuro-muscular re-education." Physician's telephone orders, dated 1/30/14 at 12:00 p.m., indicated: "Clean areas to (R) shoulder [with] N/S (normal saline) apply Silvadene cream cover [with] dry dressing [change] BID (twice a day)." On 1/31/14 at 10:46 a.m.,			

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	Occupational Therapist #1 brought in an e-stim unit. She indicated: "There is a setting to select a higher intensity, for example if you want to get a muscular contraction, can use it to increase circulation." She indicated she "gets good results from stimulating the muscle to get the message to the brain", example: if she wanted to get the wrist moving, would put the pad proximal to the wrist to get the message to the wrist to get the muscle moving to get stimulation. She indicated Resident #33 was receiving e-stim for pain management and he pads were placed on her right shoulder. Occupational Therapist #1 provided a package of "Dura-Stick Plus Self-Adhesive Tens Stimulating Electrodes" that are used with the e-stim. The Dura-Stick pad was 2 inches round. The indications for use on the package indicated: "...16. Using stimulation electrodes that are too small or incorrectly applied could result in discomfort or skin burns...." Occupational Therapist #1 indicated they had used them several weeks, and Resident #33's pain was decreasing. She said the skin "was red immediately after, and had a white area. The area was warm immediately after the e-stim." She			

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	indicated she called her supervisor and told her what happened, her supervisor called the company to calibrate the machines, and they "locked the machines up and did not use them until they were calibrated." During an interview, on 1/31/14 at 12:04 p.m., Resident #33 indicated the area on her right shoulder has not hurt, it was "just one of those things", and she has been getting the treatments for awhile and has had no problems. The area on her right upper shoulder was covered with a small bandage, the resident pulled the neck of her top over an inch and the small bandage was visible. B. 1. Resident #J's record was reviewed on 1/28/14 at 3:55 p.m. The record indicated Resident #J was admitted with diagnoses that included, but were not limited to, anxiety, pain, agitation, decreased bowel motility, dementia, edema, hypothyroidism, high blood pressure, dementia with behavior disturbance, gastro esophageal reflux disease, depression, insulin dependent diabetes mellitus, high blood fats, insomnia, and degenerative osteoarthritis.			

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	A fall risk assessment dated 8/3/13 indicated a score of 10. The assessment indicated the resident was alert, chair bound, had no falls in the last 3 months, vision was adequate, was unable to participate in the gait balance assessment, and resident takes 3-4 meds on the medication list that could increase falls. A quarterly Minimum Data Set assessment (MDS), dated 6/5/13, indicated Resident #J had no falls since the last assessment. A care plan, dated 5/21/13, indicated: "Resident is at risk for falls D/T (due to) history or recent fall. Goals: Resident will have no injuries due to falls TNR (through next review). Interventions: Attempt to keep areas free of clutter. Keep call light in reach. Maintain T (toileting) time as indicated. Maintenance to check safety belt and all connections weekly. (8/3/13 fall) Monitor seatbelt every shift for proper functioning. (3/6/13) Notify and update MD as needed. Therapy screen as indicated, quarterly and prn (as needed). (5/21/13)" Progress Notes, dated 8/3/13 at			

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	7:00 a.m., indicated: "Heard noise. Looked toward sound and seen pt. (patient) on floor in front of w/c (wheel chair). alarm not sounding. Safety belt noted to be broken on L) side of w/c. ROM WNL (range of motion within normal limits) for pt. NO (new order) inversion of feet noted. Denied pain with ROM. Skin assessment with abrasions noted on R) brow area, R) elbow, and R) knee. No bleeding, just top layer of skin off. Maintenance notified and pt. transferred to bed while repairs made to w/c. Neuro checks initiated and WNL. 140/80 (blood pressure) 96 (temperature) 70 (pulse) 18 (respirations) 02 (oxygen saturations) - 94%. MD and [name of family member] notified of fall. CNAs to check safety belt and all connections and make sure alarm working when getting pt up." An "Incident Documentation and Investigation Tool", dated 8/3/13, indicated Resident #J had an unwitnessed fall on 8/3/13 at 7:00 a.m., and received abrasions on the right brow, right elbow, and right knee. The resident was leaning forward and fell from the wheel chair, and the seat belt alarm did not sound. Maintenance was called and came in and fixed the problem of the			

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	safety belt. A new intervention was added to the care plan to "check safety belt and all connections weekly' and a "therapy screen". On 1/31/14 at 12:06 p.m., the Corporate Nurse Consultant provided a copy of the treatment records dated August 2013. She indicated this was the documentation of the seat belt and alarm checks, for Resident #J, that staff had been doing. The documentation indicated the belt alarm and pressure alarm placement and function was checked every shift, the close call alarm placement and function was checked every shift, and the battery was changed on the 15th of each month. B. 2. Resident #111's clinical record was reviewed on 01/28/14 at 09:30 a.m. The record indicated Resident #111 was admitted with diagnoses that included, but were not limited to, bilateral subdural hematoma evacuated approx 01/28/13, seizure disorder, stroke, atrial fibrillation, organic brain syndrome, heart disease, history of chronic subdural			

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	hematoma, brain compression, urinary tract infection, dehydration secondary to E-coli (bacteria). A Fall Risk Assessment, dated 02/04/13, indicated resident's total score was 18, whereas a total score of 10 or above represents high risk. Resident Admission Assessment dated 02/04/13, indicated Resident #111 used a manual wheelchair, had an unsteady gait, was with diminished eyesight, was alert and oriented to self and confusion, and had a fall in the last 30 days. A plan of care, dated 05/03/13, "Potential for falls r/t new surroundings, impaired vision, impaired mobility, diagnosis: seizures recent falls, and noncompliance with interventions. Goals: will have no significant injury from falls TNR (till next review). Intervention (initiation date 06/26/13/revision date 11/18/13) do not leave in room unattended in w/c (wheelchair)". An "Incident Report " for Resident #111 was provided by the DoN, on 01/28/14 at 4:55 p.m. The report indicated, but was not limited to, nurse (LPN #12) was called to			

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	resident's room on 01/21/14 at 6:10 p.m., and found resident on floor by bed with back resting on bed and had been in his wheelchair. The resident indicated he was going to the bathroom to wash up. The resident was assessed/assisted to wheelchair and to bathroom to get washed up and neurological checks started. Resident #111 was brought up by the nurse's station after finished washing up and nurse (LPN #12) noted that "staff member educated ". During an interview, on 01/31/14 at 9:56 a.m., LPN #12 indicated that she was the nurse that went to resident #111's room on 01/21/14 at 6:10 p.m. She indicated that this fall happened right at shift change time and she heard alarm sounding and when she got to room she found resident as she noted in the incident report. She indicated that Resident #111 had been in his wheelchair when he attempted to get up and that he was alone in the room at the time. She indicated that the plan of care was not followed as resident was alone in room in the wheelchair. She did educate the staff person (a CNA) about the plan of care intervention (do not leave in room unattended in w/c).			

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	A "Care Plan intervention edit" , dated 01/21/14, was provided by the DoN, on 01/24/14 at 3:25 p.m. The document indicated a new intervention "to get resident up at 5:30 in the am clean up and bring to the lobby to wait for breakfast". A policy and procedure for "Fall Risk Management Program Falls, Identification of Residents at Risk For", was provided by the Administrator on 1/27/14 at 2:40 p.m. The policy indicated, but was not limited to, "Purpose: Too identify those residents who may be at risk for falls. Policy: Upon completion of the initial, annual, or significant change resident assessment, those residents who trigger the area of "Falls" shall be identified and evaluated for potentially needed intervention. Procedure...2. RAP (Resident assessment protocol) trigger analysis will identify those residents who are potentially at risk for falls...5. As necessary, the Fall Risk Assessment shall be completed and recommendations made for interventions accordingly. Interventions addressed could include but not limited to recommendations for the following:			

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	a. Psychological Evaluation/Psychoactive Medication Review b. Assessment for potential drug therapy interactions causing gait difficulty c. PT, OT evaluations...7. Interventions will be addressed on the individual plan of care." This Federal tag relates to Complaint IN00134516. 3.1-45(a)(2)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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. Based on record review and interview, the facility failed to ensure that one resident's drug regimen was free from unnecessary drugs, in that 1 of 5 residents reviewed for unnecessary drugs received a medication in excessive duration. (Resident #94). Findings include: Resident #94's record was reviewed on 1/30/2014 at 10:20 a.m.	F000329	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit a medication regimen that is free from unnecessary medications or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. A. ACTIONS TAKEN: 1. Resident #94 medication order was clarified with the MD. B. OTHERS IDENTIFIED: 1. A 100% audit was completed and no other residents were affected.	02/27/2014

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	Diagnoses included, but were not limited to, hypertension, anxiety, depression, and end-stage chronic obstructive pulmonary disease (COPD). The record indicated that Resident #94 was re-admitted to the facility on 12/5/2012, following hospitalization for shortness of air related to her end stage COPD and anemia. Admitting physician's orders, written on 12/5/2013, indicated, "Prednisone 20mg x 1 PO (by mouth) QD (every day) x 30 days." A review of the Medication Administration Record (MAR) and Physician's orders for 1/1/2014 - 1/31/2014 was conducted with RN #2, Resident #94's nurse, who confirmed that Prednisone 20mg x 1 was administered daily from 1/1/14 through 1/28/2014. She indicated, "That 'ASD' (written through the dates 1/29/2014, 1/30/2014, and 1/31/2014) means 'automatic stop date'." A monthly pharmacy medication review, dated 1/23/2014, indicated, "Pred (prednisone) - dx (diagnosis): resp. (respiratory) failure in COPD. Will begin taper soon".		C. MEASURES TAKEN: 1. Facility to review all new timed orders in the daily CQI meeting. 2. Nursing staff was re- in serviced on medication orders and procedures. 3. Pharmacist consultant was in facility on 2/12-13/14 and reviewed all records for timed orders and compliance. D. HOW MONITORED: 1. DON/Designee will monitor new timed orders daily in CQI meeting for compliance 2. Pharmacist consultant on monthly visit will audit and review for timed orders for compliance. 3. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	During an interview with the Director of Nursing (DoN) on 1/30/2014 at 10:40 a.m., she confirmed that the order had been written on 12/5/2013 and the medication started on 12/6/2014. She further indicated that there were no orders to continue the medication past 30 days and no documentation regarding the medication in physician progress notes, the last of which was observed to have been written 1/3/2014. The DoN further indicated that pharmacy should have picked up that the medication was being given in excessive duration and alerted the staff during the 1/23/2014 monthly pharmacy review. A copy of the facility policy and procedure "Drug Administration - General Guidelines", last reviewed 10/8/2013, was provided by the DoN on 1/30/2014 at 12:12 p.m. The procedure included, but was not limited to, the following: 1. "Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the drug container is marked with a sticker indicating a recent change in directions or if there is any other reason to question the dosage or			

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	direction, the physician's orders are checked for the correct dosage schedule." 2. "Medications are...administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility." During an interview with the DoN, Administrator, and Corporate Nurse Consultant on 1/30/2013 at 10:22 a.m., the DoN indicated that the facility did not follow their policy and procedure related to medication discrepancies for Resident #94. A copy of the "Medication Discrepancy" policy and procedure, last reviewed 10/8/2013, was provided by the DoN on 1/30/2014 at 12:12 p.m. It included, but was not limited to, the following: 1. "It is the intent of the facility that Medication/Treatment discrepancy is to be documented on the Medication Discrepancy Form." 2. "An error shall be defined as any variation in administration of medication from the physician's orders and/or facility protocol."			

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	3. "Report promptly all medication errors/drug reactions to the shift charge nurse/supervisor." 4. "Notify the physician/alternate physician, Director of Nursing and consulting pharmacist of all occurrences." 5. "The nurse responsible for or the person who discovers the error is to complete a Medication Discrepancy Form." On 1/31/2014 at 12:12 p.m., the DoN provided a completed copy of a "Medication Discrepancy Report", dated 1/31/2014 at 11:00 a.m. The document included, but was not limited to, the following: 1. "Employee discovering discrepancy: State Surveyor" 2. "The actual discrepancy: Prednisone was given longer than 30 days per order. Also prednisone not signed out on 12/21/13 and 12/30/13." 3. "How did you discover the discrepancy? During state survey." 4. "Corrective action taken: MD notified with order given to start Prednisone 10mg x 1 p.o. (by mouth) q.d. (every day) for maintenance dose." 5. "Physician notified: Dr. XXX / Dr. XXX. Date: 1/31/2014. Time: 11:00			

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	a.m." 6. "Employee(s) Responsible: XXX, LPN and XXX, LPN. Title: LPN." 7. "How did this discrepancy occur? During rewrites the stop date was not properly marked." 3.1-48(a)(2)			
F000353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			

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	Based on interview and record review, the facility failed to provide nurse staffing in sufficient numbers. This deficiency had the potential to impact all 101 residents residing in the facility. Findings include: During an interview with Resident #11, on 1/31/2014 at 11:10 a.m., she indicated, "I have the awfulest time getting someone to give me a shower on my shower nights. Just to give you an instance, last Wednesday night, I said to [CNA #30], 'Will you give me my shower tonight and she said 'Yes, Honey, I'll give you my shower'. Then she came to me during dinner and said, 'Honey I can't give you your shower tonight, [name of] (staffing coordinator) sent me home.' [CNA #30] said she was sent home because she had worked so many hours...We talk amongst ourselves all the time & say, 'Don't you wish you had a nurse you could depend on?...'Sometimes we have just one CNA on each end of this hall (2 for all 100's halls). Then sometimes there's two. There's been more since you all have been here...One night you'll have one and one night you'll have two, but when they heard	F000353	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. A. ACTIONS TAKEN: 1. Review of resident care needs and placement of nursing staff was implemented to ensure resident care needs are met. B. OTHERS IDENTIFIED: 1. All residents have the potential to be affected. No residents were determined to be negatively affected. C. MEASURES TAKEN: 1. The Director of Nursing or designee review resident care needs and place staff per needs of residents. The placement of staff and scheduling is reviewed with the staff member who handles nursing scheduling as needed and at a minimum one time weekly. 2. A Guardian Angel program is implemented to ensure resident concerns or needs are being addressed. The Guardian Angel Program is reviewed weekly in the morning meeting. D. HOW MONITORED: 1. Administrator will monitor daily staffing hours from HR report. Administrator will review hours	02/27/2014

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	you were coming, we were loaded with CNA's." During an interview with Resident #152 on 1/22/2014 at 3:11 p.m., she indicated there was not enough staff and stated, "These girls are covered up with all the patients they have. They need more help." When asked if the staff answered her call light in a timely manner, she indicated, "Sometimes they just don't come. I've had to go the bathroom and they just didn't get there in time. They need more help." During an interview with CNA #5 on 1/22/2014 at 3:02 p.m., she indicated that staffing is a "huge problem." She further indicated that there is often 1 CNA, 1 QMA, and one nurse left to care for 50 or more residents on a wing. She further indicated that the QMAs assist the nurses with medication passes and paperwork, so there is only one CNA for resident care. She indicated that it is not uncommon for aides to leave crying in the morning, every Friday is short-staffed, and that the facility "padded" staffing while IDSH was in the building. CNA further indicated that the Administrator indicated, "My axx is covered because the Q's are under CNA hours". Indicated		daily with DON and Staffing Coordinator. 2. Social Service will complete 2 resident interviews per week for 4 weeks till no negative findings then randomly thereafter. The Administrator will review the results of the interviews weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of any ongoing monitoring E. The plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	repeatedly that QMA's are counted as aides, but assist RNs and don't act as aides. "If you come in at night, you'll see it." During an interview, on 1/24/2014 at 11:45 a.m., with LPN #3, she indicated, "There's usually one nurse for each side of the 100's and 2 CNA's for each side (4 total)." She further indicated that staffing is adequate "most of the time." She further stated, "Wednesday (1/22/2014) was the exception. We only had one nurse and one CNA for both sides/all of wing 1." During an interview with (restorative) CNA #4 on 1/24/2014 at 11:38 a.m., she indicated that the restorative care staff also answer call lights and toilet residents, but that they generally do get their resident care assignments done. During an interview, on 01/24/14 at 11:19 a.m., Resident #32 indicated: "Sometimes I have to wait a long time to get changed. We need more staff. When I need changed, it is sometimes a half hour or longer wait and this is every day at least 3 times a day ". During an interview on 01/23/14 at 3:42 p.m., Resident #114 indicated,			

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	"They need more help around here, if I have to go to bathroom, I have had to wait at least 15 to 20 minutes. That is hard to do when you have to pee. This can happen 3 to 4 times a day. There is no help on the floor and staff are at their lunch". A "Resident Census and Condition of Residents" was provided by the Director of Nurses on 1/22/14 at 2:54 p.m. The census and condition indicated a total of 101 residents residing in the facility, 1 was bedfast all or most of the time, 71 were in chairs all or most of the time, 37 ambulated with assistance or assitive device, 59 were occasionally or frequently incontinent of bladder, and 41 were occasionally incontinent of bowel. This Federal tag relates to complaint IN00132248. 3.1-17(a)			

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to prepare, and serve food under sanitary conditions, by ensuring proper hand washing during meal preparation and meal service for 2 of 2 meal observations. This deficient practice had the potential to affect 100 of 101 residents residing in the facility. Findings include: During a kitchen observation on 01/22/14 at 11:53 a.m., the Dietary Manager (DM) was observed to scrub her hands for 6 seconds. During a dining room observation on 01/22/14 at 12:15 p.m., all of the following observations occurred. The DM was observed twice to scrub her hands with soap for 6 seconds before assisting with serving meals. CNA# 8 was	F000371	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that store, prepare, distribute and serve food under sanitary conditions. A. ACTIONS TAKEN: 1. Stated employees on 2567 were in service and observed 1:1 by nursing on hand washing for compliance. B. OTHERS IDENTIFIED: 1. All have the potential to be affected. Those residents were not determined to be negatively affected. C. MEASURES TAKEN: 1. All staff in-serviced on the facility Hand Hygiene Policy 2. The Director of Nursing or Designee will monitor five (5) staff members a week for two (2) weeks then four (4) staff members a week for two (2) weeks then one (1) staff member per week. Any negative findings will be immediately corrected and proper hand washing techniques will be immediately provided to that staff	02/27/2014

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	observed to scrub her hands with soap for 5 seconds on one observation and for 4 seconds on another observation before assisting with serving meals. CNA #9 was observed to scrub her hands with soap for 8 seconds on one observation and for 5 seconds on another observation before assisting with serving meals. The Staffing Coordinator was observed to scrub her hands for 5 seconds with soap before assisting with serving meals. The Activity Director was observed to use her hand to turn off the water faucet and proceed to assist with serving meals. The ADoN was observed to scrub hands with soap for 5 seconds before assisting with serving meals. During a kitchen observation on 01/30/14 at 11:15 a.m., Dietary Aide #18 was observed to scrub her hands with soap for 5 seconds before returning to working with clean serving ware. Dietary Aide #20 was observed to scrub her hands with soap for 5 seconds before returning to working with clean serving ware. The DM was observed to scrub her hands with soap for 12 seconds on 1 observation, for 10 seconds on another observation, and for 5		member D. HOW MONITORED: 1. Director of Nursing or designee will review the monitoring of handwashing daily in the morning meeting with walking rounds sheet by IDT memebers and any trending identified will result in further preventative actions being taken to ensure proper hand hygiene practices. Results will be monitored and reviewed at the monthly QA Meeting for determination of any ongoing monitoring E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	seconds on another observation. During a kitchen observation on 01/31/14 at 10:25 a.m., Dietary Aide #19 was observed to scrub her hands with soap for 6 seconds before returning to working with clean serving ware. In an interview with the DM, Cook #21, and Dietary aide #19 on 01/3/4 at 10:30 a.m., they indicated that hand washing in the kitchen is to be done for 15 to 20 seconds. On 01/31/14 at 11:00 a.m., Rehab Aide #22 indicated that she sings the "ABC " song 3 times for the length of hand washing time. A policy for "Hand Hygiene" received on 01/27/14 at 2:40 p.m., from the Administrator indicated, but was not limited to, "...Hand Washing Procedure...3. Apply 3-5cc of soap to hands and rub hands together vigorously for at least 20 seconds...5. Use towel to turn off faucet...." A procedure titled "Glove and Hand Washing Procedures" received on 01/31/14 at 9:08 a.m., from the Administrator indicated, but was not limited to, "...Procedure:..2...c.			

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	Scrub 15 to 20 seconds or more: getting under nails, between fingers, and all exposed areas, such as back of hands and forearms ...." 3.1-21(i)(3)			
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure that the pharmacist report any irregularities to the attending physician and the Director of Nursing for 1 of 5 residents reviewed for unnecessary drug use. (Resident #94). Findings include: Resident #94's record was reviewed on 1/30/2014 at 10:20 a.m. Diagnoses included, but were not limited to, hypertension, anxiety,	F000428	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that review's the medication regimen at least once a month by a licensed pharmacist and report any irregularities. A. ACTIONS TAKEN: 1. Resident #94 MD was notified with clarification order received. B. OTHERS IDENTIFIED: 1. 100% audit was completed and no other residents were identified. 2. MEASURES TAKEN: 1. Pharmacist consultant was in facility on 2/12-13/14 and reviewed all	02/27/2014

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	depression, and end-stage chronic obstructive pulmonary disease (COPD). The record indicated that Resident #94 was re-admitted to the facility on 12/5/2012, following hospitalization for shortness of air related to her end stage COPD and anemia. Admitting physician's orders, written on 12/5/2013, indicated, "Prednisone 20mg x 1 PO (by mouth) QD (every day) x 30 days. A review of the Medication Administration Record (MAR) and Physician's orders for 1/1/2014 - 1/31/2014 was conducted with RN #2, who confirmed that the medication was administered daily from 1/1/14 through 1/28/2014. She indicated, "That 'ASD' (written through the dates 1/29/2014, 1/30/2014, and 1/31/2014) means 'automatic stop date'." A monthly pharmacy medication review, dated 1/23/2014, indicated, "Pred (prednisone) - dx (diagnosis): resp. (respiratory) failure in COPD. Will begin taper soon". During an interview with the Director of Nursing (DoN) on 1/30/2014 at 10:40 a.m., she confirmed that the		records for timed orders and compliance 2. Facility to review new timed orders to daily CQI meeting for compliance. 3. Pharmacist was re-in serviced on timed orders, review and reporting to the facility. 4. Facility has in-serviced nursing staff of medication administration on timed orders. 3. HOW MONITIORED: 1. DON/Designee will monitor timed orders daily in CQI meeting for compliance. 2. Pharmacist will review timed orders during monthly visits. Pharmacist will exit with DON monthly and report any findings of timed orders discrepancies. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring 3. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	order had been written on 12/5/2013 and the medication started on 12/6/2014. She further indicated that there were no orders to continue the medication past 30 days and no documentation regarding the medication in physician progress notes, the last of which was observed to have been written 1/3/2014. The DoN further indicated that pharmacy should have picked up that the medication was being given in excessive duration and alerted the staff during the 1/23/2014 monthly pharmacy review. A copy of the "Consultant Pharmacy Services Provider Agreement" was provided by the Director of Nursing (DoN) on 1/30/2014 at 12:12 p.m. The procedure indicated that the pharmacist responsibilities included, "...Communicating to the responsible physician potential or actual problems detected related to medication therapy." 3.1-25(i)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed	F000431	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that employs and obtains the services	02/27/2014

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	to ensure medications were stored in clean medication carts for 2 of 4 medication carts, 2 of 2 observations, and had the potential to affect 80 residents residing on the 200 hallway and the Transistional Care Unit. Findings include: On 1/31/14 at 3:23 p.m., with QMA #14, the following was observed in the medication cart on the 200 hall: - The second large drawer, from the top, had 4 rows of medication cards, and under the medication cards, scattered on the bottom of the drawer were 23 pills of different sizes, shapes, and colors. - The third large drawer from the top had 4 rows of medication cards, and scattered under the medication cards were 41 pills, and 3 half pills. - The bottom drawer had a white powder substance around the perimeter of the drawer, 2 tablets, identified by the QMA as Tums, in the left hand corner, and 2 orange colored rings on the right side. QMA #14 indicated, at that time, the white powdery substance "was probably Miralax", and the orange rings were "probably from the Dilantin bottles." A Dilantin bottle was observed to have dried orange lines down the		of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation. A. ACTIONS TAKEN: 1. Medication carts were immediately cleaned by nursing staff in accordance to facility's Policy and Procedure on Cart Maintenance and Medication Storage in the Facility. B. OTHERS IDENTIFIED: 1. 100% audit was completed on all carts and carts were cleaned. C. MEASURES TAKEN: 1. Nursing was in-serviced on Facility's Policy and Procedure of Cart Maintenance and Medication Storage Medication and will monitor using facility's audit tool. Carts have been cleaned nightly by nursing staff in accordance to facility's Policy and Procedure on Cart Maintenance and Medication Storage in the Facility. Facility received 2 larger medication carts. D. HOW MONITORED: 1. Night nursing staff will clean medication carts nightly and monitor with facility's audit tool. The DON/Designee will observed a medication cart two (2) times a week for four (4) weeks then weekly for two (2) weeks, then monthly thereafter. 1. DON/Designee will review facility's audit tool daily to ensure Policy and Procedure is followed. Any inconsistent results will be immediately clarified and	

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	length of the bottle. On 1/31/14 at 3:47 p.m., with RN #15, the following was observed in the medication cart on the Transitional Care Unit (TCU): - The second drawer from the top had 24 pills and one half pill scattered under the medication cards, and rubber bands, foil from the medication punch cards, and small paper debris. - The third drawer from the top had 23 and 1/2 pills scattered in the bottom and had rubber bands, foil from the medication punch cards, and small paper debris. RN #15 indicated they "would just destroy the pills because they don't know what they are." On 1/31/14, at 4:06 p.m., the DoN, with the Corporate Nurse Consultant present, indicated they have 1 medication cart on the 200 hall, 2 on the 100 hall, and 1 on the TCU. The DoN indicated night shift is supposed to clean them every evening, and the pills they found would not be considered misappropriation of the resident's property and would be destroyed. On 1/31/14, at 4:32 p.m., the DoN indicated that the cards the pills are		corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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	in don't seem to be sturdy enough, and when they are pulled in and out of the med cart, the pills fall out. She provided the policy for Preventative cart maintenance but indicated she could not find any daily cleaning schedule for the medication carts. A Policy and Procedure for "Preventative Cart Maintenance", with a last updated review of 2/11/2013, indicated, but was not limited to: "Policy: The medication cart(s) will be kept clean and in good operating condition at all times. Procedure: 1. The facility will develop and implement a daily cleaning schedule for the medication cart(s)...." 3.1-25(o)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented in that a physician's order for a medication listed on the Medication Administration Record (MAR) was not obtained. This affected 1 of 1 resident of 37 residents reviewed for clinical records. (Resident #N) Findings include: Resident #N's record was reviewed on 01/29/14 at 3:30 p.m. The record indicated Resident #N was admitted with diagnoses that included, but were not limited to, acute cerebrovascular accident with right) sided weakness, insulin dependent diabetes mellitus with poor control,	F000514	The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. A. ACTIONS TAKEN: 1. Resident #N's Medical Director was notified of continued medication administration with no order and medication was removed from documentaion. A complete (100%) audit of medication orders has been completed by one nurse. B. OTHERS IDENTIFIED: 1. A complete (100%) audit of medication orders has been completed. No other residents were affected. C. MEASURES TAKEN: 1.	02/27/2014

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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS THE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250	

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	diabetic neuropathy, morbid obesity, chronic obstructive pulmonary disease, chronic lumbar syndrome, chronic degenerative disk disease, coronary artery disease with history of coronary artery bypass graft, atrial fibrillation, heart valve replacement with prosthetic heart valve, hypothyroidism, history of smoking, history of urinary tract infections, anxiety, and decreased hearing. During record review, "Trazodone 50mg take 1 tablet by month 1 to 2 hours before bedtime as needed for sleep" and "Trazadone 100mg take 2 tablets by mouth 1 to 2 hours before bedtime as needed for sleep" were handwritten onto the 01/01/2014 through 01/31/2014 medication administration record MAR) with an order date of 09/26/13. The 12/01/13 through 12/31/13 MAR had "traZODone CL-50MG-TABS TAKE 1 TO 2 TABLETS BY MOUTH 1 TO 2 HOURS BEFORE BEDTIME AS NEEDED FOR SLEEP PRN" dated 09/26/13. A phone order dated 01/20/14 for "Zolpidem 10mg take 1 tablet by mouth at bedtime PRN (DX: Insomnia)" was also indicated. Physician's recapitulation orders for 01/01/2014 through 01/31/2014 did		During rewrites each month nursing staff will review all orders in relation to medications. 2. Facility's licensed pharmacist will check all current medication orders every month for current, correct orders. 3. Nursing staff will be in-serviced that all medications will have current, correct medication orders. D. HOW MONITORED: 1. Facility's licensed pharmacist will audit all records during visits for orders monthly and exit with DON any discrepancies. 2. DON/Designee will review all new orders in the daily CQI meeting for completeness. 3. Rewrites will be completed per the policy and procedure. 4. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring E. This plan of correction constitutes our credible allegation of compliance with regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/31/2014
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	not show any orders for Trazodone. The 11/01/13 through 11/30/13 physician's recapitulation orders indicated an order dated 09/26/13 for "traZODdone HCL-50MG-TABS take 1 to 2 TABLETS-(50MG TO 100MG) BY MOUTH 1 TO 2 HOURS BEFORE BEDTIME AS NEEDED FOR SLEEP PRN" that had 2 crossed lines/error written over the order. No order for trazadone was found on admission orders, any other physician's recapitulation orders, any phone order sheet, or any other MAR for Resident #N. During an interview with LPN#11 on 01/29/14 at 4:30 p.m., LPN #11 reviewed Resident #N's record and indicated that was unable to find an order for the trazadone. LPN#11 notified the DON by phone and checked the medication cart and did not find a medication card for trazodone for Resident #N. LPN #11 also checked the MAR's for Resident #N and did not find that any trazodone had ever been documented as being given to Resident #N. She also indicated that Resident #N had recently asked for his scheduled ambien for insomnia be changed to PRN as he was not having much of an issue			

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	with insomnia now. A [Name of Pharmacy] fax copy of a handwritten phone order dated 09/26/13 with resident #N's name and birthdate indicated trazodone 50mg 1 to 2 tablets 1-2 hours before bedtime PRN for sleep was provided by the DoN on 01/29/14 at 5:27 p.m. The DoN indicated that there was no order for the trazodone in the Resident #N's record, no medication card for trazodone for Resident #N, and that Resident #N had not received any trazodone. She indicated that she would try to find out further if the Dr's. office may have called this into the pharmacy and did not notify the facility. A "Quality Review, LLC Resident Care Manual Guideline" with an issue date of 07/01/11, was provided by the the Administrator on 01/30/14 at 10:21 a.m. The Guideline: It is the intent of the facility for orders received via telephone from a physician to be written immediately on a telephone order form and co-signed by physician within the required time...Procedure...5. When applicable, a telephone order must be immediately transcribed to the Medication Administration Record (MAR) if the order was for a			

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	medication...." During an interview on 01/30/14 at 11:47 a.m., the DoN indicated that there was no follow up information from the physician's office about any phone order called by the physician's office to the pharmacy. 3.1-50(a)(1) 3.1-50(a)(2)			