

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit was for the Investigation of Complaint IN00154062.</p> <p>Complaint IN00154062-Substantiated. Federal/State deficiencies related to the allegations are cited at F281, F282, F285, F323, F332, F333 and F366.</p> <p>Survey dates: August 17,18,19, &amp; 20, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team; Janet Adams, RN-TC (August 17,19, &amp; 20, 2014 Regina Sanders, RN (August 18,19, &amp; 20, 2014)</p> <p>Census bed type: SNF/NF: 85 NCC: 1 Total: 86</p> <p>Census payor type: Medicare: 11 Medicaid: 55 Other: 20 Total: 86</p>	F000000		

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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F000281 SS=D	<p>Sample: 22</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.1-3.1.</p> <p>Quality review completed on August 26, 2014, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to ensure professional standards of quality were followed related to administration of an incorrect dose of a narcotic medication for 1 of 3 residents reviewed for narcotic medication in the sample of 22. (Resident #G) (RN #2)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 8/19/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer Disease,</p>	F000281	<p><b>F281 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified:</b></p>	09/15/2014

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	<p>depressive disorder, congestive heart failure, and high blood pressure.</p> <p>The 7/29/14 Minimum Data Set Quarterly Assessment indicated the resident's cognitive skills were severally impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment also indicated the resident had no nonverbal signs of pain.</p> <p>Review of a 8/1/14 initial Incident Report Form indicated the resident was given the wrong dose of Morphine Sulfate (a narcotic medication) in error by RN #2 on 7/31/14 at 11:45 p.m. The form indicated the resident was sent to the hospital Emergency Room and returned to the facility.</p> <p>Review of a 8/5/14 final Incident Report Form indicated the Physician was interviewed and verified the order was for Morphine Sulfate one milligram as needed every hour for pain. The form also indicated RN #2 was interviewed and said she had given 1 ml (milliliter) of Roxanol (a liquid form of Morphine) to the resident on 7/31/1/4 at 11:45 p.m.</p> <p>The 7/2014 MAR (Medication Administration Record) was reviewed.</p>		<p><b>Resident G has been discharged from the facility.</b></p> <p><b>2) How the facility identified other residents: All residents that receive narcotic pain medication are at risk to be affected. All narcotic count sheets reviewed to identify those residents that receive narcotic pain medications.</b></p> <p><b>3) Measures put into place/ System changes: Narcotic Count Sheets for 5 residents will be reviewed weekly by DON or designee to ensure that the correct dosage has been administered. Any discrepancies will be documented and addressed per policy with the individual that made the error. DON or designee will be responsible for oversight of these audits. Nurses have been re-educated on the Rights of Medication Administration. A conversion document for Roxanol 20 mg/ml has been placed in each Medication Administration Book. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</b></p>		

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	<p>The MAR indicated a dose of Morphine Sulfate 1 milligram and a dose of Ativan (no dose listed) were signed out as given once on 7/31/14. The back page of the MAR indicated on 7/31/14 Morphine and Ativan were given at 11:45 p.m.</p> <p>A Medication Error Report was completed on 8/1/14. The Report indicated Roxanol 1 milligram was ordered and Roxanol 20 milligrams was given on 7/31/14 at 11:45 p.m. The Report indicated the Nurse who administered the incorrect dose of the medication" failed to perform medication verifications per standards of practice ..."</p> <p>The 8/1/14 hospital "Emergency Documentation" records were reviewed. The records indicated the resident presented with an accidental overdose and the substance ingested was Morphine and 20 milligrams was possibly given at the nursing home. The records indicated Narcan (a medication to reverse the negative effects of Morphine) 2 milligrams was given by EMS pre-arrival to the hospital. Physical exam of the resident noted the resident was unresponsive, her pupils were pinpoint, and her respirations were non-labored.</p> <p>When interviewed on 8/19/14 at 9:10 a.m., the DON (Director of Nursing)</p>			

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	<p>indicated there was a medication error for Resident #G. The DON indicated on 7/31/14 at 11:45 the resident was given Roxanol at the incorrect dose. The DON indicated RN #2 was working the Evening shift on 7/31/14 and an Agency Nurse was working the Night shift. The DON indicated RN #2 obtained the order from the Physician on 7/31/14 and did not initially write the Physician's order on an order form. She wrote the order on a Fax Reorder Form to send to Pharmacy to get the order. The DON indicated the Morphine Sulfate 1 milligram every one hours as needed for pain or SOB (shortness of breath) was written on the Fax Reorder form sent to Pharmacy. The DON indicated RN #1 administered a dose of Roxanol 20 milligrams on 7/31/14 at 11:45 p.m. The DON indicted the medication had to be obtained from the Pixis (a locked supply of medications in the facility). The DON indicated Agency Nurses were not allowed to access the Pixis system.</p> <p>Continued interview with the DON on 8/19/14 at 9:10 a.m. indicated an Agency Nurse came in to care for the resident on the night shift. On that shift the Agency Nurse noted the resident didn't look right and then also noted later the bottle of Roxanol marked as having 29 ml's left of a total of 30 ml's when first obtained</p>			
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	<p>from facility supply. The Agency Nurse attempted to call the Physician on call and then called the Medical Director and orders were obtained to send the resident to the hospital.</p> <p>The Indiana State Board of Nursing Statue for RN's indicated the following: Rule 2. Registered Nursing: 848 IAC 2-2-3, Section 3 indicates "nursing behaviors failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors include, but are not limited to the following: (1) Using unsafe judgement, technical skills, or inappropriate interpersonal behaviors in providing nursing care."</p> <p>The Nursing 2010 Drug Handbook listed the "rights" of medication administration. The third right was identified as the right dose. The right dose included verifying that the dose of medication and form of the medication was appropriate for the patient, and check the drug label with the prescriber's order.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-35(g)(1)</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>Based on observation, record review, and interview, the facility failed to follow Physician's orders and care plans, related to medications and nutrition, for 3 of 22 residents reviewed for Physician's orders and care plans in a total sample of 22 (Residents #B, #C, and #M)</p> <p>Findings include:</p> <p>1. During an interview on 08/18/14 at 11:50 a.m., Resident #M, indicated she is served pork and she is unable to eat pork because it hurts her stomach. She indicated the staff does not always offer other food. She indicated she would like smaller portions at lunch and would also like soup.</p> <p>During an observation of the noon meal on 08/18/14 at 12:26 p.m., Resident #M received ham, green beans, stuffing, and cake. During an interview with the</p>	F000282	<p><b>F282 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.</b></p> <p><b>1.Immediate actions taken for those residentsidentified: ResidentM food preferences were reviewed and care plan updated to reflect currentpreferences. ResidentB had no adverse effects from missed doses of medication. Physician and family notified of misseddoses. Responsible nurse wasdisciplined.</b></p>	09/15/2014

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	<p>resident at the time of the observation, she indicated the CNA who had delivered the tray had not offered her a replacement for the ham. She indicated the CNA told her not to eat the ham if she did not want it.</p> <p>During an interview on 08/18/14 at 12:30 p.m., the Activity Director indicated there was ham on the resident's tray. She then asked the resident if she would like something else and the resident indicated she would like soup.</p> <p>During an interview on 08/18/14 at 12:36 p.m., CNA #1 indicated the resident did not want the ham which was served. CNA #1 indicated she did not know there were other choices. She indicated she did not offer a replacement for the ham.</p> <p>Resident #M's record was reviewed on 08/18/14 at 12:54 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy and neurogenic bladder.</p> <p>A care plan, dated 07/28/14, indicated the resident had a nutritional risk related to a therapeutic diet. The approaches included, soup/fresh fruit daily at lunch, offer available substitutes, and honor food preferences.</p> <p>2. Resident # B's record was reviewed on</p>		<p><b>ResidentC had no adverse effects from missed doses of medication. Physician and family notified of misseddoses. Responsible nurse wasdisciplined.</b></p> <p><b>1.How the facility identified otherresidents: August2014 MAR/TAR reviewed for any missed doses. Medication carts were checked for any doses left in the cart. All identified will have a Medication ErrorReport completed including physician and family notification. All affected residents will be monitored foradverse effects. Allresidents receiving an oral diet have the potential to be affected. Resident preferences will be reviewed by theDietary Manager or designee. Tray cardsand care plans will be updated to reflect preferences as indicated.</b></p> <p><b>3) Measures put intoplace/ System changes: Nurses and QMAS have been re-educated on the Rights of MedicationAdministration. MAR/TAR for a minimum of 5 residents will be reviewed weekly. Any discrepancies will be addressed perpolicy. Responsible Nurse or QMA will beeducated and counseled as appropriate. DON or designee will be responsible for</b></p>		

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	<p>08/18/14 at 10:21 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease with behaviors and hypertension.</p> <p>A Physician's Telephone Order, dated 07/04/14, indicated an order for Probiotic (supplement), one capsule twice a day for seven days.</p> <p>The Physician's Recapitulation Orders, dated 07/14, indicated an order 12/01/11 for Aricept (Alzheimer's medication), 10 mg (milligram) at bedtime and 02/07/12 Seroquel (antipsychotic) 25 mg at bedtime.</p> <p>The Medication Administration Record (MAR), dated 07/14, had no initials to indicate the Probiotic was given as ordered on 07/06/14 and 07/07/14 at 4 p.m., the Aricept and Seroquel was given on 07/07/14 at 8 p.m., and the Aricept was given on 07/28/14 at 8 p.m.</p> <p>A Medication Error Report, dated 07/30/14 indicated the date of the errors were 07/07/14 and 07/26/14 (sic) and the medications were found, still in their package, in the return to the pharmacy bin in the medication cart.</p> <p>3. Resident #C's record was reviewed on 08/18/14 at 10:32 a.m. The resident's</p>		<p><b>oversight of these audits. Staff that assist in the Dining Rooms will be re-educated on the need to check the tray card for dislikes and check the tray to ensure that residents are not being served foods that they dislike. Alternates will be offered and provided. A minimum of 5 resident trays will be checked weekly at varied meals and dining locations to ensure that they are not receiving dislikes and that alternates are offered and provided. Administrator or designee will be responsible for oversight of these audits.</b></p> <p><b>4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</b></p>				

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	<p>diagnoses included, but were not limited to, dementia, osteoarthritis, hyperlipidemia, and chronic obstructive pulmonary disease.</p> <p>The Physician's Recapitulation Orders, dated 07/14, indicated the following orders: 01/22/14-acetaminophen 650 mg, one tablet at bedtime 01/22/14-atorvastatin (cholesterol medication), 20 mg, one tablet at bedtime 01/22/14-Sertraline (antidepressant), 100 mg, one tablet at bedtime 01/22/14-Advair (breathing medication), inhale one puff twice daily.</p> <p>The MAR, dated 07/14, indicated by initials, on 07/07/14, the acetaminophen was administered as ordered at 8 p.m. and the Sertraline and atorvastatin were administered as ordered at 9 p.m.</p> <p>A Medication Error Report, dated 07/30/14, indicated the 07/07/14 bedtime medications of acetaminophen, Sertraline, and atorvastatin were found unopened, in the return to pharmacy bin.</p> <p>The Medication Administration Record (MAR), dated 07/14, had no initials to indicate the Advair was administered as ordered on 07/09/14, 07/22/14, 07/27/14, and 07/28/14. The MAR had no initials</p>			

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F000285 SS=D	<p>to indicate the atorvastatin was administered as ordered on 07/28/14.</p> <p>During an interview on 08/19/14 at 8:28 a.m., the Timbre Unit Manager indicated she had been aware the medications had not been administered to the residents as ordered and she documented the errors on a Medication Error Report and submitted the report to the Director of Nursing.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-35(g)(2)</p> <p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI &amp; MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health</p>				

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	<p>authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>Based on record review and interview, the facility failed to coordinate assessments with the Pre-admission Screening at the time of admission for 2 of 3 residents reviewed for pre-admission screening in the sample of 22. (Residents #C and #J)</p> <p>Findings include:</p>	F000285	<p><b>F285 The facility requestspaper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the</b></p>	09/15/2014

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	<p>1. Resident #C's record was reviewed on 08/18/14 at 10:32 a.m. The resident's diagnoses included dementia and hypertension.</p> <p>The resident was admitted into the facility on 01/21/14 from another long term care facility.</p> <p>There was a lack of documentation to indicate a Pre-admission Screening had been completed upon admission into the facility.</p> <p>2. Resident #J's record was reviewed on 08/19/14 at 8:50 a.m. The resident's diagnoses included, but were not limited to, dementia and major depression.</p> <p>The resident was admitted into the facility on 01/14/14 from an acute care hospital.</p> <p>There was a lack of documentation to indicate a Pre-admission Screening had been completed upon admission into the facility.</p> <p>During an interview on 08/19/14 at 9:09 a.m., the Admissions Coordinator indicated it does not matter what the resident's payment status was, a Pre-admission Screening had to be</p>		<p><i>statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and statelaw. 1) Immediate action taken for those residents identified: Pre-Admission Screening for Residents C and J have been submitted. 2) How the facility identified other residents: Audits of resident files to ensure that Pre-Admission Screening is complete. 3) Measures put into place/ System changes: Each new admission record will be audited to ensure that Pre-Admission Screening documents are completed and submitted timely. Audit/Log will be updated with each new admission. Any discrepancies will have Pre-Admission Screening documents completed and be submitted immediately. Business Office Manager and Administrator will be responsible for the oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</i></p>		

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F000323 SS=D	<p>completed for all residents who were admitted into the facility. She indicated a Pre-admission Screening had not been completed on Resident #C and Resident #J.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-16(d)(1)(A) 3.1-16(d)(1)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to transferring a resident without non-skid footwear, non skid floor strips not in place, and monitoring a resident with new onset of wandering for 2 of 3 residents reviewed for falls and 1 of 1 residents reviewed for elopements in the</p>	F000323	<p><b>F323 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The</b></p>	09/15/2014

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	<p>sample of 22. (Residents #P, #R, &amp; #V) (CNA #3)</p> <p>Findings include:</p> <p>1. During orientation tour on 8/17/14 at 4:45 a.m., LPN #5 indicated Resident #V had a recent fall and a right wrist fracture. The resident was observed asleep in bed. There was a bed alarm in place.</p> <p>The resident's bathroom was observed on 8/20/14 at 8:25 a.m. The bathroom in the resident's room was checked. There was one non-skid skid strip on the floor in front of the toilet. There were no non-skid strips in place on the floor in front of the bathroom sink.</p> <p>The record for Resident #V was reviewed on 8/19/14 at 12:14 p.m. The resident's diagnoses included, but were not limited to, dementia, anxiety disorder, edema, and peripheral vascular disease.</p> <p>Review of the 7/30/14 Minimum Data Set Quarterly Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The Assessment also indicated the resident</p>		<p><i>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate action taken for those residents identified: Resident V's care plan reviewed and all interventions put into place. CNA information sheet updated to include all interventions. Resident R's care plan was reviewed and updated to include use of non-skid footwear when up. CNA information sheet updated to include use of non-skid footwear when up. Resident P care plan reviewed to ensure that all needed interventions in place. Resident had been assessed, placed on 15 minute checks, wander-guard bracelet applied and was transferred to the secured Dementia Unit. Resident is currently residing on a secured Dementia Unit. 2) How the facility identified other residents: Elopement Risk Assessments will be completed for all residents to determine if any other residents are at risk. Any residents that are found to be at risk for elopement will have appropriate interventions implemented and care plans will be updated accordingly. All residents Fall Prevention/Risk Care Plans will be reviewed and updated to ensure that all appropriate</i></p>		

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	<p>was able to walk in his room.</p> <p>A Fall Risk Assessment completed on 7/31/14 indicated the resident's score was (17). A score of (15) or higher indicated the resident was at high risk for falls. The assessment indicated the resident had diminished safety awareness and had 1-2 falls in the past three months.</p> <p>A Fall Risk Assessment completed on 8/7/14 indicated the resident's score was (16). A score of (15) or higher indicated the resident was at high risk for falls. The assessment indicated the resident had (3) or more fall in the past three months and had balance problems while standing.</p> <p>A Care Plan initiated on 7/27/14 indicated the resident was at risk for falls related to weakness and a cognitive deficit. A care plan intervention for non skid strips to be applied to the bathroom floor in front of the toilet and in front of the sink was added on 8/11/14.</p> <p>The 7/2014 Nursing Progress Notes were reviewed. An entry made on 7/30/14 at 7:20 a.m. indicated at 7:00 a.m., the CNA informed the Nurse she had heard a noise coming from the resident's bathroom and found the resident on the floor in the bathroom in front of the sink. Reddened swelling was observed to the resident's</p>		<p><b>interventions are in place. 3) Measures put into place/ System changes: Staff will be re-educated that if a resident is seen wandering and/or exit seeking that new interventions must be implemented immediately and documented after each wandering/exit seeking episode. Staff will be re-educated regarding plan of care for fall prevention interventions and proper safety precautions during transfers. All progress Notes will be reviewed 5 days per week during Clinical Review Meeting to identify any residents exhibiting wandering or exit seeking behaviors and to ensure that new interventions were implemented right away. A minimum of 5 residents will be observed per week on varied shifts to ensure that safety interventions are in place and plan of care is followed, including observation of transfers. DON or designee will be responsible for the oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</b></p>	

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	<p>forehead on the right side and neurological checks were started. The entry also indicated the Nurse asked the resident what happened and he stated "I felt faint." The Physician was called and request an order to check the resident's blood pressure every shift for 72 hours while the resident was standing and laying down. An order for PT (Physical Therapy) and OT (Occupational Therapy) to see the resident was also requested. Continued review of the 7/2014 Nursing Progress Notes indicated the resident had no further falls after the 7/30/14 fall.</p> <p>The 8/2014 Nursing Progress Notes were reviewed. There was no documentation of the resident having any falls 8/1/14 thru 8/6/14. An entry made on 8/2/14 at 7:36 a.m. indicated the resident complained of pain to the right hand and arm. No swelling or bruising was noted. PRN (as needed) Tylenol 500 milligrams one tablet was given. An entry made on 8/2/14 at 8:00 a.m. indicated the resident c/o pain was 0/10 at this time. An entry on 8/2/14 at 10:27 a.m. indicated the resident had no complaints of pain and had AROM (Active Range of Motion) to all extremities and ambulated to meals without difficulty.</p> <p>Continued review of the 8/2014 Nursing Progress Notes indicated an entry was</p>			

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	<p>made on 8/5/14 at 11:25 a.m. The entry indicted the resident's right hand/wrist area appeared swollen and upon hyperflexing of the hand the resident stated the area hurt. The Physician and POA (Power of Attorney) were notified. An entry made on 8/5/14 at 1:45 p.m. indicated orders were received for a right hand X-ray to be completed.</p> <p>The results of the right hand X-ray report were reviewed. The report indicated the X-ray was completed on 8/5/14. The report indicated there was a minimally displaced intra-articular fracture of the distal radial (arm bone) metaphysis and epiphysis with no dislocation.</p> <p>Review of the 8/6/14 facility Incident Report Form indicated the resident complained of right/ hand wrist area pain on 8/5/14. The resident was assessed by the Nurse and swelling to the right hand/wrist area was observed. The Physician was notified and an X-ray was ordered and done on 8/5/14. The X-ray results were received on 8/6/14. The X-ray showed a minimally displaced intra-articular fracture of the distal metaphysis. The resident was interviewed and stated he was "getting sleepy in the toilet, I went boom off the john and hit my wrist." The resident denied anyone being rough or mean with</p>			

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	<p>him. The resident had a previous fall. The resident's last fall was on 7/30/14 and no injury to the wrist/hand was noted at that time. The resident performs most ADL's (Activities of Daily Living) independently. Staff interviews were completed and no staff observed any changes until 8/5/14.</p> <p>When interviewed on 8/20/14 at 9:15 a.m., the Director of Nursing indicated the resident had a recent fracture. The Director of Nursing indicated the non-skid strips should have been in place as per the care plan.</p> <p>2. On 8/17/14 at 5:28 a.m. CNA #3 was observed preparing to render AM care to Resident #R. The resident was in bed, a bed alarm was in place and floor mats were in place on both sides of the resident's bed. The CNA removed the resident's bed sheet. The resident did not have any socks or slippers on. The CNA removed a pair of plain white socks from the resident's dresser draw and placed them on the resident's feet. The CNA then assisted the resident to a sitting position to dangle at the bed side. CNA #3 held the resident's hands and told the resident he was going to take him to the bathroom. The resident began to stand with the CNA assisting him. The resident did not have any shoes or non</p>			

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	<p>skid socks on. There was a pair of house slippers on the floor less than one foot away from the resident and the CNA. The CNA did not put the slippers on when assisting the resident to a standing position. The resident stood with CNA #3 holding his hands and turning to the wheelchair with the CNA holding his hands. The resident's feet appeared to slide across the floor mat the resident was standing on. The CNA then assisted the resident into the wheelchair and pushed the wheel chair into the bathroom in the resident's room. CNA #3 then assisted the resident to pivot to the toilet. The resident was pivoted to the toilet without any non skid footwear. The CNA began to shave the resident while the resident was sitting on the toilet commode. The resident started to attempt to stand and the CNA instructed the resident not to stand.</p> <p>The record for Resident #R was reviewed on 8/17/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer Disease, high blood pressure, Lewy-Body dementia, depressive disorder, and difficulty walking.</p> <p>The 7/8/14 Minimum Data Set Quarterly Assessment indicated the resident's cognitive skills were severely impaired.</p>			

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	<p>The Assessment also indicated the resident was not steady moving from a seated to a standing position.</p> <p>Review of the resident's current care plans indicated the resident was at risk for falling. The care plan was first initiated on 11/20/13. The care plan was last updated with a target goal date of 10/31/14. Care plan interventions included for the resident to have a scoop mattress, low bed, bed alarm, and a set belt.</p> <p>A CNA sheet for Resident #R was reviewed on 8/17/14 at 11:30 a.m. The sheet indicated the resident was a high fall risk, leans forward in his wheelchair, and was to have a personal alarm to the bed and a self releasing belt to his wheelchair.</p> <p>When interviewed on 8/17/14 at 11:45 a.m., the Timbre Unit Manager indicated the resident was a high fall risk and should have had some type of non skid footwear on when he was being transferred.</p> <p>3. On 8/17/14 at 5:40 a.m., Resident #P was observed asleep in bed. The resident's bed was in the low position and a bed pad alarm was in place.</p>						

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	<p>On 8/19/14 at 11:50 a.m., the entrance/exit doors on the second floor were observed. These doors were in the lounge which was across from the Dining Room. The Dining Room was between the Pines North and the Pines South Units. There was a Wanderguard detection device on the door frame. The Pines Unit Manager was able to open the doors. The Unit Manager indicated the doors are kept unlocked during the day and are locked at for the night at 8:00 p.m. daily.</p> <p>The record for Resident #P was reviewed on 8/19/14 at 10:21 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, osteoarthritis, pacemaker, and hypothyroidism. The resident resided on Pines North unit on 7/4/14.</p> <p>Review of the 6/12/14 Minimum Data Set Quarterly Assessment indicated the the resident's BIMS (Brief Interview for Mental Status) score was 8. A score of 8 indicated the resident's cognitive patterns were moderately impaired. The Assessment indicated the resident had no behaviors or wandering. The Assessment indicated the resident's mobility device used was a wheelchair.</p> <p>An Elopement Risk Assessment dated</p>						

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	<p>5/17/13 indicated two of the six questions on the Assessment were answered "yes". The question regarding making attempts to leave the facility when it was not safe for the resident, pushing on doors or door keypads, or standing at door trying to leave when door opened was answered "no." The question regarding if the resident had left the facility when it was not safe was answered "no." There was writing on the bottom of the above Assessment indicating on 9/19/13 there were no changes since the last assessment. There were no further Elopement Risk Assessments in the resident's record until 7/7/14. The 7/7/14 Assessment indicated the resident had left the facility recently, a Wanderguard was placed, and the resident was now on a secured unit.</p> <p>A care plan initiated on 7/7/14 indicated the resident was at risk for elopement. Care plan interventions included for the resident to have a Wanderguard on at all time and for staff to check the placement of the Wanderguard.</p> <p>A 7/4/14 "Incident Report Form" indicated Resident #P eloped on 7/4/14 and was returned to the facility by the Nurse. The form indicated a Wanderguard was applied and the resident was moved to a room on the</p>			

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	<p>secured unit.</p> <p>The 7/4/14 Nursing Progress Notes were reviewed. An entry made at 9:06 a.m. indicated the resident was noted to be wandering the halls in a wheelchair. The resident was found on the South Hall which was closed at at this time. The resident thought her room was still down there and was redirected by staff.</p> <p>An entry made on 7/4/14 at 12:07 p.m. indicated the resident left facility with her family. An entry made at 4:08 p.m. indicated the resident was returned to the facility by her family.</p> <p>An entry made on 7/4/14 at 5:05 p.m. indicated the resident was wandering up and down halls and staff noticed the resident going on the South Hall which was closed at that time. Staff were able to redirect the resident.</p> <p>An entry made on 7/4/14 at 6:00 p.m. indicated the resident finished with dinner and was directed to the North Hall lounge area but the resident continued to wander and attempts to go to South Hall but staff were are able to redirect.</p> <p>The next entry in the 7/4/14 Nursing Progress Notes was made on 7/4/14 at 7:10 p.m. This entry indicated the</p>				

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	<p>resident was found outside on the sidewalk by the street. Staff were immediately notified and the resident was recovered and brought back to the facility. A head to toe assessment was performed and no injuries were noted and the resident had no complaints of pain. The Physician and the POA (Power of Attorney) were notified. The facility Executive Director , Director of Nursing, and the Unit Manager were notified. Orders were obtained for a Wanderguard to be placed .</p> <p>An entry made on 7/4/14 at 7:15 p.m. indicated 15 minute checks were initiated. An entry made on 7/4/14 at 9:45 a.m. indicated the resident was transferred to the Elm Unit (a secured unit).</p> <p>When interviewed on 8/19/14 at 1:00 p.m., the Nurse Consultant indicated Resident #P was out of the facility on 7/4/14. The Nurse Consultant indicated she had spoken with LPN #2, the Nurse who saw the resident outside the facility on the corner.</p> <p>When interviewed on the telephone on 8/19/14 at 2:10 p.m., LPN #2 indicated she was working on 7/4/14 on the unit Resident #P was on. The LPN indicated she had left the facility for her break</p>			

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	<p>after the dinner meal was completed. The LPN indicted this was approximately 6:45 p.m. The LPN indicated she was driving into the facility North lot and noticed the resident in her wheelchair on the side walk. The LPN indicated she went inside to tell staff and went to the resident . The LPN indicated she and another Nurse and a CNA returned the resident. LPN #2 indicated she was present during the dinner meal and did observe the resident at the dinner meal.</p> <p>When interviewed on 8/20/14 at 10:00 a.m. the Housekeeping/Laundry Manager indicated the front doors on the Pines Units have been opened during the day and locked at night. The Manager indicated she was called and informed a resident had gotten out through the doors and the doors were checked. The Manager indicated the doors were still alarmed at night only</p> <p>The facility "Elopement Assessment Policy and Procedure" was reviewed on 8/19/14 at 11:15 a.m. There was no date on the policy. The policy was received from the Director of Nursing who identified the policy as current. The policy indicated all residents were to have an elopement risk assessment completed upon admission. The policy also indicated "Any resident assessed to</p>			

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F000332 SS=D	<p>have impaired decision making ability and is oblivious to their own safety needs and had the ability and intent to leave the facility will be identified upon admission and appropriate interventions and care plans will be implemented to reduce the risk of elopement." The policy also indicated if wandering behavior occurred post admission, the resident would be reassessed, and interventions and care plans completed.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-45(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to remain free of a medication error rate of five percent or greater related to the administration of the incorrect amount of</p>	F000332	<b>F332 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of</b>	09/15/2014

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	<p>a Potassium medication, failure to administer an anti-diabetic medication, and crushing a Potassium medication prior to administration for 3 of 9 residents observed during the Medication Administration Pass. A total of 26 opportunities for error were observed and there were 3 medication errors observed. This resulted in a medication error rate of 11.5 %. (Residents #R, #B and #Y) (LPN # 2, LPN #3, and LPN #6)</p> <p>Findings include:</p> <p>1. The Morning Medication Administration Pass was observed on 8/19/14 at 10:10 a.m. LPN #6 was observed preparing medication for Resident #Y. The LPN prepared eight pills for the resident. The LPN crushed all the eight pills and mixed then in a pudding type food substance. One of the medication was Potassium Chloride 20 meq (milliequivalents). The individual plastic wrapper on the potassium pill included the resident's name and the time this pill was to be administered was listed as 8:00 a.m. on the wrapper. LPN #6 then administered the pills to Resident #Y using a spoon. The resident consumed the pudding type food substance with the pills.</p> <p>The record for Resident #Y was reviewed</p>		<p><i>this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate action taken for those residents identified:</b> Resident Y had no adverse effects from medications being administered outside of acceptable time frame or from Potassium being crushed. Resident R had no adverse effects from lesser dose of Potassium provided. Medication syringe obtained so that accurate dosage could easily be prepared. Resident B had no adverse effects from glipizide being administered prior to meal.</p> <p><b>1. How the facility identified other residents:</b> All residents that receive medications have the potential to be affected. <b>3) Measures put into place/ System changes:</b> Medication syringes have been obtained so that they are readily available. Pharmacy has been instructed to send medication syringes with liquid medications. Nurses and QMAS have been re-educated on the Rights of Medication Administration, dosage</p>				

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	<p>on 8/19/14 at 11:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, high blood pressure, and seizures.</p> <p>Review of the 8/2014 Physician Order Statement indicated there was an order for the resident to receive Potassium Chloride micro tab (tablet) 20 meq (milliequivalents) ER (extended release) by mouth daily at 8:00 a.m. The Physician Order Statement indicated the Potassium Chloride medication formulary for K-Dur and was not to be crushed.</p> <p>The "Medications Not To Be Crushed" list on the Medication Cart on the unit Resident #Y resided on was reviewed on 8/19/14 at 1:00 p.m. The list indicated K- Dur tablets were not be crushed. The reason listed for not crushing K-Dur was "Time release formulation."</p> <p>Review of the Nursing 2014 Drug Handbook indicated Potassium sustained release forms of Potassium Chloride were not to be crushed</p> <p>The facility policy titled "Specific Medication Administration Procedures" was received from the Director of Nursing on 8/18/14 at 10:49 a.m. The policy was dated July 1, 2010. The Director of Nursing indicated the policy</p>		<p><b>calculation, and checking for medications that cannot be crushed. A minimum of 5 nurses/QMA's will be observed per week during medication administration on varied shifts utilizing the Medication Observation QIS forms until all have successfully completed competency. A minimum of 2 nurses/QMA's will be observed on varied shifts per week thereafter to ensure ongoing compliance.</b></p> <p><b>Any discrepancies will be reviewed with the Nurse/QMA and education and counseling provided as appropriate.</b></p> <p><b>DON or designee will be responsible for the oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</b></p>	

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	<p>was current. The policy indicated "Crush medications if indicated for this resident only after checking the Crush List."</p> <p>When interviewed on 8/19/14 at 1:35 p.m., the Nurse Consultant indicated the resident's Potassium Chloride medication package noted the Potassium Chloride medication package listed it as formulary for K-Dur and the facility Crush List on the Medication cart noted K-Dur was not to be crushed.</p> <p>2. During a medication pass observation on 08/18/14 at 9:30 a.m., LPN #3 prepared Resident #R's medication, which included potassium 10% liquid. LPN #3 poured the potassium liquid into a plastic medication measuring cup. LPN #3 indicated there were four milliliters in one dram, so she measured out three drams to equal 12 milliliters (ml). LPN #3 then administered the medications, including the potassium to Resident #R.</p> <p>Resident #R's record was reviewed on 08/18/14 at 5 p.m. The resident's diagnoses included, but were not limited to, dementia and hypokalemia (low potassium).</p> <p>The Physician's Recapitulation Orders and Medication Administration Record (MAR), dated 08/14, indicated an order for potassium chloride liquid 10%, mix</p>			

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	<p>12 ml in four ounces of water or juice twice daily.</p> <p>A professional resource web site, "www.convertunits.com", indicated there were 3.696 ml in one dram. The resident received 11.088 ml of potassium.</p> <p>3. During a medication pass observation on 08/18/14 at 4:25 p.m., LPN #2 prepared Resident #B's medication, which included glipizide (blood sugar medication) 5 milligram (mg), 1/2 tablet (2.5 mg). LPN #2 then administered the medications, including the glipizide to the resident and left the resident's room.</p> <p>The MAR, dated 08/14, and reviewed immediately after the medications were given, indicated the glipizide was to be administered with meals. During an interview at the time of the MAR review, LPN #2 indicated supper was served at 6 p.m. and indicated the order was to give the medication with meals.</p> <p>The resident's record was reviewed on 08/18/14 at 5 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 08/14, indicated an order for glipizide 5 mg, take 1/2 tablet (2.5 mg)</p>			

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F000333 SS=G	<p>twice daily with meals.</p> <p>A meal time schedule, received from the Dietary Manager on 08/19/14 at 8:40 a.m., indicated dinner was served in the Pines Main Dining Room at 6 p.m.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to remain free of significant medications errors related to the incorrect dose of a narcotic medication administered to 1 of 3 residents reviewed for the administration of narcotic medications in the sample of 22. The medication error resulted in the resident receiving Narcan (a medication to reverse negative effect of narcotic medications) upon being transferred to the hospital Emergency Room by ambulance for a change in condition. (Resident #G) (RN #2)</p> <p>Findings include:</p>	F000333	<p><b>F333 Please note: The facility disputes that any actual harm occurred to this resident as a result of the medication error as alleged and requests an IDR to be conducted in person. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for</b></p>	09/15/2014			

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	<p>The closed record for Resident #G was reviewed on 8/19/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer Disease, depressive disorder, congestive heart failure, and high blood pressure.</p> <p>The 7/29/14 Minimum Data Set Quarterly Assessment indicated the resident's cognitive skills were severally impaired. The Assessment indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The Assessment also indicated the resident had no nonverbal signs of pain.</p> <p>Review of a 8/1/14 initial Incident Report Form indicated the resident was given the wrong dose of Morphine Sulfate (a narcotic medication) in error by RN #2 on 7/31/14 at 11:45 p.m. The form indicated the resident was sent to the hospital Emergency Room and returned to the facility.</p> <p>Review of a 8/5/14 final Incident Report Form indicated the Physician was interviewed and verified the order was for Morphine Sulfate one milligram as needed every hour for pain. The form also indicated RN #2 was interviewed and said she had given 1 ml (milliliter) of</p>		<p><b>those residents identified:</b> <b>Resident G has been discharged from the facility. 2)</b> <b>How the facility identified other residents: All residents that receive narcotic pain medication are at risk to be affected. All narcotic count sheets reviewed to identify those residents that receive narcotic pain medications. 3)</b> <b>Measures put into place/ System changes: Nurses have been re-educated on the Rights of Medication Administration and dosage calculations. A conversion document for Roxanol 20 mg/ml has been placed in each Medication Administration Book. Narcotic Count Sheets for 5 residents will be reviewed weekly by DON or designee to ensure that the correct dosage has been administered. Any discrepancies will be documented and addressed per policy with the individual that made the error. A minimum of 5 nurses/QMA's will be observed per week during medication administration on varied shifts utilizing the Medication Observation QIS forms until all have successfully completed competency. A minimum of 2 nurses/QMA's will be observed</b></p>				

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	<p>Roxanol (a liquid form of Morphine) to the resident on 7/31/14 at 11:45 p.m.</p> <p>The 7/2014 MAR (Medication Administration Record) was reviewed. The MAR indicated a dose of Morphine Sulfate 1 milligram and a dose of Ativan (no dose listed) were signed out as given once on 7/31/14. The back page of the MAR indicated on 7/31/14 Morphine and Ativan were given at 11:45 p.m.</p> <p>A Medication Error Report was completed on 8/1/14. The Report indicated Roxanol 1 milligram was ordered and Roxanol 20 milligrams was given on 7/31/14 at 11:45 p.m. The Report indicated the Nurse who administered the incorrect dose of the medication " failed to perform medication verifications per standards of practice ..."</p> <p>The 8/1/14 hospital "Emergency Documentation" records were reviewed. The records indicated the resident presented with an accidental overdose and the substance ingested was Morphine and 20 milligrams was possibly given at the nursing home. The records indicated Narcan (a medication given to reverse the negative effects of Morphine) 2 milligrams was given by EMS pre-arrival to the hospital. Physical exam of the resident noted the resident was</p>		<p><b>on varied shifts per week thereafter to ensure ongoing compliance.</b></p> <p><b>Any discrepancies will be reviewed with the Nurse/QMA and education and counseling provided as appropriate.</b></p> <p><b>DON or designee will be responsible for the oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</b></p>	

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	<p>unresponsive, her pupils were pinpoint, and her respirations were non-labored.</p> <p>When interviewed on 8/19/14 at 9:10 a.m., the DON (Director of Nursing) indicated there was a medication error for Resident #G. The DON indicated on 7/31/14 at 11:45 the resident was given Roxanol at the incorrect dose. The DON indicated RN #2 was working the Evening shift on 7/31/14 and an Agency Nurse was working the Night shift. The DON indicated RN #2 obtained the order from the Physician on 7/31/14 and did not initially write the order on an order form. She wrote the order on a Fax Reorder Form to send to Pharmacy to get the order. The DON indicated the Morphine Sulfate 1 milligram every one hours as needed for pain or SOB (shortness of breath) was written on the Fax Reorder form sent to Pharmacy. The DON indicated RN #1 administered a dose of Roxanol 20 milligrams on 7/31/14 at 11:45 p.m. The DON indicted the medication had to be obtained from the Pixis (a locked supply of medications in the facility). The DON indicated Agency Nurses were not allowed to access the Pixis system.</p> <p>Continued interview with the DON on 8/19/14 at 9:10 a.m. indicated and Agency Nurse came in to care for the</p>			

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F000366 SS=D	<p>resident on the night shift. On that shift the Agency Nurse noted the resident didn't look right and then also noted later the bottle of Roxanol marked as having 29 ml's left of a total of 30 ml's when first obtained from facility supply. The Agency Nurse attempted to call the Physician on call and then called the Medical Director and orders were obtained to send the resident to the hospital.</p> <p>This Federal tag relates to Complaint IN00154062.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p> <p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. Based on observation, interview, and record review, the facility failed to ensure a resident was offered a substitute for food she refused to eat, related to meat served for a lunch meal, for 1 of 2</p>	F000366	<b>F366 The facility requests paper compliance for this citation. This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of</b>	09/15/2014

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	<p>residents reviewed for nutrition, in a total sample of 22. (Resident #M)</p> <p>Findings include:</p> <p>During an interview on 08/18/14 at 11:50 a.m., Resident #M, indicated she is served pork and she is unable to eat pork because it hurts her stomach. She indicated the staff does not always offer other food. She indicated she would like smaller portions at lunch and would also like soup.</p> <p>During an observation of the noon meal on 08/18/14 at 12:26 p.m., Resident #M received ham, green beans, stuffing, and cake. During an interview with the resident at the time of the observation, she indicated the CNA who had delivered the tray (CNA #1) had not offered her a replacement for the ham. She indicated the CNA told her not to eat the ham if she did not want it.</p> <p>The meal card on the resident's tray, dated 08/18/14, Monday lunch, indicated the resident disliked pork.</p> <p>During an interview on 08/18/14 at 12:30 p.m., the Activity Director indicated there was ham on the resident's tray. She then asked the resident, after acknowledging ham was served to the resident, if she</p>		<p><i>correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1. Immediate actions taken for those residents identified: Resident M's food preferences reviewed and care plan updated to reflect current preferences.</b></p> <p><b>2) How the facility identified other residents: All residents have the potential to be affected. Resident preferences will be reviewed by the Dietary Manager or designee and tray cards and care plans will be updated accordingly.</b></p> <p><b>3) Measures put into place/ System changes: Staff that assist in the Dining Rooms will be re-educated on the need to check the tray card for dislikes and check the tray to ensure that residents are not being served foods that they dislike. Alternates will be offered and provided. A minimum of 5 resident trays will be checked weekly at varied meals and dining locations to ensure that they are not receiving dislikes and that alternates are offered and provided. Administrator or designee will be responsible for oversight of</b></p>				

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	<p>would like something else and the resident indicated she would like soup.</p> <p>During an interview on 08/18/14 at 12:36 p.m., CNA #1 indicated the resident did not want the ham served at lunch. CNA #1 indicated she did not know there were other choices. She indicated she did not offer a substitute for the ham.</p> <p>Resident #M's record was reviewed on 08/18/14 at 12:54 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy and neurogenic bladder.</p> <p>The Physician's Recapitulation Orders, dated 08/14, indicated the resident was on a regular diet, which was ordered on 07/17/14.</p> <p>During an interview on 08/18/14 at 12:43 p.m., the Dietary Manager indicated the resident should not have received ham on her meal tray. She indicated she should have received the alternate meat, which was chicken.</p> <p>This Federal tag relates to complaint IN00154062.</p> <p>3.1-21(a)(4)</p>		<p>these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/15/2014</p>		