

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2014
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 14, 15, 16, 17, and 20, 2014</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Survey team: Heather Tuttle, RN-TC Lara Richards, RN Caitlyn Doyle, RN</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 9 Medicaid: 16 Other: 4 Total: 29</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 23, 2014, by Janelyn Kulik, RN.</p>	F000000	Neither the signing or submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies ". This plan of correction id being submitted in good faith by the facility because it is the law.Compliance Date is 11/19/2014	

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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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure the least restrictive restraint was attempted and there was a medical symptom to justify the use of a restraint for 2 of 3 residents reviewed for restraints. (Residents #20 and #24)</p> <p>Findings include:</p> <p>1. On 10/14/14 at 11:59 a.m., Resident #20 was observed seated in his wheelchair with a lap buddy (a cushion that fits across the resident's wheelchair) restraint in use.</p> <p>On 10/15/14 at 8:38 a.m., the resident was again observed in his wheelchair with a lap buddy restraint in use. At 1:11 p.m., the resident returned from therapy and was positioned in the hall outside of his room. The resident's lap buddy was not in use. At 1:29 p.m., LPN #1 reapplied the resident's lap buddy. The resident made no attempt to stand unassisted while the lap buddy was not in</p>	F000221	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The seatbelts have been removed from resident #24 chair and resident #20 now has a self-release seatbelt on his chair.</p> <p>2.How will you identify other residents that may be affected by the alleged deficient practice? An audit will be completed to ensure all residents will restraints have appropriate documentation.</p> <p>3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff will be reinserviced on documentation requirements for restraints. The DON/Designee will audit weekly residents with restraints to ensure appropriate documentation is in place.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? A restraint audit tool will be developed. Restraint audits will be conducted weekly x4weeks, then bi-weekly x1 month, then monthly for 3 months to ensure</p>	11/19/2014			

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	<p>place.</p> <p>The record for Resident #20 was reviewed on 10/15/14 at 2:42 p.m. The resident's diagnoses included, but were not limited to, arthritis and weakness.</p> <p>An entry in the Nursing progress notes dated 9/25/14 at 6:30 a.m., indicated the resident was found on the floor in his room at 5:50 a.m. He indicated he tried to get out of his wheelchair and slid to the floor, he denied hitting his head. No injury was evident.</p> <p>Documentation in the Nursing progress notes at 9/26/14 at 8:30 p.m., indicated the resident made no attempts to self transfer.</p> <p>An entry in the Nursing progress notes on 9/27/14 at 9:30 p.m., indicated the resident was being laid down by an aide, he had been up in his wheelchair at the Nurses' station for supervision since 5:15 p.m. due to multiple attempts at trying to get out of bed. The resident was alert to self and aware he's not at home. No attempts to self transfer while in wheelchair.</p> <p>On 10/2/14 at 12:40 a.m., documentation in the Nursing progress notes indicated an alarm was sounding in the resident's</p>		<p>that the deficient practice does not recur. The DON will present findings to Quality Assurance committee, monitoring will continue for a quarter(3 months), if QA findings show error rate of greater than 20% by end of quarter, audits will continue until error rate is <20% Completion date: November 19, 2014</p>	

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	<p>room. Staff found the resident on the floor mat next to his bed. He was alert to self only. He indicated he was trying to get out of bed to his wheelchair. Upon assessment, no injury was evident.</p> <p>Documentation in the Nursing progress notes on 10/4/14 at 1:00 p.m., indicated an aide alerted the writer the resident was found in his bedroom laying on his stomach in front of the closet. The right side of the resident's head was laying on the floor. The resident indicated he was trying to get up from his wheelchair. A reddened area to the right side of the resident's head was noted. The area was slightly raised and the resident expressed pain when the area was touched. The Physician was notified and he indicated he would be in later to see the resident.</p> <p>Additional documentation in the Nursing progress notes on 10/4/14 (no time) indicated the Physician was in to see the resident. He spoke with the family regarding frequent falls. A new order for a lap buddy restraint while sitting in wheelchair was given. Family aware and at bedside, will continue to monitor for falls, Physician also here to assess resident, orders to keep bed in lowest position.</p> <p>A Physician's order dated 10/4/14,</p>			

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	<p>indicated the resident was to have a lap buddy for his wheelchair.</p> <p>Documentation in the 10/4/14 Physician's progress note, indicated the resident had head trauma with a mild bruise, will monitor neuro status and will get lap buddy and bed alarm.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 9/30/14, indicated the resident's Brief Interview of Mental Status (BIMS) score was "11" indicating he was cognitively intact at the time of the assessment. The resident was identified as being totally dependent on staff for transfers and he had one fall since the prior assessment with no injury.</p> <p>A Physical Restraint consent form signed and dated 10/4/14, indicated the following less restrictive, alternative non-restraint approaches had proven to be ineffective: bed in lowest position, clip alarm and wheelchair seat cushion.</p> <p>Interview with the Director of Nursing (DON) on 10/17/14 at 2:30 p.m., indicated chair alarms had been attempted prior to applying the lap buddy. She indicated a self release alarm belt should have been attempted prior to applying the lap buddy.</p>			

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	<p>2. On 10/16/14 at 8:10 a.m., and 10:00 a.m., Resident #24 was observed seated in her wheelchair in front of the Nurse's station. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/16/14 at 11:00 a.m., the resident was observed seated in her wheelchair in the dining room, listening to activities. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/16/14 at 12:40 a.m., the resident was observed seated at a table in dining room finishing lunch. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/17/14 at 10:45 a.m., the resident was observed seated in her wheelchair. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>The record for Resident #24 was reviewed on 10/16/14 at 1:35 p.m. The</p>						

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	<p>resident's diagnoses included, but were not limited to, urosepsis, dementia, stroke, debility, post fall, high blood pressure, depressive disorder, acute renal impairment, unsteady gait, right knee replacement, and osteoporosis.</p> <p>Review of Physician Orders on the current 10/2014 recap indicated sensor pad alarm to wheelchair at all times when up in wheelchair. Further review of Physician Orders indicated there was no order for the seat belt restraint.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/26/14 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 5, indicating she was not alert and oriented. She needed extensive assist with one person physical assist for bed mobility, transfers, dressing, and personal hygiene. She had no impairment to her upper and lower extremities and used a wheelchair for primary locomotion. Under the restraint section, none of the above was coded, indicating the resident did not have a trunk restraint.</p> <p>Review of the current plan of care indicated there was no care plan for the seat belt restraint.</p> <p>Further record review indicated there was</p>			

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F000241 SS=D	<p>no evidence a restraint assessment had been completed for the resident.</p> <p>Interview with CNA #2 on 10/17/14 at 1:45 p.m., indicated the resident wore a seat belt restraint. Further interview with the CNA indicated she could not remove the belt restraint on command. She indicated the resident was not alert and oriented.</p> <p>Interview with the Director of Nursing on 10/17/14 at 2:45 p.m., indicated the resident was using another resident's wheelchair who had since expired. She further indicated there was no order for the restraint, or an assessment or a reason why the resident had the seat belt restraint around her waist. She indicated the resident should not be wearing the seat belt restraint.</p> <p>3.1-26(o)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained</p>	F000241	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	11/19/2014			

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	<p>related to being dressed in a hospital gown and the exposure of a resident's abdomen while sitting in the hallway for 3 of 5 residents reviewed for dignity of the 6 residents who met the criteria for dignity. (Residents #16, #38, & #42)</p> <p>Findings include:</p> <p>1. On 10/14/14 at 11:00 a.m., Resident #38 was observed in bed wearing a hospital gown.</p> <p>On 10/15/14 from 9:00 a.m., until 11:00 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 10/15/14 1:54 p.m., and 3:30 p.m., the resident was observed in bed, wearing a hospital gown.</p> <p>On 10/16/14 at 8:15 a.m., and 10:00 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>The record for Resident #38 was reviewed on 10/15/14 at 3:07 p.m. The resident's diagnoses included, but were not limited to, anemia, dementia, and high blood pressure.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident had</p>		<p>Resident #38 daughter was notified that even though the resident is on Hospice staff can put nightgowns and dusters on the resident and also encouraged to bring a few gowns in. Gowns were purchased by the facility to dress resident on 10/16/14. Resident #42 is expired. Resident #16- SSD notified residents sister and his sister brought larger clothes in for resident. MDS coordinator and SSD bagged up all residents clothes that did not fit him on 10/21/14. 2. How will you identify other residents that maybe affected by the alleged deficient practice? All residents have the potential risk to be affected by the alleged deficient practice. SSD or designee will conduct audit to ensure that all residents have clothing and/or clothing that fits by 11/19/14. 3. What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not occur? SSD will discuss clothing during admission process and ensure residents have proper clothing and/or clothing that fits on a quarterly basis at care plan meetings.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not occur? SSD will contact families when resident have clothing issues. SSD or designee will conduct a random audit to go</p>				

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	<p>short and long term memory problems, and was severely impaired for decision making. She had no behaviors. The resident was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene.</p> <p>Review of the current plan of care updated 9/2014 indicated there was no evidence of any care plan indicating the resident preferred to wear a hospital gown all day.</p> <p>Review of Social Service Progress Notes dated 8/2014, 9/2014 and 10/2014 indicated there was no documentation indicating the resident preferred to wear hospital gowns all day.</p> <p>Interview with CNA #1 on 10/16/14 at 1:50 p.m., indicated she had no idea why the resident was dressed in a hospital gown and not in regular clothes. She further indicated there was no reason for her not to be dressed in regular clothes.</p> <p>Interview with the Social Service Director on 10/16/14 at 2:00 p.m., indicated she was aware the resident should not be dressed in a hospital gown, and she further indicated the daughter had come in and took all her clothes home, due to a weight gain a couple</p>		<p>through closets bi weekly to ensure residents have appropriate clothing for 3 months and present findings at Quality Assurance committee for 3 months, monitoring will continue for a quarter (3 months). If QA findings show error rate of greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014</p>				

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	<p>months ago, but that was before she became a hospice resident. The Social Service Director, further indicated she had not made the family aware to bring nightgowns or dusters so the resident could wear them now due to her decline.</p> <p>2. On 10/14/14 at 11:10 a.m., Resident #42 was observed sitting in a broda chair in the physical therapy room. At that time, the resident was dressed in a hospital gown.</p> <p>On 10/15/14 at 8:52 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 10/15/14 at 1:07 p.m., the resident was observed sitting in the broda chair in the therapy room. At that time, the resident was dressed in a hospital gown.</p> <p>On 10/15/14 from 2:00 p.m., until 3:30 p.m. the resident was observed in bed wearing a hospital gown.</p> <p>On 10/16/14 at 10:30 a.m., the resident was observed in bed wearing a hospital gown.</p> <p>On 10/16/14 at 1:00 p.m., the resident was observed sitting in the broda chair. At that time, she was wearing a hospital gown.</p>			

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	<p>The record for Resident #42 was reviewed on 10/15/14 at 1:08 p.m. The resident was recently admitted to the facility on 9/20/14. The resident's diagnoses included but were not limited to, coccyx ulcer, right foot ulcer, history of right hip fracture, anemia, dementia, depression, anxiety, high blood pressure, stroke, and recent septic shock.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 9/27/14 indicated the resident had short and long term memory problems and was severely impaired for decision making. She had no behaviors. She was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene.</p> <p>Review of the current plan of care dated 9/2014 indicated there was no care plan the resident preferred to be dressed in a hospital gown.</p> <p>Interview with CNA #1 on 10/16/14 at 10:13 a.m., indicated she had already performed morning care for the resident.</p> <p>Continued interview with CNA #1 on 10/16/14 at 1:50 p.m., indicated the resident had no clothes, therefore she dressed her in a hospital gown. She</p>			

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	<p>indicated she was aware the resident was supposed to be dressed in regular clothes.</p> <p>Interview with the Social Service Director on 10/16/14 at 2:00 p.m., indicated she was aware the resident should not be dressed in a hospital gown. She further indicated she was unaware the resident had no clothes.</p> <p>3. On 10/15/14 at 1:05 p.m., Resident #16 was observed sitting in his wheelchair in the hallway right outside of his room. At that time, the resident's pants were down slightly below his hips. The resident's abdomen was also exposed as well as his right thigh.</p> <p>On 10/15/14 at 1:49 p.m., the resident was still seated in his wheelchair outside of his room. At that time, the resident's pants were down slightly below his hips. The resident's abdomen was also exposed as well as his right thigh. Many staff members were observed to walk right by the resident and did not stop to adjust his clothing.</p> <p>On 10/15/14 at 2:26 p.m., the resident was observed seated in his wheelchair in the main dining room. The resident was participating in a birthday party with other residents and volunteers present. At that time, the resident's sweatshirt was</p>				

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	<p>lifted up over his abdomen exposing his skin. The Activity Director was also observed in the room and noted to speak with the resident, however, she did not pull down his sweatshirt.</p> <p>On 10/15/14 at 3:30 p.m., the resident remained in the dining room seated in his wheelchair at the same table. The resident's abdomen and right side of his hip were still exposed.</p> <p>On 10/16/14 at 9:30 a.m., and 10:25 a.m., the resident was observed sitting in his wheelchair outside of his room. His sweater was lifted up over his abdomen exposing his skin.</p> <p>On 10/16/14 at 11:29 a.m., the resident was still observed with his sweater pulled up over his abdomen exposing his skin.</p> <p>The record for Resident #16 was reviewed on 10/15/14 at 1:59 p.m. The resident's diagnoses included but were not limited to, seizure activity, adult failure to thrive, rheumatoid arthritis, depression, and dementia with behavioral disturbance.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/26/14 indicated the resident's Brief Interview for Mental Status (BIMS) was 11</p>			

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F000247 SS=A	<p>indicating the resident was alert and oriented. The resident had no behaviors. The resident needed extensive assist with one person physical assist for dressing and personal hygiene.</p> <p>Review of the current plan of care updated 9/2014 indicated there was no care plan the resident had behaviors of lifting up his clothing.</p> <p>Interview with the Director of Nursing on 10/16/14 at 2:00 p.m., indicated they informed the daughter yesterday to bring in bigger clothes, for the resident. She indicated they were aware the resident needed larger clothes.</p> <p>3.1-3(t)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to notify a resident when they were receiving a new roommate for 1 of 1 residents reviewed for Admission, Transfer, and Discharge, of the 1 resident who met the criteria for Admission, Transfer, and Discharge. (Resident #37)</p>	F000247	<p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? SSD spoke to resident # 37and she let him know that she will let him know whenever he will get a new roommate and gave resident #37 a residents rights booklet on 10/21/14. 2.What corrective action(s) will be accomplishedfor</p>	11/19/2014

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	<p>Findings include:</p> <p>The record for Resident #37 was reviewed on 10/20/14 at 9:00 a.m.</p> <p>Continued review indicated the resident received a new roommate on 8/30/14.</p> <p>Review of Social Service Progress Notes indicated there was no documentation the resident was notified he was getting a new roommate on 8/30/14.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 2/26/14 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating he was alert and oriented.</p> <p>Interview with the Social Service Director on 10/20/14 at 9:00 a.m., indicated she had been documenting in her progress notes when a resident received a new roommate. She further indicated there was no documentation in the resident's chart regarding the new roommate on 8/30/14.</p> <p>3.1-3(v)(2)</p>		<p>those residents found to have been affected by the deficient practice? All residents have the potential risk to be affected by the alleged deficient practice. No other residents were affected by this practice. 3. What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not occur? SSD will be re- inserviced on notification and resident rights by 11/19/14. 4. How will the corrective actions be monitored to ensure the deficient practice will not occur? SSD will develop a log to monitor all room changes or new roommates. Administrator will monitor log monthly x3 months to ensure notification was given to all parties who are getting a new roommate. Administrator will present findings at Quality Assurance Meeting for 3 months, monitoring will continue for a quarter (3 months). If QA findings show error rate of 20% or greater, audits will continue until error rate is <20% Completion date: November 19, 2014</p>		

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure cognitively impaired dependent residents received ongoing stimulation and recreational services related to their past and current preferences regarding activities for 2 of 2 residents reviewed for activities. (Residents #38 and #42)</p> <p>Findings include:</p> <p>1. On 10/14/14 during the day tour of duty (7:00 a.m., until 3:00 p.m.) Resident #38 was observed in bed. During that time, there was no stimulation for the resident. There was no radio observed in the room, however, there was a television set but it was turned off.</p> <p>On 10/15/14 at 8:35 a.m., the resident was observed in bed. At that time, there was no radio or television on in the room.</p> <p>On 10/15/14 from 9:00 a.m., until 11:00 a.m., the resident was observed in bed.</p>	F000248	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A TV and radio was provided to Resident #38 on 10/16/14. Resident #42 expired. 2. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Activities Director will conduct an audit to ensure all residents will have appropriate stimulation per resident likes and dislikes in their rooms. 3. What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not occur? Activity Director will be re-serviced on activity programming for dependent residents by 11/19/14. 4. How will the corrective actions be monitored to ensure the deficient practice will not occur? Administrator or designee will complete rounds 2 times per week to ensure dependent residents have appropriate stimulation in the room x 3</p>	11/19/2014	

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	<p>During that time, there was no radio or television turned on for the resident.</p> <p>On 10/15/14 at 1:54 p.m., and 3:30 p.m., the resident was observed in bed. Again there was no television or radio turned on in the room.</p> <p>On 10/16/14 at 8:15 a.m., and 10:30 a.m., the resident was observed in bed. During those times there was no television or radio turned on for the resident. The room was also noted to be dark.</p> <p>The record for Resident #38 was reviewed on 10/15/14 at 3:07 p.m. The resident's diagnoses included, but were not limited to, anemia, dementia, and high blood pressure.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident had short and long term memory problems, and was severely impaired for decision making. She had no behaviors. The resident was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene. The activity preferences which were completed by staff indicated the resident preferred to listen to music.</p> <p>Review of an Activity assessment dated</p>		<p>months and bring findings to Quality Assurance monthly times three months, monitoring will continue for a quarter (3 months). If QA findings show an error rate of greater than 20%, audits will continue until error rate is < 20% Completion date: November 19, 2014</p>		

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	<p>1/13/14 indicated the resident's current interests were cards, games, crafts, exercise, sports, music, reading, baking, religious needs, trips, watching movies, gardening, and keeping up with the news.</p> <p>Review of the current plan of care dated 8/21/14 indicated the resident had the following preferences books, newspapers, listening to music, being around animals, and to go outside. The Nursing approaches were to provide 1 to 1 visits daily. Hospice services provided for recreation as needed and provide leisure supplies as needed for self directed pursuits.</p> <p>Review of the last documented Activity Progress Note dated 8/21/14 indicated the resident was alert and verbally responsive at times. She had difficulty expressing her words and had poor cognitive abilities. She was dependent on others for transfers, and required assistance to attend activities in her broda chair. The resident accepted one to one visits and listened to music, and watched movies on the television. The resident attended church services and had a very good family support. The goal was still the same as she would participate in one to one visits and activities of her choice.</p> <p>Review of the one to one visits for the</p>				

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	<p>months of 8/2014, 9/2014, and 10/2014, indicated the resident was visited by the Activity Aide three times a week. The visits consisted of mostly reading to the resident.</p> <p>Interview with the Activity Director on 10/16/14 at 10:30 a.m., indicated the resident enjoyed being read to during the one to one visits. She further indicated the resident rarely attends activities now that she was on hospice care. She indicated the television should be turned on in her room while she was in bed. She further indicated there should also be a radio in the room for the resident and turned on when the television was off.</p> <p>2. On 10/15/14 at 8:30 a.m., Resident #42 was observed in bed. At that time, the resident was awake and there was no radio or television on in her room. Further observation indicated there was no radio or television in her room to listen to or watch.</p> <p>On 10/15/14 from 2:00 p.m., until 3:30 p.m., the resident was observed in bed. She was awake and counting numbers to herself. At those times there was no television or radio in her room to turn on to listen to.</p> <p>On 10/16/14 at 8:15 a.m. and 10:30 a.m.,</p>						

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	<p>the resident was observed in bed. The room was dark and the resident's eyes were open. At those times, there was no radio or television in the room so the resident could listen to music or watch television.</p> <p>The record for Resident #42 was reviewed on 10/15/14 at 1:08 p.m. The resident was recently admitted to the facility on 9/20/14. The resident's diagnoses included but were not limited to, coccyx ulcer, right foot ulcer, history of right hip fracture, anemia, dementia, depression, anxiety, high blood pressure, stroke, and recent septic shock.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 9/27/14 indicated the resident had short and long term memory problems and was severely impaired for decision making. She had no behaviors. She was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene. The resident's activity preferences completed by the resident's family member indicated it was very important for her to have books and newspapers, very important to listen to music, very important to keep up with the news, very important to do her favorite activities, and very important to do things in a group of people.</p>			

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	<p>Review of the current plan of care plan dated 9/22/14 indicated resident had the following preferences based on interview/staff assessment: listening to music, keep up with the news, being around animals, do things in groups, go outside and get fresh air, and participate in religious services. The Nursing approaches were to provide leisure supplies as needed for self directed pursuits, invite to scheduled activities of resident's choice, offer variety of activity types and locations and offer to assist and/or escort resident to activity functions as needed.</p> <p>Review of the Activity Assessment dated 9/22/14 indicated the resident's current interests included, exercise, music, reading books, spending time outdoors, watching television, and watching movies.</p> <p>Review of the only documented Activity Progress Note dated 9/25/14 indicated the resident required assistance to and from activities. The resident liked television and accepted visits from staff.</p> <p>Interview with the Activity Director on 10/16/14 at 10:30 a.m., indicated the resident was not on 1 to 1 visits. She indicated the resident was usually up for</p>			

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F000272 SS=D	<p>therapies and sometimes she went to activities, but this week she had not. She indicated there was no ongoing stimulation in the resident's room. She further indicated there should be a radio in her room.</p> <p>3.1-33(a)</p> <p>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.</p> <p>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;</p>			

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	<p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure restraint assessments were completed prior to applying a restraint for 2 of 3 residents reviewed for restraints. (Residents #20 and #24)</p> <p>Findings include:</p> <p>1. On 10/14/14 at 11:59 a.m., Resident #20 was observed seated in his wheelchair with a lap buddy (a cushion that fits across the resident's wheelchair) restraint in use.</p> <p>On 10/15/14 at 8:38 a.m., the resident was again observed in his wheelchair with a lap buddy restraint in use. At 1:11 p.m., the resident returned from therapy and was positioned in the hall outside of his room. The resident's lap buddy was not in use. At 1:29 p.m., LPN #1 reapplied the resident's lap buddy. The resident made no attempt to stand unassisted while the lap buddy was not in place.</p> <p>The record for Resident #20 was</p>	F000272	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The seatbelts have been removed from resident #24 chair and resident #20 now has a self-release seatbelt on his chair.</p> <p>1.How will you identify other residents that may be affected by the alleged deficient practice? All residents who are at risk for or that have had recent falls have the potential to be affected by the alleged deficient practice. 2.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff will be in-serviced on the pre-restraint assessment which will be used prior to applying a restraint. The pre-restraint assessment will be used to identify the least restrictive intervention. 3.How will the corrective actions be monitored to ensure the deficient practice will not recur? Once the pre-restraint assessment is completed, the licensed nurse will give it to the DON, who along with the rest of the IDT members will meet to determine if the correct device is in place. Therapy will</p>	11/19/2014
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	<p>reviewed on 10/15/14 at 2:42 p.m. The resident's diagnoses included, but were not limited to, arthritis and weakness.</p> <p>An entry in the Nursing progress notes dated 9/25/14 at 6:30 a.m., indicated the resident was found on the floor in his room at 5:50 a.m. He indicated he tried to get out of his wheelchair and slid to the floor, he denied hitting his head. No injury was evident.</p> <p>Documentation in the Nursing progress notes at 9/26/14 at 8:30 p.m., indicated the resident made no attempts to self transfer.</p> <p>An entry in the Nursing progress notes on 9/27/14 at 9:30 p.m., indicated the resident was being laid down by an aide, he had been up in his wheelchair at the Nurses' station for supervision since 5:15 p.m. due to multiple attempts at trying to get out of bed. The resident was alert to self and aware he's not at home. No attempts to self transfer while in wheelchair.</p> <p>On 10/2/14 at 12:40 a.m., documentation in the Nursing progress notes indicated an alarm was sounding in the resident's room. Staff found the resident on the floor mat next to his bed. He was alert to self only. He indicated he was trying to</p>		<p>also evaluate the resident for the appropriateness of the device. The Care Plan coordinator will update the resident's care plan. The DON will monitor this process x 3 months. Findings will be presented by the DON in Quality Assurance committee monthly times three months. Monitoring will be for a quarter (3 months). If QA findings show an error rate of greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014.</p>				

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	<p>get out of bed to his wheelchair. Upon assessment, no injury was evident.</p> <p>Documentation in the Nursing progress notes on 10/4/14 at 1:00 p.m., indicated an aide alerted the writer the resident was found in his bedroom laying on his stomach in front of the closet. The right side of the resident's head was laying on the floor. The resident indicated he was trying to get up from his wheelchair. A reddened area to the right side of the resident's head was noted. The area was slightly raised and the resident expressed pain when the area was touched. The Physician was notified and he indicated he would be in later to see the resident.</p> <p>Additional documentation in the Nursing progress notes on 10/4/14 (no time) indicated the Physician was in to see the resident. He spoke with the family regarding frequent falls. A new order for lap buddy while sitting in wheelchair was given. Family aware and at bedside, will continue to monitor for falls, Physician also here to assess resident, orders to keep bed in lowest position.</p> <p>A Physician's order dated 10/4/14, indicated the resident was to have a lap buddy for his wheelchair.</p> <p>A Physical Restraint consent form signed</p>			

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	<p>and dated 10/4/14, indicated the following less restrictive, alternative non-restraint approaches had proven to be ineffective: bed in lowest position, clip alarm and wheelchair seat cushion.</p> <p>Interview with the Director of Nursing (DON) on 10/17/14 at 2:30 p.m., indicated the facility did not utilize restraint assessments, they used the Restraint consent forms. The DON indicated a restraint assessment should have been completed prior to the use of the lap buddy.</p> <p>On 10/16/14 at 8:10 a.m., and 10:00 a.m., Resident #24 was observed seated in her wheelchair in front of the Nurse's station. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/16/14 at 11:00 a.m., the resident was observed seated in her wheelchair in the dining room, listening to activities. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/16/14 at 12:40 a.m., the resident was observed seated at a table in dining</p>			

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	<p>room finishing lunch. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>On 10/17/14 at 10:45 a.m., the resident was observed seated in her wheelchair. At that time, the resident was observed wearing a seat belt restraint around her waist. The resident was sitting upright and was not leaning to either side.</p> <p>The record for Resident #24 was reviewed on 10/16/14 at 1:35 p.m. The resident's diagnoses included, but were not limited to, urosepsis, dementia, stroke, debility, post fall, high blood pressure, depressive disorder, acute renal impairment, unsteady gait, right knee replacement, and osteoporosis.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/26/14 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 5, indicating she was not alert and oriented. She needed extensive assist with one person physical assist for bed mobility, transfers, dressing, and personal hygiene. She had no impairment to her upper and lower extremities and used a wheelchair for primary locomotion. Under the restraint section, none of the above was</p>			

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F000279 SS=D	<p>coded, indicating the resident did not have a trunk restraint.</p> <p>Further record review indicated there was no evidence a restraint assessment had been completed for the resident.</p> <p>Interview with the Director of Nursing on 10/17/14 at 2:45 p.m., indicated the resident was using another resident's wheelchair who had since expired. She further indicated there was no order for the restraint, or an assessment or a reason why the resident had the seat belt restraint around her waist.</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>						

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	<p>mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop resident care plans, related to medications which can thin the blood (Plavix and aspirin), for 2 of 5 residents reviewed for unnecessary medications. (Residents #31 and #49)</p> <p>Findings include:</p> <p>1. Resident #31's record was reviewed on 10/16/14 at 9:14 a.m. The resident's diagnoses included, but were not limited to coronary artery disease and hypertension.</p> <p>The Physician's Order Summary, dated 10/2014, indicated orders for aspirin 81 mg (milligrams) daily.</p> <p>Review of the September 2014 and October 2014 Medication Administration Record (MAR) indicated the resident had received the aspirin medication daily.</p> <p>There was a lack of documentation to indicate the resident had a care plan to inform the staff of the risks of taking aspirin related to the blood thinning</p>	F000279	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care Plans for residents #31 and #49 have been updated. 1.How will you identify other residents that may be affected by the alleged deficient practice? An audit will be completed for all residents on blood thinners to ensure proper documentation is in place. 2.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All resident's charts will be audited to determine whether or not they are receiving blood thinners, MDS coordinator will then audit each resident's care plan to ensure that a care plan has been put into place for blood thinners. 3.How will the corrective actions be monitored to ensure the deficient practice will not recur? The DON/Designee will audit 5 resident charts and Care Plans weekly to ensure that the correct care plan is in place. Care Plans will be updated quarterly per MDS. DON will present findings to Quality Assurance monthly times three months. Monitoring will continue for a</p>	11/19/2014

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	<p>action of the medication.</p> <p>During an interview on 10/20/14 at 12:08 p.m., the Minimum Data Set (MDS) Coordinator indicated there was no care plan for the aspirin. She indicated she usually does not write a care plan for the medication, but she would immediately. She further indicated a resident who took aspirin daily would be at risk for bleeding and bruising.</p> <p>2. Resident #49's record was reviewed on 10/15/14 at 1:05 p.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke) and hyperlipidemia.</p> <p>The Physician's Order Summary, dated 10/2014, indicated orders for aspirin 81 mg daily and Plavix 75 mg daily.</p> <p>Review of the September 2014 and October 2014 Medication Administration Record (MAR) indicated the resident had received the aspirin and Plavix medications daily.</p> <p>There was a lack of documentation to indicate the resident had a care plan to inform the staff of the risks of taking aspirin and Plavix related to the blood thinning action of the medications.</p>		<p>quarter (3months). If QA findings show an error rate greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014.</p>				

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F000282 SS=E	<p>During an interview on 10/20/14 at 12:08 p.m., the Minimum Data Set (MDS) Coordinator indicated there was no care plan for the aspirin or Plavix. She indicated she usually does not write a care plan for these medications, but she would immediately. She further indicated a resident who took these medications daily would be at risk for bleeding and bruising.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to monitoring bruises for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 6 residents who met the criteria for skin conditions (non-pressure related). The facility also failed to ensure laboratory tests were obtained as ordered and an assessment was completed prior to administering as needed (prn) pain medication for 2 of 5 residents reviewed for unnecessary</p>	F000282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #16, #27 & #30 areas were measured and skin sheets put in place during survey. PRN pain sheet was put into place for resident #49 and MD has been notified of missing labs for resident #31 with new orders to d/c lab order for lipids q 6 weeks.</p> <p>1.How will you identify other residents that may be affected by the alleged deficient practice? All residents receiving anticoagulant therapy have the potential to be</p>	11/19/2014

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	<p>medications. (Residents #16, #27, #30, #31, and #49)</p> <p>Findings include:</p> <p>1. On 10/14/14 at 2:52 p.m., Resident #30 was observed with an area of purple green bruising to the right elbow area. The resident also had a small area of reddish/purple bruising to the top of her right hand.</p> <p>On 10/15/14 at 1:05 p.m. and 3:24 p.m., the reddish/purple bruising remained to the top of the resident's right hand.</p> <p>On 10/16/14 at 8:48 a.m., 10:05 a.m., and 12:48 p.m., the resident was observed with a fading green bruise to the right elbow and forearm area. The reddish/purple bruises remained to the top of the resident's right hand.</p> <p>On 10/17/14 at 1:48 p.m., the fading bruise to the right elbow area and the right forearm remained. Dark reddish/purple areas of discoloration remained on top of the resident's right hand.</p> <p>The record for Resident #30 was reviewed on 10/16/14 at 10:09 a.m. The resident's diagnoses included, but was not limited to, anemia.</p>		<p>affected by this alleged deficient practice. Any resident receiving prn pain medications have the potential to be affected by this alleged deficient practice and all residents with lab orders have the potential to be affected by this alleged deficient practice. A full house skin sweep will be conducted to ensure documentation and treatments are in place. 2.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be re-in serviced on prn pain monitoring sheets. Nursing staff will be re-in serviced monitoring of resident's who receive anticoagulant therapy. During re-writes, DON/Designee will compile a list of current lab orders per each resident. 3.How will the corrective actions be monitored to ensure the deficient practice will not recur? A Random audit of 5 MARs will be performed weekly per DON/ Designee to ensure that there is proper documentation related to prn pain medications x 3 months. Using an audit tool, lab orders will be audited weekly per DON/Designee to ensure that labs are drawn per MD orders x 3 months. A random audit of 5 residents per week will be reviewed to ensure all skin areas are documented appropriately and include order x 3 months. DON will present findings to</p>		

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	<p>A Physician's order dated 10/6/14 indicated the resident's Coumadin (a blood thinner) was to be resumed at 2.5 milligrams (mg).</p> <p>Review of the Skin book on 10/17/14 at 1:40 p.m., indicated there were no non-pressure skin sheets related to the resident's bruising.</p> <p>Interview with LPN #1 on 10/17/14 at 1:48 p.m., indicated the resident did have bruising to the right elbow area and the top of her right hand. He also indicated a non-pressure skin sheet should have been initiated.</p> <p>Review of the plan of care dated 9/22/14, indicated the resident had a potential for complications and/or injury related to anticoagulant therapy. The interventions included, but were not limited to, daily skin inspection. Report abnormalities to the Nurse and observe/report to Physician as needed for signs and symptoms of anticoagulant complications such as bruising.</p> <p>2. On 10/15/14 at 11:33 a.m. and 1:53 p.m., Resident #27 was observed with a fading greenish bruise to the top of her right hand.</p>		<p>Quality Assurance monthly for three months. Monitoring will continue for a quarter (3 months)) If QA findings show an error rate greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014</p>				

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	<p>On 10/17/14 at 10:05 a.m., the fading green bruise remained to the top of the resident's right hand. At 1:50 p.m., the resident was observed with a fading green bruise to her right wrist area . She also had a fading bruise to the top of her right hand.</p> <p>The record for Resident #27 was reviewed on 10/16/14 at 1:04 p.m. The resident's diagnoses included, but was not limited to, chronic anemia.</p> <p>A Physician's order dated 10/10/14, indicated the resident was to receive Plavix (a blood thinner) 75 milligrams (mg) daily and Coumadin (a blood thinner) 2 mg daily)</p> <p>A Physician's order dated 10/10/14, indicated to monitor/measure the following bruises weekly on Wednesday: right elbow, posterior right upper arm, posterior left lower arm, and anterior left lower arm.</p> <p>Review of the Skin book on 10/17/14 at 1:40 p.m., indicated the resident did not have a non-pressure skin sheet completed for the right wrist and hand area.</p> <p>Interview with LPN #1 on 10/17/14 at 1:50 p.m., indicated the resident did have fading bruises to the right wrist and hand</p>			

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	<p>area. He indicated the resident was a recent return from the hospital. He also indicated a non-pressure skin sheet should have been initiated.</p> <p>Review of the plan of care dated 10/10/14, indicated the resident had a potential for complications and/or injury related to anticoagulant therapy/clot prevention. The interventions included, but were not limited to, daily skin inspection and observe/report to Physician as needed signs and symptoms of anticoagulant complications such as bruising.</p> <p>3. On 10/14/14 at 1:26 p.m., Resident #16 was observed sitting in his wheelchair by his room. At that time, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/15/14 at 1:05 p.m., and 1:49 p.m., the resident was observed sitting in his wheelchair outside of his room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/15/14 at 2:26 p.m., and 3:30 p.m., resident was seated in his wheelchair in the dining room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p>			

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	<p>On 10/16/14 at 8:30 a.m., 9:30 a.m., 10:25 a.m., and 11:29 a.m., the resident was observed sitting in his wheelchair outside of his room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/16/14 at 2:45 p.m., LPN #1 was asked to perform a skin assessment to the resident's right hand. At that time, he indicated he was unaware the resident had a bruise to the back of his right hand. The LPN indicated he was not made aware in the morning shift report the resident had sustained a bruise. He further indicated when a bruise was noticed by staff, he was to complete an incident report, fill out the wound sheets with the measurement of the bruise, notify the Physician and family and monitor the bruise every week until it had healed.</p> <p>The record for Resident #16 was reviewed on 10/15/14 at 1:59 p.m. The resident's diagnoses included but were not limited to, seizure activity, adult failure to thrive, rheumatoid arthritis, depression, and dementia with behavioral disturbance.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/26/14 indicated the resident's Brief Interview</p>						

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	<p>for Mental Status (BIMS) was 11 indicating the resident was alert and oriented. The resident had no behaviors. The resident needed extensive assist with one person physical assist for dressing and personal hygiene.</p> <p>Review of Physician Orders dated 10/6/14 indicated Coumadin (an anticoagulant medication used to thin the resident's blood) 7.5 milligrams (mg) daily.</p> <p>Review of the current plan of care dated 9/30/14 indicated potential for complications and or injury related to anticoagulant therapy. The Nursing approaches were to do a daily skin inspection and report abnormalities to the nurse. Observe/report to Physician as needed signs and symptoms of anticoagulant complications such as bruising.</p> <p>Review of the wound sheets for the month of 10/2014 indicated there were no sheets available for the bruise to the right hand.</p> <p>Interview with LPN #1 on 10/16/14 at 3:00 p.m., indicated the bruise should have been measured and recorded on the wound sheet and monitored until healed.</p>			

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	<p>4. Resident #31's record was reviewed on 10/16/14 at 9:14 a.m. The resident's diagnoses included, but were not limited to coronary artery disease and hypertension.</p> <p>Review of the Physician's Order Summary (POS), dated 10/2014, indicated lab orders for CBC (complete blood count), CMP (electrolytes), Lipids, TSH (thyroid stimulating hormone, a laboratory test to assess thyroid function), and HGA1C (hemoglobin A1C, a laboratory test to assess blood glucose levels) in 3 months then every 6 months after that. The order was dated 1/5/14. The POS also indicated an order for Lipids every 6 weeks. The order was dated 3/29/14.</p> <p>Review of the lab results indicated there was a lack of documentation in the record to indicate the labs had been completed as ordered.</p> <p>Resident #31 had a care plan for hypertension. The nursing interventions included, "...Labs as ordered and report results to physician..."</p> <p>During an interview with the Director of Nursing (DON) on 10/20/14 at 9:20 a.m., she indicated the labs had not been completed as ordered. She indicated they</p>			

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	<p>had been missed.</p> <p>5. Resident #49's record was reviewed on 10/15/14 at 1:05 p.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke) and hyperlipidemia.</p> <p>Review of the 10/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 7.5/325 mg (milligrams), one tablet by mouth twice daily as needed for pain.</p> <p>Review of the Medication Administration Record (MAR), dated 10/2014, indicated there was no indication of any assessment of the pain prior to administration of the Norco, no indication of interventions attempted prior to the administration of the Norco, or any indication that the effectiveness of the medication had been assessed following administration on 10/1/14, 10/3/14, 10/4/14, 10/6/14, 10/8/14, 10/10/14, 10/11/14, 10/12/14, 10/13/14, 10/18/14, and 10/19/14.</p> <p>Review of the MAR, dated 9/2014, indicated there was no indication of any assessment of the pain prior to administration of the Norco, no indication of interventions attempted prior to the administration of the Norco, or any indication that the effectiveness of</p>			

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	<p>the medication had been assessed following administration on 9/1/14, 9/2/14, 9/4/14, 9/5/14, 9/6/14, 9/7/14, 9/9/14, 9/10/14, 9/15/14, 9/16/14, 9/17/14, 9/18/14, 9/19/14, 9/20/14, 9/21/14, 9/22/14, 9/23/14, 9/25/14, 9/27/14, 9/29/14, and 9/30/14.</p> <p>Resident #49 had a care plan for risk for pain related to chronic physical disability, left ear pain, and depression. The nursing interventions included, "...Observe for effectiveness of pain interventions..."</p> <p>During an interview with the DON on 10/20/14 at 9:00 a.m., she indicated there was usually a PRN (as needed) flow sheet in the MAR where nurses should document pain scale, prior interventions, and effectiveness of PRN medications. She further indicated she could not find a PRN flow sheet for Resident #49 for September or October. She indicated staff had been completing the flow sheet previously but stopped for some reason. She further indicated there should have been a PRN flow sheet in place.</p> <p>A facility policy, dated 8/26/13, titled, "Pain Management," received from the DON as current on 10/20/14 at 10:37 a.m., indicated, "...2. When pain is identified:...b. IDT will review and</p>			

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F000309 SS=D	<p>develop an individualized plan of care that includes pharmacological and non pharmacological interventions. 3. Medication (s) received, refused and response to prn medication will be documented on the Medication Administration Record (MAR)...5. Documentation regarding pain management status and effects of pharmacological treatment may be found on Pain Management Flowsheet, nursing notes and/or MAR. 6. Documentation regarding pain status and effects of non-pharmacological treatment may be found in nursing notes and/or monthly summaries..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure bruises were monitored and assessed for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 6</p>	F000309	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # #16, #27 & #30 areas were measured and skin sheets put in place during survey. PRN pain	11/19/2014

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	<p>residents who met the criteria for skin conditions (non-pressure related). (Residents #16, #27, and #30)</p> <p>Findings include:</p> <p>1. On 10/14/14 at 2:52 p.m., Resident #30 was observed with an area of purple green bruising to the right elbow area. The resident also had a small area of reddish/purple bruising to the top of her right hand.</p> <p>On 10/15/14 at 1:05 p.m. and 3:24 p.m., the reddish/purple bruising remained to the top of the resident's right hand.</p> <p>On 10/16/14 at 8:48 a.m., 10:05 a.m., and 12:48 p.m., the resident was observed with a fading green bruise to the right elbow and forearm area. The reddish/purple bruises remained to the top of the resident's right hand.</p> <p>On 10/17/14 at 1:48 p.m., the fading bruise to the right elbow area and the right forearm remained. Dark reddish/purple areas of discoloration remained on top of the resident's right hand.</p> <p>The record for Resident #30 was reviewed on 10/16/14 at 10:09 a.m. The resident's diagnoses included, but was not</p>		<p>sheet was put into place for resident #49 and MD has been notified of missing labs for resident #31 with new orders to d/c lab order for lipids q 6 weeks.</p> <p>1.How will you identify other residents that may be affected by the alleged deficient practice? All residents receiving anticoagulant therapy have the potential to be affected by this alleged deficient practice. Any resident receiving prn pain medications have the potential to be affected by this alleged deficient practice and all residents with lab orders have the potential to be affected by this alleged deficient practice. A full house skin sweep will be conducted to ensure documentation and treatments are in place. 2.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be re-in serviced on prn pain monitoring sheets. Nursing staff will be re-in serviced monitoring of resident's who receive anticoagulant therapy. During re-writes, DON/Designee will compile a list of current lab orders per each resident. 3.How will the corrective actions be monitored to ensure the deficient practice will not recur? A Random audit of 5 MARs will be performed weekly per DON/ Designee to ensure that there is proper documentation related to prn pain medications. Using an audit tool,</p>	

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	<p>limited to, anemia.</p> <p>A Physician's order dated 10/6/14, indicated the resident's Coumadin (a blood thinner) was to be resumed at 2.5 milligrams (mg).</p> <p>Review of the Skin book on 10/17/14 at 1:40 p.m., indicated there were no non-pressure skin sheets related to the resident's bruising.</p> <p>Interview with LPN #1 on 10/17/14 at 1:48 p.m., indicated the resident did have bruising to the right elbow area and the top of her right hand. He also indicated a non-pressure skin sheet should have been initiated.</p> <p>Review of the plan of care dated 9/22/14, indicated the resident had a potential for complications and/or injury related to anticoagulant therapy. The interventions included, but were not limited to, daily skin inspection. Report abnormalities to the Nurse and observe/report to Physician as needed for signs and symptoms of anticoagulant complications such as bruising.</p> <p>Review of the Wound assessment records dated 10/17/14 on 10/20/14 at 11:00 a.m., indicated the resident had a purple/greenish bruise to the right elbow</p>		<p>lab orders will be audited weekly per DON/Designee to ensure that labs are drawn per MD orders x 3 months. A random audit of 5 residents per week will be reviewed to ensure all skin areas are documented appropriately and include order x 3 months. DON will present findings to Quality Assurance monthly for three months. Monitoring will continue for a quarter (3 months), if QA findings show an error rate greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014. F309 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #16, #27 and #30 have had their areas measured, skin sheets and treatments in place. 2.How will you identify other residents that may be affected by the alleged deficient practice? A full house skin sweep will be performed and any residents found to be affected by this alleged deficient practice will have immediate corrections made. 3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? The nursing staff will be re-in serviced on the policy and procedure on skin and wound management. New MD orders will be brought to clinical meeting to be reviewed by the IDT and residents' care plans</p>				

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	<p>which measured 2.5 centimeters (cm) x 3 cm and a purple bruise to the right hand which measured 2 cm x 2.5 cm.</p> <p>2. On 10/15/14 at 11:33 a.m. and 1:53 p.m., Resident #27 was observed with a fading greenish bruise to the top of her right hand.</p> <p>On 10/17/14 at 10:05 a.m., the fading green bruise remained to the top of the resident's right hand. At 1:50 p.m., the resident was observed with a fading green bruise to her right wrist area . She also had a fading bruise to the top of her right hand.</p> <p>The record for Resident #27 was reviewed on 10/16/14 at 1:04 p.m. The resident's diagnoses included, but was not limited to, chronic anemia.</p> <p>A Physician's order dated 10/10/14, indicated the resident was to receive Plavix (a blood thinner) 75 milligrams (mg) daily and Coumadin (a blood thinner) 2 mg daily.</p> <p>A Physician's order dated 10/10/14, indicated to monitor/measure the following bruises weekly on Wednesday: right elbow, posterior right upper arm, posterior left lower arm, and anterior left lower arm.</p>		<p>will be updated at that time.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? The DON will audit the non-pressure sheets weekly using a non-pressure log to ensure that residents with areas have the appropriate interventions and orders are being carried through x 3 months. The DON will present findings to the Quality Assurance Committee, monthly for three months. Monitoring will continue for a quarter (3 months), if QA findings show an error rate greater than 20%, audits will continue until error rate is <20% Completion date: November 19, 2014</p>				

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	<p>Review of the Skin book on 10/17/14 at 1:40 p.m., indicated the resident did not have a non-pressure skin sheet completed for the right wrist and hand area.</p> <p>Interview with LPN #1 on 10/17/14 at 1:50 p.m., indicated the resident did have fading bruises to the right wrist and hand area. He indicated the resident was a recent return from the hospital. He also indicated a non-pressure skin sheet should have been initiated.</p> <p>Review of the plan of care dated 10/10/14, indicated the resident had a potential for complications and/or injury related to anticoagulant therapy/clot prevention. The interventions included, but were not limited to, daily skin inspection and observe/report to Physician as needed signs and symptoms of anticoagulant complications such as bruising.</p> <p>Review of the Skin book on 10/20/14 at 11:00 a.m., indicated Wound assessment sheets for the right wrist and right hand bruises were initiated on 10/17/14.</p> <p>3. On 10/14/14 at 1:26 p.m., Resident #16 was observed sitting in his wheelchair by his room. At that time, there was a large purple and red bruise to the back of the resident's right hand.</p>				

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	<p>On 10/15/14 at 1:05 p.m., and 1:49 p.m., the resident was observed sitting in his wheelchair outside of his room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/15/14 at 2:26 p.m., and 3:30 p.m., resident was seated in his wheelchair in the dining room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/16/14 at 8:30 a.m., 9:30 a.m., 10:25 a.m., and 11:29 a.m., the resident was observed sitting in his wheelchair outside of his room. At those times, there was a large purple and red bruise to the back of the resident's right hand.</p> <p>On 10/16/14 at 2:45 p.m., LPN #1 was asked to perform a skin assessment to the resident's right hand. At that time, he indicated he was unaware the resident had a bruise to the back of his right hand. The LPN indicated he was not made aware in the morning shift report the resident had sustained a bruise. He further indicated when a bruise was noticed by staff, he was to complete an incident report, fill out the wound sheets with the measurement of the bruise, notify the Physician and family and</p>			

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	<p>monitor the bruise every week until it had healed.</p> <p>The record for Resident #16 was reviewed on 10/15/14 at 1:59 p.m. The resident's diagnoses included but were not limited to, seizure activity, adult failure to thrive, rheumatoid arthritis, depression, and dementia with behavioral disturbance.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/26/14 indicated the resident's Brief Interview for Mental Status (BIMS) was 11 indicating the resident was alert and oriented. The resident had no behaviors. The resident needed extensive assist with one person physical assist for dressing and personal hygiene.</p> <p>Review of Physician Orders dated 10/6/14 indicated Coumadin (an anticoagulant medication used to thin the resident's blood) 7.5 milligrams (mg) daily.</p> <p>Review of the current plan of care dated 9/30/14 indicated potential for complications and or injury related to anticoagulant therapy. The Nursing approaches were to do a daily skin inspection and report abnormalities to the nurse. Observe/report to Physician as</p>			

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	<p>needed signs and symptoms of anticoagulant complications such as bruising.</p> <p>Review of the wound sheets for the month of 10/2014 indicated there were no sheets available for the bruise to the right hand.</p> <p>Review of Nursing Progress Notes dated 10/1-10/16/14 indicated there was no evidence of any documentation of the bruise to the right hand.</p> <p>Review of the wound sheet completed by LPN #1 on 10/16/14 indicated the bruise to the back of the resident's right hand measured 6 centimeters (cm) by 5.5 cm and the color of the bruise was purple.</p> <p>Interview with LPN #1 on 10/16/14 at 3:00 p.m., indicated the bruise should have been measured and recorded on the wound sheet and monitored until healed.</p> <p>Review of the current and undated policy on bruising provided by the Director of Nursing indicated "Assess bruise for color, location, warmth and or pain. Measure the bruise in centimeters. Notify Family and Doctor of the bruise. Document the bruise, how it occurred if able in the nurses notes. complete documentation on the skin sheet. Weekly</p>			

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F000312 SS=D	<p>measurements will be conducted until resolved."</p> <p>Interview with the Director of Nursing on 10/17/14 at 2:45 p.m., indicated bruises were to measured and monitored weekly until healed.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to maintain good personal hygiene related to facial hair for 1 of 3 residents reviewed for Activities of Daily Living of the 4 residents who met the criteria for Activities of Daily Living. (Resident #42)</p> <p>Findings include:</p> <p>On 10/14/14 at 12:02 p.m., Resident #42 was observed in a broda chair. At that time, she was noted with a large amount of black facial hair to her upper lip.</p>	F000312	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #42 has expired. Resident #38 facial hair has been removed. 2.How will you identify other residents that may be affected by the alleged deficient practice? An audit will be completed on all male and female residents to ensure shaving needs have been addressed, or care plans updated if resident refuses shave. 3 What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff will be re in serviced on residents' rights and dignity.</p>	11/19/2014

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	<p>On 10/15/14 at 8:30 a.m., the resident was observed in bed. At that time, she was noted with a large amount of black facial hair to her upper lip.</p> <p>On 10/15/2014 1:07 p.m., the resident was observed up in the broda chair in the therapy room. At that time, she was noted with a large amount of black facial hair to her upper lip.</p> <p>On 10/15/14 from 2:00 p.m., until 3:30 p.m., the resident was observed in bed. During that time, she was noted with a large amount of black facial hair to her upper lip.</p> <p>On 10/16/14 at 8:15 a.m. and 1:00 p.m., the resident was observed with a large amount of black facial hair to her upper lip.</p> <p>The record for Resident #38 was reviewed on 10/15/14 at 3:07 p.m. The resident's diagnoses included, but were not limited to, anemia, dementia, and high blood pressure.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident had short and long term memory problems, and was severely impaired for decision</p>		<p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? Room rounds will be conducted by the IDT 5 times per week, to ensure that all residents are properly groomed and dressed. Any care needs will be reported to the Nurse on the unit who will ensure that corrections are made. Room round sheets will be turned in 5 days per week to the Administrator to ensure corrections have been made x 3 months. Findings will be reported to the Quality Assurance Committee monthly for three months. Monitoring will be for a quarter (3 months) If QA findings show an error rate of greater than 20%, audits will continue until error rate is <20% Completion date: November 19, 2014</p>				

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F000328 SS=D	<p>making. She had no behaviors. The resident was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene.</p> <p>Review of the current plan of care dated 9/20/14 indicated the resident had an activity of daily living self care deficit performance related to stroke, limited mobility, and confusion. The Nursing approaches were that staff will assume needs if resident was unable to logically communicate needs.</p> <p>Interview with CNA #1 on 10/16/14 at 10:13 a.m., indicated she had already provided morning care for the resident and provided all of the resident's activities of daily living care as well.</p> <p>Continued interview with CNA #1 on 10/16/14 at 1:50 p.m., indicated she did notice the resident had black facial hair on her upper lip that needed to be shaved. She further indicated the resident was totally dependent on staff for personal hygiene.</p> <p>3.1-38(a)(3)(D)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents</p>						

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	<p>receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the proper treatment and care related foot care for 1 of 3 residents reviewed for Activities of Daily Living of the 4 residents who met the criteria for Activities of Daily Living. (Resident #42)</p> <p>Findings include:</p> <p>On 10/14/14 at 12:02 p.m., Resident #42 was observed in a broda chair. At that time, her toenails were noted to be long, thick and discolored.</p> <p>On 10/15/14 at 8:30 a.m., the resident was observed in bed. At that time, her toenails were noted to be long, thick and discolored.</p> <p>On 10/15/2014 1:07 p.m., the resident was observed up in the broda chair in the therapy room. At that time, her toenails were noted to be long, thick and discolored.</p>	F000328	<p>1. What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? Resident #42 is expired but was seen by podiatrist on Monday 10/20/14 in the morning. Resident #38 was seen by the podiatrist on7/21/14 and 9/22/14.</p> <p>2. What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? An audit will be completed on all residents to identify podiatry needs.</p> <p>3. What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? A random audit will be completedby DON or designee on 3 residents weekly to ensure nails have been trimmed weekly for 1 month, then every other week times one month, then monthly. SSD will be notified ofresidents with podiatry needs.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Administrator will monitor audit weekly to ensure follow</p>	11/19/2014

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	<p>On 10/15/14 from 2:00 p.m., until 3:30 p.m., the resident was observed in bed. During that time, her toenails were noted to be long, thick and discolored.</p> <p>On 10/16/14 at 8:15 a.m. and 1:00 p.m., the resident's toenails were observed to be long, thick and discolored.</p> <p>The record for Resident #38 was reviewed on 10/15/14 at 3:07 p.m. The resident's diagnoses included, but were not limited to, anemia, dementia, and high blood pressure.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident had short and long term memory problems, and was severely impaired for decision making. She had no behaviors. The resident was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, and personal hygiene.</p> <p>Review of the current plan of care dated 9/20/14 indicated the resident had an activity of daily living self care deficit performance related to stroke, limited mobility, and confusion. The Nursing approaches were that staff will assume needs if resident was unable to logically</p>		<p>through has been completed for podiatry services if needed x3 months. Findings will bereviewed in Quality Assurance Committee monthly for 3 months. Monitoring will continue for a quarter (3 months) If QA findings show an error rate of greater than 20%, audits will continue until error rate is <20% Completion date: November 19, 2014</p>		

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	<p>communicate needs.</p> <p>Review of the consent form indicated the resident's responsible party agreed for the resident to be seen by the podiatrist. The consent form was signed and dated on 9/22/14.</p> <p>Review of the Nursing admission assessment dated 9/20/14 indicated the description of the resident's toenails were "thick."</p> <p>Interview with the Social Service Director on 10/16/14 at 2:00 p.m., indicated she was not aware the resident had long thick toenails. She further indicated the podiatrist was last at the facility on 9/22/14. She indicated there was no communication from nursing staff to her regarding the resident being in need of her toenails to be trimmed and cut. The Social Service Director indicated she was informed by the podiatrist that they can come out whenever there was a need for a resident to have their toenails trimmed.</p> <p>Continued interview with the Social Service Director on 10/16/14 at 2:30 p.m., indicated the podiatrist would be coming to the facility on Monday 10/20/14 to cut the resident's toenails.</p>			

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F000329 SS=D	<p>3.1-47(a)(7)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs related to no indication for the use of an antipsychotic medication, monitoring laboratory results, and assessing the need for an as needed (prn) pain medication for 3 of 5 residents reviewed for unnecessary medications. (Residents #30, #31, and #49)</p>	F000329	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? PRN pain sheet was put into place for resident #49 and MD has been notified of missing labs for resident #31 with new orders to d/c lab order for lipids q 6 weeks, a call was made to the Primary Physician for resident #30 regarding the Seroquel, orders were received to have the</p>	11/19/2014	

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	<p>Findings include:</p> <p>1. The record for Resident #30 was reviewed on 10/16/14 at 10:09 a.m. The resident's diagnoses included, but was not limited to, dementia with delusions and depression.</p> <p>A readmission Physician's order dated 9/8/14, indicated the resident was to receive Seroquel (an antipsychotic medication) 25 milligrams (mg) daily due to anxiety. The resident was not receiving this medication prior to her hospitalization.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/24/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating she was cognitively intact. The MDS indicated the resident had no mood or behavior issues.</p> <p>Review of the 9/12/14 Pharmacy recommendation form indicated the following: "was recently readmitted to the facility following a nephrolithotomy. She was placed on Seroquel 25 mg every day with a diagnosis of anxiety. Previously she was not on any psychoactive therapy. I would assume this is being used for acute delirium. May</p>		<p>resident evaluated by the psychiatrist. The DON spoke with the POA regarding the MD orders, she agreed to have the resident seen by the psychiatrist and came into the facility and signed the consent form. The psychiatrist has been notified of the new orders and will see the resident on her next visit. Also, the DON again attempted to ascertain who actually ordered the medication for this resident while she was hospitalized and it was determined that her neurologist ordered it. The resident has an appointment scheduled with her neurologist on November 6, 2014. 2.How will you identify other residents that may be affected by the alleged deficient practice? Any resident receiving prn pain medications, all residents with lab draws, and residents receiving psychotropic meds have the potential to be affected by this alleged deficient practice. 3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be re-in serviced on prn pain monitoring sheets, during re-writes, DON/Designee will compile a list of current lab orders per each resident, SSD will monitor psychotropic medication orders to ensure that each resident has the correct diagnoses and monitoring for each prescribed medication.</p>		

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	<p>we please place an order dated to taper this off as I would assume that long term use of this is unnecessary." This recommendation had not been acted upon by the Physician.</p> <p>Interview with the Director of Nursing (DON) on 10/17/14 at 2:30 p.m., indicated that she was unaware of the indication for the use of the Seroquel, she also indicated that she had been in contact with the Physician and Nurse Practitioner and no explanation was given for the use of the Seroquel.</p> <p>2. Resident #31's record was reviewed on 10/16/14 at 9:14 a.m. The resident's diagnoses included, but were not limited to coronary artery disease and hypertension.</p> <p>Review of the Physician's Order Summary (POS), dated 10/2014, indicated lab orders for CBC (complete blood count), CMP (electrolytes), Lipids, TSH (thyroid stimulating hormone, a laboratory test to assess thyroid function), and HGA1C (hemoglobin A1C, a laboratory test to assess blood glucose levels) in 3 months then every 6 months after that. The order was dated 1/5/14. The POS also indicated an order for Lipids every 6 weeks. The order was dated 3/29/14.</p>		<p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? Random audit of 5 MARs will be performed weekly per DON/ Designee to ensure that there is proper documentation related to prn pain medications and that diagnoses for psychotropic meds match the documented behaviors and/or psychiatrist's notes x3 months. Using an audit tool, lab orders will be audited weekly per DON/Designee to ensure that labs are drawn per MD orders x3 months. DON will present findings to the Quality Assurance committee monthly for three months. Monitoring will continue for a quarter (3 months). If QA findings show an error rate of greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014.</p>				

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	<p>Review of the lab results indicated there was a lack of documentation in the record to indicate the labs had been completed as ordered.</p> <p>Resident #31 had a care plan for hypertension. The nursing interventions included, "...Labs as ordered and report results to physician..."</p> <p>During an interview with the Director of Nursing (DON) on 10/20/14 at 9:20 a.m., she indicated the labs had not been completed as ordered. She indicated they had been missed.</p> <p>3. Resident #49's record was reviewed on 10/15/14 at 1:05 p.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke) and hyperlipidemia.</p> <p>Review of the 10/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 7.5/325 mg (milligrams), one tablet by mouth twice daily as needed for pain.</p> <p>Review of the Medication Administration Record (MAR), dated 10/2014, indicated there was no indication of any assessment of the pain prior to administration of the Norco, no indication of interventions</p>						

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	<p>attempted prior to the administration of the Norco, or any indication that the effectiveness of the medication had been assessed following administration on 10/1/14, 10/3/14, 10/4/14, 10/6/14, 10/8/14, 10/10/14, 10/11/14, 10/12/14, 10/13/14, 10/18/14, and 10/19/14.</p> <p>Review of the MAR, dated 9/2014, indicated there was no indication of any assessment of the pain prior to administration of the Norco, no indication of interventions attempted prior to the administration of the Norco, or any indication that the effectiveness of the medication had been assessed following administration on 9/1/14, 9/2/14, 9/4/14, 9/5/14, 9/6/14, 9/7/14, 9/9/14, 9/10/14, 9/15/14, 9/16/14, 9/17/14, 9/18/14, 9/19/14, 9/20/14, 9/21/14, 9/22/14, 9/23/14, 9/25/14, 9/27/14, 9/29/14, and 9/30/14.</p> <p>Resident #49 had a care plan for risk for pain related to chronic physical disability, left ear pain, and depression. The nursing interventions included, "...Observe for effectiveness of pain interventions..."</p> <p>During an interview with the DON on 10/20/14 at 9:00 a.m., she indicated there was usually a PRN (as needed) flow sheet in the MAR where nurses should</p>			

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	<p>document pain scale, prior interventions, and effectiveness of PRN medications. She further indicated she could not find a PRN flow sheet for Resident #49 for September or October. She indicated staff had been completing the flow sheet previously but stopped for some reason. She further indicated there should have been a PRN flow sheet in place.</p> <p>A facility policy, dated 8/26/13, titled, "Pain Management," received from the DON as current on 10/20/14 at 10:37 a.m., indicated, "...2. When pain is identified:...b. IDT will review and develop an individualized plan of care that includes pharmacological and non pharmacological interventions. 3. Medication (s) received, refused and response to prn medication will be documented on the Medication Administration Record (MAR)...5. Documentation regarding pain management status and effects of pharmacological treatment may be found on Pain Management Flowsheet, nursing notes and/or MAR. 6. Documentation regarding pain status and effects of non-pharmacological treatment may be found in nursing notes and/or monthly summaries..."</p> <p>3.1-48(a)(6)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			
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	<p>Based on observation and interview, the facility failed to prevent the spread of infection related to the proper storage of urinals for 1 of 1 units observed. (The Main Unit)</p> <p>Findings include:</p> <p>1. On 10/15/14 at 10:23 a.m., in room 16, there was an urinal on top of the over bed table. The lid was not covering the urinal. There were two residents who resided in the room.</p> <p>Interview with the Maintenance Director on 10/20/14 at 7:15 a.m., indicated the resident uses his urinal all the time and leaves it on top of the table like that.</p> <p>2. On 10/14/14 at 10:24 a.m., in room 11 there were two urinals noted on each of the bedside tables. The resident in bed one had his urinal on the table uncovered and it was half full of urine. The resident in bed two had his empty urinal sitting on the bedside table uncovered and not in a plastic bag.</p> <p>Interview with the Maintenance Director on 10/20/14 at 7:15 a.m., indicated those residents want their urinals within reach all the time.</p> <p>Interview with the Director of Nursing on</p>	F000441	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Urinals for residents in rooms 16 and 11 have been replaced with lidded urinals. Care Plans have been put into place regarding the resident's preference of having their urinals within reach at all times. 2.How will you identify other residents that may be affected by the alleged deficient practice? All male continent residents have the potential to be affected by the alleged deficient practice. 3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All staff will be in serviced on the storage and proper care of urinals, during room rounds IDT members will observe the condition of urinals in resident's rooms. Any deficiencies will be corrected and reported to the DON, MDS will develop care plans for any resident that prefers to keep their urinal within reach. 4.How will the corrective actions be monitored to ensure the deficient practice will not recur? Rounds will be done each shift per Nurses and round sheets will be turned into the DON on a daily basis, IDT room round sheets will be turned in daily to the Administrator to ensure corrections have been made. This process will be monitored x 3 months. Findings</p>	11/19/2014

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F000465 SS=D	<p>10/20/14 at 7:25 a.m., indicated the above residents want their urinals within reach all the time. She further indicated the resident's did not have a care plan for their preferences and the staff were supposed to be monitoring the urinals and emptying them on an as needed basis. She indicated the facility did not have a policy regarding the storage of urinals, but she would expect the lids to be on them at all times.</p> <p>3.1-18(b)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to marred walls, holes in walls, urine odors, stained privacy curtains and exposed wires from old phone and cable boxes for 1 of 1 units observed. (The Main Unit)</p> <p>Findings include:</p> <p>1. On 10/20/14 at 7:15 a.m., the following was observed during the environmental tour on the Main Unit:</p>	F000465	<p>will be presented to the Quality Assurance Committee monthly for three months. Monitoring will continue for a quarter , if QA findings show an error rate of greater than 20%, audits will continue until error rate is <20%. Completion date: November 19, 2014</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Items A, B, C, D.F, and G were corrected during the survey. Item E was immediately covered and will be patched and painted by 11/19/2014. 2.How will you identify other residents that may be affected by the alleged deficient practice? A survey of the other resident rooms discovered no other issues. If other issues had been discovered, they would have been corrected as needed by 11/19/2014.</p>	11/19/2014			

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	<p>A. There was a strong and stale urine odor in room 13. There was no face plate over an electrical outlet above heat register. There were two residents who resided in the room.</p> <p>B. The privacy curtain between beds 1 and 2 was stained with dark circular stains in room 11. There were two residents who resided in the room.</p> <p>C. The wall on side of bed 1 in room 10 was observed with holes. The tape around the pipes above the sink was torn. There were two residents who resided in the room.</p> <p>D. The wall was marred next to bed 2 in room 1. There was also a large amount of spackle on wall. There were two residents who resided in the room.</p> <p>E. There was a large gaping hole in the wall next to bed 2 in room 2. There were two residents who resided in the room.</p> <p>F. In room 15, the face plate of an old cable jack was loose and exposed wires were noted. There were two residents who resided in the room.</p> <p>G. In room 14, there was an old phone jack noted on the wall by bed 2. There</p>		<p>3.What measures have been put into place or what systematic changes will be made to ensure that the deficient practice does not recur? In order to ensure that such issues do not arise in the future, the Maintenance Director will twice monthly inspect all residents' room for compliance. Additionally, all staff will be re-in serviced on the location of the Maintenance requests forms and how to properly fill them out.</p> <p>4.How will the corrective actions be monitored to ensure the deficient practice will not recur? The maintenance Director will submit a summary report to QA Committee as to issues found and corrected. Compliance date: November 19, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000520 SS=D	<p>were exposed wires also noted from the phone jack. There were two residents who resided in the room.</p> <p>Interview with the Maintenance Supervisor on 10/20/14 at 7:25 a.m., indicated all of the above were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview,</p>	F000520	It is the practice of Highland	11/19/2014

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	<p>the facility failed to identify non-compliance of the facility's restraint use and for non pressure related areas related to the monitoring and assessment of bruises through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator and Director of Nursing on 10/20/14 at 1:00 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of both, the Administrator, the Director of Nursing, Social Service, Dietary, Activities, and Nursing as well as the Medical Director. The Director of Nursing indicated at the time, non pressure related areas such as bruising had not been discussed, addressed or identified as being a problem in Quality Assurance since the last survey. She further indicated there had been no action plan or system put into place to identify the problem of not identifying, assessing, or monitoring bruises. She indicated they had put the problem of monitoring bruising back into compliance during the April 24, 2014 Quality Assurance meeting.</p> <p>The Director of Nursing further indicated they had not been aware there was another problem of not monitoring or</p>		<p>Nursing & Rehab to have systems in place to identify, assess, and monitor adverse happenings as they relate to our residents, families, and staff.</p> <ol style="list-style-type: none"> All residents with bruises were identified. Skin sheets with treatments were established. All residents with restraints were identified and corrected. All residents with falls and/or bruises have the potential to be effected. Bruises and restraints will be monitored on an on-going basis at the morning meeting. Q A Committee will be in-serviced on the facility policy concerning Bruises and Restraints. Bruises and Restraints will be monitored on a monthly basis. Q A Committee and HFA to monitor Compliance by 11/16/2014 		

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	<p>assessing new bruises. She further indicated the process/system that was in place to identify changes with the residents was to discuss the issues and talk about the problems in the daily morning meeting. She indicated they (department heads) would discuss any significant changes that had happened to the residents and what interventions needed to be put in place. She indicated it seemed to go in "spurts", they would have a lot of residents with bruising and then they would have any.</p> <p>Interview with LPN #1 on 10/16/14 at 2:45 p.m., indicated when a bruise was noticed by staff, he was to complete an incident report, fill out the wound sheets with the measurement of the bruise, notify the Physician and family and monitor the bruise every week until it had healed.</p> <p>Continued interview with the Director of Nursing at that time, indicated restraints were discussed every morning meeting if new orders had been obtained for the restraint. She indicated they would ask about restraints daily if there were any new orders for one. She further indicated she was completely unaware Resident #24 had a seat belt restraint in place. She further indicated the Physician and the family wanted Resident</p>				

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	#20 to have a restraint, so they allowed a lap buddy restraint. The Director of Nursing indicated the facility did not have any type of restraint assessments to continue to monitor and assess for reduction for as long as she had been working there. She indicated restraints were only discussed on a quarterly basis and the last time restraints were discussed was 8/2014. She indicated there have never been any action plan required for restraints due to the fact they had not had any or very few. 3.1-52(b)(2)				