

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2012
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F0000	<p>This visit was for the Investigation of Complaints IN00111937 and IN00112652.</p> <p>Complaint IN00111937 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F248, F279, F250, F309, F323, F329, and F365.</p> <p>Complaint IN00112652 - Substantiated. Federal/state deficiencies related to the allegation are cited at F323.</p> <p>Survey dates: July 31 - August 2, 2012</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team: Janet Adams, RN, TC Shannon Pietraszewski, RN July 31, 2012 & August 2, 2012</p> <p>Census bed type: SNF: 3 SNF/NF: 109 NCC: 1 Total: 113</p> <p>Census payor type:</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Whispering Pines desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on September 1, 2012.</p>	

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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	<p>Medicare: 13 Medicaid: 70 Other: 30 Total: 113</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/09/12 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Physician was notified of changes in the resident's condition related to a choking episode, bruises, refusal of treatments,</p>	F0157	F157 It is the policy of this facility to ensure the Physician is notified of changes in a resident's condition, refusal of treatments, and follow up after a medication change. <u>I. Specific Corrective</u>	09/01/2012

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	<p>and follow up after a medication change, for 3 of 11 residents reviewed for Physician notification in the sample of 11. (Residents #F, #G, and #J)</p> <p>Findings include:</p> <p>1. The closed record for resident #F was reviewed on 7/31/12 at 12:45 p.m. The resident was discharged from the facility on 7/5/12. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, neuropathy, and cerebral vascular disease.</p> <p>Review of the 10/11 Medication Administration Record indicated the resident had been receiving lorazepam(generic name for Ativan which is an anti anxiety medication) 0.5 milligrams daily at 2:00 p.m. and Lorazepam 1.5 milligrams daily at night. The above medications were signed out as given from 10/11/12 thru 10/25/12. The above medications were circled as not given on 10/26 and 10/27/12. The medications were then signed out as given 10/28/12 through 10/31/12.</p> <p>The 10/11 Nurses' Notes were reviewed. An entry made on 10/26/11 at 1:00 p.m. indicated the resident was lethargic, was not able to feed herself breakfast, and refused to get up for lunch. The</p>		<p>Actions: 1. The nurse(s) involved in not making sure the attending physician was notified, or when no call back was received, making sure the Medical Director was notified, have been given staff educations regarding proper procedure. 2. The physician was immediately notified of the resident's non-compliance with the abductor pillow; staff members involved were given staff educations regarding proper procedure related to physician notification. 3. The physician was immediately notified of the coughing episode and LPN#1 was given a staff education related to proper procedure. II. Identification and correction of others: All residents have the potential to be affected by Physician notification not being completed as per policy. Resident charts were reviewed for proper Physician notification regarding a change in condition, treatment refusal, and medication change follow up. III. Systemic Changes: All nurses will be re-educated regarding the Physician Notification Policy prior to September 1, 2012. IV. Monitoring: The Unit Managers or designee will review daily the New Physician Orders Form and the updated 24 Hour Report Form. Any resident listed on either Form related to incidents, change in condition, treatment refusals, or medication</p>				

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	<p>Physician was called and new orders were given to hold the resident's Ativan (an anti anxiety medication) for two days and then update the Physician. An entry made on 10/28/11 at 2:45 p.m. indicated the Physician was paged and no return call was received. An entry made on 10/29/11 indicated the Physician was paged related the Ativan being held and no return call was received. There was no further documentation provided to indicate the Physician had been notified as ordered.</p> <p>When interviewed on 8/1/12 at 11:40 a.m., the Director of Nursing provided no further documentation of the Physician being notified as ordered.</p> <p>2. On 7/31/12 at 12:40 p.m., Resident G was observed in bed, laying on his side, asleep. The abductor pillow (wedge pillow) was lying on the bed behind the resident's legs. During this time, the Unit Program Director indicated the resident was not cooperative with the abductor pillow and has constantly removed it from his legs.</p> <p>On 8/2/12 at 10:45 a.m., Resident G was observed lying on his side in bed asleep. The abductor pillow was observed to be on a table in the corner of the resident's room. Upon interviewing CNA #4 at this time, she did not indicate if she had</p>		changes; will have their chart audited for proper Physician Notification. The DNS or designee will choose eight (8) random charts weekly to ensure audits were completed. The daily and weekly audits will continue for at least the next eight (8) months. [Forms: updated 24 Hour Report Sheet and New Order/Physician Notification Audit]				

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	<p>attempted to put the abductor pillow between the resident's legs.</p> <p>Resident G's record was reviewed on 7/31/12 at 1:50 p.m. Resident G's diagnoses included, but were not limited to, femoral fracture of the right hip and dementia.</p> <p>Discharge orders from the hospital on 7/14/12 indicated "...Abductor pillow for 6 weeks..."</p> <p>The Physician orders for 7/14/12 to 7/31/12 indicated the resident was to use an abductor pillow for six weeks when he was in bed or in the chair.</p> <p>An Initial Care Plan dated 7/14/12 indicated the resident was to use the abductor pillow for six weeks. A Care Plan for pain indicated interventions initiated on 7/23/12 included for the resident to have an abductor pillow while in the bed or the chair for 6 weeks.</p> <p>Nursing Notes dated 7/14/12 at 7:00 p.m. indicated "...pulling at abductor pillow-has (L) leg out of abductor pillow..." At 9:00 p.m., a nursing note indicated "...Abductor pillow put back in place..." At 10:20 p.m., a nursing note indicated "CNA (certified nursing assistant) reports that pt (patient) has</p>			

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	<p>removed abductor pillow from (L) leg..."</p> <p>On 7/15/12 at 12:30 a.m., a nursing note indicated "...Abductor pillow in place, but attempting to remove..."</p> <p>A Physical Therapy Evaluation dated 7/16/12 indicated</p> <p>"...Precautions/Complications: Right (R with circle around it) hip Arthroplasty precautions, Abductor pillow when in bed and wheelchair x 6 weeks, Fall Risk, Confusion...Positioning needs-Requires Abd (abductor) pillow in bed and wc (wheelchair) x 6 wks (weeks)."</p> <p>There was no further documentation indicating the resident's removal of the abductor pillow and there was no documentation indicating the doctor was notified of the resident removing the abductor pillow.</p> <p>When interviewed on 8/2/11 at 11:00 a.m., the Unit Director indicated the physician should have been notified of the resident's refusal to use the abductor pillow.</p> <p>3. On 7/31/12 at 11:55 a.m., Resident J's record was reviewed. Resident J's diagnoses included, but were not limited to, dysphagia, GERD (gastro-esophageal reflux disease), malaise, and ischemia.</p>			

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	<p>Review of the 8/12 Physician Order Sheet indicated there was an order for the resident to have a mechanical soft diet. The order was initially written on 1/9/12.</p> <p>A nursing note dated 6/25/12 at 5:20 p.m. indicated "Res (resident) eating cole slaw, started coughing-able to clear throat with (c with line above it) cough. Four min (minutes) later, drinking nectar thick coffee & (and) began to cough..."</p> <p>A modified barium swallow study on 8/11/2011 indicated the resident had "multiple episodes of coughing during the study which could have indicated a small aspiration beyond the coal folds...pt (patient) with aspiration with mixed consistency. Pt unable to coordinate chewing and swallowing effectively/safely..."</p> <p>There were no further documentation beyond 6/25/12 to indicate if the physician was notified of the "coughing" episode.</p> <p>When interviewed on 7/31/12 at 2:50 p.m., LPN #1 indicated the physician should have been notified of the choking episode.</p> <p>This federal tag relates to Complaint IN00111937.</p>			

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	3.1-5(a)(2) 3.1-5(a)(3)			

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F0248 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 provide activities to meet the individual needs and interests of residents for 3 of 3 residents with diagnoses of dementia reviewed for activities in the sample of 11. (Residents #C, #G, and #L)</p> <p>Findings include:</p> <p>1. On 7/31/12 at 12:00 p.m., Resident #C was observed in recliner in the lounge area connected to unit Dining Room. The resident's eyes were closed. There were no staff members in the room. The resident was not involved in any activity.</p> <p>On 8/1/12 at 7:55 a.m., the resident was observed sitting in a wheel chair in the dining room. CNA#3 was feeding the resident her breakfast. At 9:39 a.m., the CNA transferred the resident from her wheel chair into the same recliner she was observed in on 7/31/12. The CNA elevated the resident's feet in the reclined position. The CNA did not provide any activity materials for the resident. The</p>	F0248	<p>F248 It is the policy of this facility to ensure 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. I. Specific Corrective Actions: 1. Resident C's activity related care plans were updated to reflect the change in condition and new activities to be provided based on his/her individual preferences. CNA #3 received a staff education related to providing activities to all residents based on their care plans. 2. Resident L's "Caleb's Basket" was placed in his chart so staff could offer activities geared to his/her individual preferences. Staff members responsible for providing activities to Resident L on 8/1 received staff educations related to trying to engage the resident(s) under their care to find out what activity he/she may enjoy if unsure of preferences. 3. Resident G's activity care plan was updated to reflect his/her declined status and new interventions were included for</p>	09/01/2012			

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	<p>there was a television near the top of the wall in the activity room. The Olympics were being shown on the television. There was no music playing in the room. Resident #C was not watching the television.</p> <p>On 8/1/12 at 10:05 a.m., the resident remained in the recliner and was not engaged in any activity nor was any music playing. The Olympics remained on the television screen. There was a Watermelon activity being conducted by CNA occurring in the Dining Room that was connected to the lounge. At 11:00 a.m. and 11:15 a.m., the resident was still observed in the recliner in the lounge area. The resident was awake and was not engaged in any activity. There were no staff or visitors in the room. There was no music playing. The television remained on showing the Olympics.</p> <p>On 8/1/12 at 1:10 p.m., the resident was observed sitting in a wheel chair in the lounge area. The resident was awake and was not facing the television and was not engaged in any activity. There was no music playing in the room. There was no activity taking place at this time. At 1:11 p.m., CNA #3 transferred the resident from the wheel chair into the same recliner in the lounge area. The resident was awake. No activity was provided at</p>		<p>staff to follow. CNA #4 received a staff education related to checking care plans to see what type of stimulation to provide each resident under his/her care.</p> <p>II. Identification and correction of others: All residents with dementia have the potential to be affected by a lack of activities designed to meet their individual interests/needs. All of these residents' charts were reviewed and care plans updated, if needed, to indicate their individual interests/needs. III. Systemic Changes: All staff who provide care on the dementia unit will attend an in-service related to discovering the individual interests/needs of the residents under their care and providing activities throughout the residents' day. Activity Books will include each resident's care plans and Caleb's Basket with participation records. IV. Monitoring: The Program Director on the dementia unit or designee will randomly audit three Activity Books on Elm [census of 15] and Linden [census of 14] and four on Maple [census of 21] for a total of ten per day (Mon-Fri) for the next four weeks. It will then decrease to weekly for at least the next seven (7) months. The audit will be turned into the ED every Monday for the previous week.</p>				

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	<p>this time. There were a total of five residents in the lounge and no activity was being provided. There were no verbal interactions between the residents that were in the lounge. CNA #3 was the only staff member in the room and she exited the room after Resident #C was placed in the recliner. At 1:20 p.m., the resident remained in the recliner along with the other residents. There was no activity occurring at this time. No staff members were observed in the lounge.</p> <p>On 8/1/12 at 1:55 p.m., the resident remained in the recliner chair in the lounge. The other residents also remained in the room. There was no interaction occurring between the residents that were in the lounge room. The resident remained in the recliner at 2:30 p.m., 2:45 p.m., and 3:00 p.m. No activity was provided to the resident at any of the above times. No music was playing at any of the above times.</p> <p>The record for Resident #C was reviewed on 8/1/12 at 8:42 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and failure to thrive. The 6/8/12 MDS (Minimum Data Set) quarterly assessment indicated the BIMS (Brief Interview for Mental Status) indicated the resident's cognitive skills were severely impaired. The assessment</p>			

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	<p>also indicated the resident required assistance from staff for transferring, dressing, eating, personal hygiene and locomotion on the unit.</p> <p>A care plan initiated on 5/25/12 indicated the resident required routine, structure, & cues of the therapeutic program of special care. The care plan also indicated the resident had a recent illness has been sleeping much of the day. The care plan was last updated with a goal date of 8/12. Care plan interventions include for staff to invite and transport the resident to programs that she is not able to take herself to, staff to ask the resident if she would like to sit "by the the birds." Other interventions included for staff to encourage social interaction with peers and staff and to ensure the resident is at the live musical programs and have her sit up front as her hearing was impaired.</p> <p>The 12/19/11 Activities Progress Note indicated the resident is up daily in the wheel chair and is able to propel self and ambulates daily with restorative. The note also indicated the resident participated in unit programs of music, crafts, cooking, church services and watching the birds. The 3/19/12 Activities Progress Note indicated the resident resided on a unit of the Special Care Program. This note also indicated</p>			

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	<p>the resident currently was being treated for a respiratory infection and was on oxygen and nebulizer breathing treatments. The note also indicated the resident was now up in the wheel chair for meals and otherwise in the recliner or in bed due to her weakness and being tired. The 6/11/12 Activities Progress Note indicated the resident continues to sleep most of the time and enjoys listening to music and is able to answer simple yes/no questions.</p> <p>When interviewed on 8/1/12 at 12:20 p.m., RN#1 indicated Resident #C has had a decline in her condition. The RN indicated the resident had a respiratory infection around March and has showed signs of decline since then and is not eating well and is sleeping a lot . The RN indicated the resident used to be able to assist with transfers around and liked to go sit by the birds in the hall and watch the birds all morning.</p> <p>When interviewed on 8/2/12 at 9:30 a.m., the Activity Director indicated she was not responsible for completing activity assessments, care plans, or providing activities for the residents on the three dementia special care units. The Activity Director indicated the Program Director for those units completed the above for all the residents on those units.</p>						

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	<p>When interviewed on 8/2/12 at 9:50 a.m., the Alzheimer's Program Director indicated there are three dementia units which are for different levels of functioning. The Director indicated there are no residents currently on 1:1 activities. The Director indicated Activity staff do not provide activities on these units. The Director indicated there is one calendar for the three units and staff alter the activity some for each unit. The Director indicated the Resident #C had had a decline in her condition over the past months and was spending most of the time in the recliner.</p> <p>2. On 8/1/12 at 9:45 a.m., Resident #L was observed sitting in a chair in dining room in one of the special care dementia units. There were no other residents at the table with the resident. The resident's hands were folded and his head was down. There was a Watermelon activity taking place at a table behind the resident. At 10:02 a.m. and 10:25 a.m., the resident remained in the chair with his hands folded across his chest. There was no television or music on.</p> <p>On 8/1/12 at 10:50 a.m., 10:55 a.m., and 11:15 a.m., the resident remained in the chair in the dining room. He was not offered anything activity supplies from</p>			

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	<p>staff.</p> <p>On 8/1/12 at 1:10 p.m., Resident #L was observed in the unit Dining Room. The resident was sitting in a chair next to the table where he had been observed earlier as above. The resident was observed in the chair in the same above area at 1:10 p.m., 1:55 p.m., 2:25 p.m., and 3:00 p.m. There was no television or music playing at the above times. There were no activities being conducted in the room at the above times</p> <p>On 8/1/12 at 3:00 p.m., the resident remained in the chair in the dining room at the location. He was awake. There were no staff members in the dining room. There was no music or television on. The resident was interviewed at this time. The resident was asked if he could recall what he had for lunch and he indicated he could not remember but stated " I know what I had last night. I had blue gill." The resident was smiling and continued to talk about fishing he and his son had done in the past and how he taught his son to fish and how he enjoys those times.</p> <p>The record for Resident #L was reviewed on 8/1/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease,</p>			

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	<p>arthritis, and high blood pressure. The resident resided on one of the Special Care dementia units. The resident was admitted to the facility on 5/8/12.</p> <p>The 5/14/12 MDS (Minimum Data Set) admission assessment indicated the resident was able to make himself understood and was able to understand others. The resident's BIMS (Brief Interview for Mental Status) indicated his cognitive skills were moderately impaired. The assessment also indicated the resident felt it was very important to him to have books, newspapers, or magazines to read and to do his favorite activity. The assessment also indicated it was somewhat important to him to listen to music he liked, to keep up with the news, and to do things with groups of people.</p> <p>A care plan initiated on 5/8/12 indicated the resident had cognitive loss secondary to Alzheimer's disease and he needed cues, routine activities and structure of the therapeutic program to function at maximum potential. There were nothing listed under the "past interests" section on the care plan. Care plan interventions included for staff to provide the resident segmentation, set up and cues to participate in programs. Other interventions included for staff to</p>			

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	<p>encourage the resident to participate in programs of interest for short periods of time such as sensory books, puzzles, sorting, and music, and for staff to encourage social interaction with staff and peers daily.</p> <p>An Activities Progress Note completed for the Initial Assessment reference dates of 5/8/12 through 5/14/12 indicated the resident enjoys socializing with staff, watches television in his room and had participated in the walk and roll program. The note also indicated staff will continue to engage the resident in programs of interest. There were no further Activities Progress Notes.</p> <p>The August 2012 "Individual Resident Daily Activities Log" for the 6a-2p shift indicated there was documentation checked to indicate the any activities that were provided for or that the resident attended on 8/1/12.</p> <p>When interviewed on 8/2/12 at 9:30 a.m., the Activity Director indicated she was not responsible for completing activity assessments, care plans, or providing activities for the residents on the three dementia special care units. The Activity Director indicated the Program Director for those units completed the above for all the residents on those units.</p>			

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	<p>When interviewed on 8/2/12 at 9:30 a.m., the Alzheimer Program Director indicated there is one calendar for the three units and staff alter the activity some for each unit. The Director indicated the activity history of each resident is obtained by completing a form titled "Caleb's Basket". The Program Director indicated she recalled giving the form to the resident's wife to complete and she received the form back from the wife but was currently unable to locate the form.</p> <p>3. On 7/31/12 at 12:40 p.m., Resident G was observed in bed, laying on his side, asleep. The wedge pillow was lying on the bed behind the resident's legs.</p> <p>On 8/2/12 at 10:45 a.m., Resident G was observed laying in bed asleep. During this time, CNA #4 was interviewed and indicated the resident used to be independent in walking and was known to "get into things" before his fall/hip fracture. Since the resident returned from the hospital with the hip fracture, "all he wants to do is sleep. If he gets up for breakfast and lunch, he wants to go right back to bed after the meals."</p> <p>Resident G's record was reviewed on 7/31/12 at 1:50 p.m.. Resident G's diagnoses included, but were not limited to, femoral fracture of the right hip and</p>						

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	<p>dementia.</p> <p>A care plan initiated on 7/27/12, indicated the resident had a need for routine, structure & cues for the therapeutic program of the special care unit. Care plan interventions included for staff to offer brief 1:1 stimulation when he is out in the chair and to play soft music for the resident.</p> <p>The Unit Program Director was interviewed on 8/2/12 at 11:00 a.m., regarding the resident's activities and changes he has displayed. She indicated she did not have 1:1 activities for the resident or had updated his activity care plan to reflect his declined status.</p> <p>This federal tag relates to Complaint IN00111937.</p> <p>3.1-33(a) 3.1-33(b)(8) 3.1-33(d)(2)</p>						

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to monitor behaviors and develop and implement interventions for repeated behaviors, according to their policy and procedure, for 1 of 3 residents reviewed for behaviors and receiving psychoactive medications in the sample of 11. (Resident #H)</p> <p>Finding include:</p> <p>The record for Resident H was reviewed on 7/31/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), gait difficulty, high blood pressure, and Alzheimer's/dementia.</p> <p>On 7/8/12 (no time), the Behavior Tracking Sheet indicated Resident H "Kept grabbing other resident hand and squeezing it saying give me my money". There was no nursing documentation indicating the incident. There was no investigation.</p> <p>On 7/9/12 at 12:55 p.m., a nursing note</p>	F0250	<p>F250 It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. I. Specific Corrective Actions: The staff involved in not properly communicating behaviors and/or concerns have been given staff educations regarding proper procedure. II. Identification and correction of others: All residents have the potential to be affected by inconsistent documentation and non-compliance with the facility behavior policy. The policy was reviewed and updated. All behavior books were reviewed for proper documentation and consistent follow through. III. Systemic Changes: All staff will be educated on the new behavior monitoring program and forms prior to Sept. 1, 2012. IV. Monitoring: The behavior books will be reviewed daily (Mon-Fri) by Social Service and the clinical team. Any resident listed in the behavior book and having a behavior will have their chart audited for proper documentation and follow through for at least the next eight (8) months. A facility</p>	09/01/2012			

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	<p>indicated, "CNA reported to this writer that resident had hit another resident on her face..." The incident was not indicated on the Behavior Tracking Sheet.</p> <p>A Social Services Intervention /Referral form dated 7/10/12 was filled out by nursing and given to the social service department. The explanation on the form indicated "(Resident H) hit (Resident name) on (L) side of her face. (Resident H) was in (Resident name) room. No redness or bruising noted." On the bottom of the page, both residents' names with the dates of 7/10/12, 7/11/12 and 7/12/12 was written with check marks next to the dates with "Addressed" handwritten in the right corner. A social service note on 7/10/12 indicated, "... made aware this day that res. (resident) had psy (physical) aggression toward another res. Social services met with resident. res. (resident) had no recall of behavior. no behavior seen [sic] aggression." The 7/11/12, social service note indicated, "... met w/res. No recall of aggression. Res is on behavior tracking and no behavior seen [sic] aggression. A Nurse Practitioner from a medical group saw the resident on 7/11/12 and ordered Lexapro (an antidepressant) medication) 5 mg daily to decrease symptoms." The 7/12/12 social service note indicated, "no signs of</p>		<p>Behavior/GDR Book has been initiated. [Updated: Behavior Monitoring Program P&P, Daily Behavior Tracking Form, Behavior Monitoring Log, Monthly Behavior Summary form, Psychotropic Review and PRN Medication Administration Audit form]</p>	

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	<p>distress or increase in behaviors."</p> <p>A Behavior Tracking Sheet dated 7/17/12 at 8:00 a.m., indicated the resident had said, "get the Hell away from me or I will slap your face." No nursing note indicated the incident and Social Service was not made aware. No Medication behavior log was initiated during this time.</p> <p>On 7/18/12 at 9:00 a.m., a nursing note indicated, "Restorative aide reported res hit another res in back of neck." The incident was not indicated on the Behavior Tracking Sheet.. The Medication behavior log was not initiated during this time.</p> <p>A Social Services Intervention/Referral form dated 7/18/12 was filled out by nursing and given to the social service department. The explanation on the form indicated, "(Resident H) hit (Resident name) in back of neck. "Bottom right corner indicated "Received 7/18/12 @ 10 a (a.m.)" and "Addressed." A social service note on 7/18/12 indicated, "... was informed that res. open handed hit another res. in the back of the head. Social Services met w/res. She had no recall of aggression. Nursing & writer agreed to 24 hr. (hours) intervention. Res did have an increase of Lexapro (a medication for</p>						

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	<p>depression) 5mg on 7/11/12. Res has dx (diagnoses) of dementia and receives donepezil (Alzheimer/Dementia medication) 10 mg @ (at) bedtime & Namenda (Alzheimer medication) 10 mg x2 daily (twice a day). She is currently being seen by (name of specialty group) for mental health services. Physician schedule to see res. July 23rd. Resident showed no behaviors or aggression after (p with line over it) a.m. Social Service met with resident @ approx (approximately) 3 p.m. Res was assisted by staff to shower room. No signs of aggression. Res was laughing & making small talk w/staff. "</p> <p>On 7/19/12 at 8:40 a.m., a social service note indicated, "... met with resident. She was eating breakfast with peers. No signs of aggression." On 7/20/12, a social service note indicated, "... met with resident. No signs of behaviors...."</p> <p>A nursing note on 7/20/12 at 8:30 p.m. indicated, "increased (arrow pointing up) agitation noted this shift. Resident removing items from other residents' rooms, yelling out at times towards staff..." This was not indicated on the Behavior Tracking Sheet, Medication Behavior Log, or by the social service department.</p>			

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	<p>A nursing note on 7/22/12 at 10:20 a.m. indicated, "Episode involving res (resident) with another res reported to writer..." This was not indicated on the Behavior Tracking Sheet or the Medication Behavior Log. A Social Services Intervention /Referral form was filled out by nursing and given to the social service department. The explanation on the form indicated, "was in (room number) kissing resident." Interventions on the Incident Report form indicated for Resident H "encourage res to stay in common area. Continue to observe. Offer activity."</p> <p>On 7/22/12 at 2:00 p.m., the Behavior Tracking Sheet indicated the resident, "slapped aid in face and grabbed aides buttocks." At 4:00 p.m., the Behavior Tracking Sheet indicated the resident, "punched aide in face and kicked aide. Tried grabbing aide into her w/ (with) her legs." A nursing note on at 4:15 p.m. indicated, "Res hit CNA in nose and laughed. CNA turned from res. Res kick her in buttocks. Writer ask res please not to do that res [sic] said yes well I sock you to. Res then relaxed and began singing." The writer did notify the physician and received an order for Ativan (an anti anxiety medication) and a UA (urinalysis) C&S (culture and sensitivity). A nursing note at 7:00 p.m.</p>			

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	<p>indicated, "Res. cont (continued) to verbally threaten staff with (c with a line above it) hitting them." At 9:30 p.m., a nursing note indicated a UA C&S was obtained.</p> <p>A Social Services Intervention /Referral form dated 7/22/12 was filled out by nursing and given to the social service department. The explanation on the form indicated, "[Resident H] hit (socked CNA #5 in mouth) kick her in butt and hit her butt. Separate occasions today." Bottom right corner indicated "received 7/23/12." The social services note on 7/23/12 indicated, "Resident was seen by (name of specialty medical group) due to psy (physical) aggressive behaviors. Resident was given a medication change of "add Risperdal (an anti psychotic medication) 0.25 mg for mood, decrease (arrow pointing down) delusions. Social Services met with resident. Res expressed no aggression or actions. Re has Dx. of : dementia. Res is on behavior tracking for behaviors."</p> <p>A nursing note on 7/24/12 at 5:00 p.m. indicated Cipro (an antibiotic) was ordered twice a day for 10 days for a urinary tract infection. At 6:45 p.m., a nursing note indicated, "resident in w/c (wheel chair) by emergency exit looking out window as writer walked by she</p>			

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	<p>noticed resident sitting on the floor in front of her w/c..." A social service note (no time) indicated, "... met w/res. No behaviors reported. Res was visiting with peers."</p> <p>A nursing note on 7/25/12 at 3:20 p.m. indicated the Cipro was discontinued and Gentamycin (an antibiotic) was ordered for the urinary tract infection. A social service note (no time) indicated, "...met w/res. Res was in dinning [sic] area eating a.m. meal making conversation w/staff. No behaviors reported."</p> <p>On 7/26/12 at 7:00 p.m., the Behavior Tracking Sheet indicated the resident, "grabbed aide and dug nails into aide, scratched aide on arm & (and) threatened to punch aide." A nursing note at 8:00 p.m. indicated, "IM (intra muscular injection) Gentamycin given...Risperdal continues without A/R (adverse reactions). Res attempted to hit staff during care...Res would laugh and state you better watch it..." The behaviors were not documented on the Medication Behavior log. A social service note indicated, "no signs of distress." A social service note on 7/27/12 indicated, "...met with (name of specialty group). Writer request follow up w/res. No behaviors reflected. Nursing informed."</p>			

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	<p>A Medication Behavioral Log for July was initiated on 7/19/12. The behaviors listed on the Log were Verbal and Physical aggression. No episodes of verbal aggression were indicated on all shifts. Two episodes of physical aggression were indicated on the evening shifts on 7/22/12 and 7/24/12.</p> <p>A "Behavior Monitoring Program Policy and Procedure" was provided by the DON on 7/31/12 at 4:00 p.m. The Policy and Procedure indicated, "...Behaviors that are potentially harmful to the welfare of the resident's safety or the safety of others, or behaviors that violate the rights of others will be reviewed for possible daily behavior tracking. The Goal of the Daily Behavior Tracking program is to provide a safe and secure environment for residents exhibiting psychosocial and physical well-being concerns as well as to provide a safe and secure environment for all residents...When a problematic behavior has been identified, a plan of action will be developed to hopefully reduce, manage or eliminate the problematic behavior... Benign agenda behaviors that are expected outcomes with the progression of Alzheimer's and dementia disease...will be identified on the care plan with concentration on approaches that enable the resident to freedom to complete these agenda</p>						

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	<p>behaviors in a safe and appropriate manner...If the resident has the potential to cause harm to self or others, the 1:1 Policy will be implemented until the resident can be assessed and revision of the Care Plan done...The Behavior Monitoring flow Record will be used to track behaviors related to anti-anxiety and anti-psychotics...Social Services will do weekly tracking of residents on Behavior Management...."</p> <p>During an interview with the DON and Administrator on 8/2/12 at 8:40 a.m., they indicated they were not aware of the 7/8/12 incident. Both the DON and Administrator indicated the staff are allowed on the weekend to initiate Incident Reports and the 7/8/12 "slipped by the Unit Manager." For the 7/9/12 incident, DON indicated "monitoring" was the intervention for the resident. When asked to clarify what monitoring included, the DON indicated "engaging the resident." The intervention for the 7/18/12 incident was indicated by the DON to be "monitoring" and the Lexapro was started on 7/11/12. When asked about the intervention for the 7/22/12 incident, the DON indicated the (Name of specialty group) was contacted to see the resident and the new order for a UA, ativan and Risperdal. When asked for the protocol and 1:1 with the resident, The</p>			

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	<p>DON indicated she wasn't sure about the protocol but believed the resident did not qualify for 1:1. When asked what would qualify the resident for 1:1, she indicated attempting to hurt him/herself or "something like that." The DON and Administrator was not aware of the 7/26/12 incident. The Administrator indicated the ADON, DON has discussions with the Unit Managers every morning and they go over the 24 hour report. Every Tuesday, there is a "Stand up" meeting where falls and behaviors are addressed. Both DON and Administrator acknowledged the Medication Behavior log was initiated late.</p> <p>On 8/2/12 at 11:20 a.m., the Administrator provided the "1:1 Policy for Residents with Behaviors." During an interview with the Administrator at this time, she indicated if she was aware of the 7/8/12 incident, she would have considered the 1:1 policy and why it was happening. If there was actual harm, the 1:1 policy would have been enforced. Asked to define "potential for harm and actual harm". She indicated the need to verify if the incident was isolated, if the resident was not redirectable or did the action cause actual/physical harm. Administrator indicated the 7/18/12 incident had the potential for harm and they should have looked into IDT</p>			

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	<p>(Interdisciplinary Team) and put measures into place." She also indicated they should have looked at the using the policy. When asked how they are monitoring the resident, she indicated she is hoping staff is watching the resident when observed at the door, checking on the resident more frequently/what they are doing/and for increased agitation.</p> <p>The 1:1 Policy for Residents with Behaviors indicated, "...When a resident exhibits behaviors that could be harmful to themselves or other residents, a staff member will be assigned to take care of them and be with them at all times for their safety and the safety of other residents. This staff member will be scheduled as soon as one is available, which might not be until the next shift. In this instance, the resident will not be left unattended at any time. The nurse and/or a CNA from another unit will provide assistance to ensure the resident is never alone. After the first 24 hours of 1:1, the time frames for the 1:1 will be adjusted according to the times found as patterns when the resident is demonstrating behaviors that could be harmful to them or other residents..."</p> <p>During an interview with Social Worker (SW) #1 on 8/2/12 at 12:30 p.m., she indicated the other SW was off on 7/9/12</p>			

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	<p>and she thought SW #2 was aware of the 7/8/12 incident. She also indicated SW #2 puts check marks on the Behavior Tracking Log when she had addressed the problem. She indicated they follow up with residents who have behaviors by 72 hour charting and they check the Behavior Tracking Log for new behaviors on a daily basis. For ongoing behaviors, they check the Behavior Tracking Sheets daily to every other day, review care plans or they get informed by nursing. She indicated they are thinking of more interventions. The resident is always looking for her husband, and talk to the Activities Director about getting the resident involved. She indicated the psychiatrist visits the facility one to two times a month and the psychologist visits monthly. She indicated they contact these physicians when it is a severe situation and they need to come see the resident such as resident to resident, verbal/physical aggression, elopement cases and toward staff. She indicated she is not aware of Lexapro being used as as anxiety or behavior medication. She also indicated she speaks to staff if there are inconsistencies between incident reports, behavior sheets/logs, and nursing documentation.</p> <p>This federal tag relates to Complaint IN00111937.</p>			

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	3.1-34(a)(1) 3.1-34(a)(2)			

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F0279 SS=D	<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, 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 observation, record review, and interview, the facility failed to ensure care plans were initiated and updated to reflective condition changes and refusal of ordered treatments for 3 of 11 residents reviewed for care planning in the sample of 11. (Residents #F, #G, and #J)</p> <p>Findings include:</p> <p>1. The closed record for record for Resident #F was reviewed on 7/31/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to,</p>	F0279	F279 It is the policy of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The comprehensive care plan for each resident includes measurable objectives and timetable to meet a resident's medial, nursing, mental and psychosocial needs. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. I. Specific Corrective Actions: 1. Any staff involved in Resident F's	09/01/2012	

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	<p>dementia, cerebral vascular disease, and neuropathy.</p> <p>The 1/17/12 Minimum Data Set (MDS) quarterly assessment indicated the resident required only supervision of staff for bed mobility, transfers, walking in her room and the corridors.</p> <p>Review of the 5/2012 Nurses' Notes indicated an entry was made on 5/14/12 at 1:50 p.m. This entry indicated a skin assessment was completed and new bruises were found on the resident's right and left hands and right lower extremity and skin assessment sheets were completed. An entry made on 5/24/12 at 12:40 p.m. indicated area of purpura was noted to the resident's right forearm and the resident had no complaints of pain.</p> <p>The Non-Pressure Ulcer Skin Conditions sheets were reviewed. There were three sheets initiated on 5/14/12. The first sheet indicated a bruise measuring 4 cm (centimeters) x 1.2 cm was observed to the resident's left hand. The second sheet indicated a bruise measuring 5cm x 5.6cm was observed to the resident's right hand. The third sheet indicated a purple bruise measuring 1.6cm x 2.4cm was observed to the resident's right lower extremity. There was one sheet initiated on 5/24/12. This sheet indicated an onset purpura</p>		<p>care plan updates had a review of Resident F's fragile skin and that it should have been added to the care plan. 2. The physician was immediately notified of Resident G's non-compliance with the abductor pillow; staff members involved were given staff educations regarding proper procedure related to physician notification and updating care plans. 3. The physician was notified of Resident J's coughing episode; an order was requested for speech evaluation, and the care plan was updated. II. Identification and correction of others: All residents have the potential to be affected by care plans not being initiated or updated to reflect condition changes and/or refusal of ordered treatments. The skin books were reviewed and the residents' charts were reviewed for proper updates on care plans. III. Systemic Changes: All nurses will attend an in-service related to their responsibility to ensure care plans are updated regarding changes in condition and refusal of ordered treatments prior to September 1, 2012. IV. Monitoring: The clinical team will review daily the updated 24 Hour Report Form for new skin issues, condition changes, and refusal of treatments. Any resident listed will have their chart audited for proper documentation and care plan updates. The audits will be submitted to the DNS every</p>				

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	<p>area measuring 7cm x 4cm was observed on the residents right forearm and the date of onset was 5/24/12.</p> <p>A "Follow Up Investigation for Injury of Unknown Etiology" form was initiated on 5/14/12 for the above bruises. The form indicated the CNA noted the skin areas and brought them to the attention of the Nurse. The form also indicated the CNAs were interviewed and a CNA indicated the resident may have bumped on the table when scooting her chair in at the table. Actions taken were to monitor the areas weekly and to assist the resident in pushing the stationary chair to the table. There was no form available related to the 5/24/12 right forearm bruise. There was no documentation of any further interventions being put into place after the 5/24/12 purpura noted to the resident's right forearm. There was no care plan available related to resident's bruises or fragile skin or interventions put into place to prevent further bruising.</p> <p>When interviewed on 8/2/12 at 11:00 a.m., MDS nurse indicated there was no care plan in place related to the resident's fragile skin.</p> <p>2. On 7/31/12 at 12:40 p.m., Resident G was observed in bed, lying on his side, asleep. The abductor pillow (wedge pillow) was lying on the bed behind the</p>		Friday. Daily reviews will continue for at least the next eight (8) months.				

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	<p>resident's legs. During this time, the Unit Program Director indicated the resident was not cooperative with the abductor pillow and had constantly removed it from his legs.</p> <p>At 1:50 p.m., Resident G's record was reviewed. Resident G's diagnoses included but not limited to, femoral fracture of the right hip and dementia.</p> <p>A care plan initiated on 7/27/12, indicated the resident had a need for routine, structure & cues for the therapeutic program of the special care unit. Care plan interventions included for staff to offer brief 1:1 stimulation when he is out in the chair and to play soft music for the resident. The care plan did not address the increased periods the resident was sleeping and not getting out of bed.</p> <p>An interview with the DON and MDS coordinator on 8/1/12 at 11:40 a.m. confirmed the care plan should have been updated regarding the resident's behaviors related to the abductor pillow.</p> <p>On 8/2/12 at 10:45 a.m., Resident G was observed lying in bed asleep. Upon interview with CNA #4 at this time, she had indicated the resident was independent in walking and was known to "get into things". Since the resident</p>			

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	<p>returned from the hospital with the hip fracture, "all he wants to do is sleep. If he gets up for breakfast and lunch, he wants to go right back to bed after the meals."</p> <p>The Unit Program Director was interviewed on 8/2/12 at 11:00 a.m., regarding the resident's activities and changes he has displayed. She indicated she did not have 1:1 activities for the resident or had updated his activity care plan to reflect his declined status. There also was no care plan in place for the abductor pillow and the resident's non-compliance with wearing it.</p> <p>3. On 7/31/12 at 11:55 a.m., Resident J's record was reviewed. Resident J's diagnoses included but not limited to, dysphagia, GERD (gastro-esophageal reflux disease) , malaise, and ischemia.</p> <p>A nursing note dated 6/25/12 at 5:20 p.m. indicated "Res (resident) eating cole slaw, started coughing-able to clear throat with (c with line above it) cough. Four min (minutes) later, drinking nectar thick coffee & (and) began to cough..."</p> <p>A nursing note dated 6/25/12 at 5:20 p.m. indicated "Res (resident) eating cole slaw, started coughing-able to clear throat with (c with line above it) cough. Four min (minutes) later, drinking nectar thick</p>			

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	<p>coffee & (and) began to cough..."</p> <p>A modified barium swallow study on 8/11/2011 indicated the resident had "multiple episodes of coughing during the study which could have indicated a small aspiration beyond the vocal folds...pt (patient) with aspiration with mixed consistency. Pt unable to coordinate chewing and swallowing to effectively/safely..."</p> <p>A Nutritional Risk care plan was reviewed. The care plan was last reviewed with a goal date 9/12. The care plan indicated the resident had a diagnosis of dysphagia (difficulty swallowing) and was to receive a mechanically altered diet.</p> <p>The care plan was not updated in regard to Resident J's coughing episodes, monitoring for aspiration or speech therapy education on proper swallowing/prevention of aspiration.</p> <p>This federal tag relates to Complaint IN00111937.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

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F0309 SS=D	<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.</p> <p>Based on record review and interview, the facility failed to ensure ongoing assessment of non pressure related skin conditions were monitored related to bruises, for 1 of 3 residents reviewed for bruises in the sample of 11. (Resident #F)</p> <p>Findings include:</p> <p>The The closed record for record for Resident #F was reviewed on 7/31/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to, dementia, cerebral vascular disease, and neuropathy.</p> <p>The 1/17/12 Minimum Data Set (MDS) quarterly assessment indicated the resident required only supervision of staff for bed mobility, transfers, walking in her room and the corridors.</p> <p>Review of the 5/2012 Nurses' Notes indicated an entry was made on 5/14/12 at 1:50 p.m. This entry indicated a skin</p>	F0309	<p>F309 It is the policy of this facility to ensure residents are provided the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. I. Specific Corrective Actions: Any nurses responsible for monitoring of Resident F's bruises received staff educations related to following facility policy related to weekly monitoring. II. Identification and correction of others: All residents have the potential to be affected by assessments not completed per policy and care plans not updated as per policy. The skin books were reviewed and the care plans on residents with skin issues were reviewed for proper updates. III. Systemic Changes: The Unknown Etiology Form was revised to include interventions put in place and renamed: Follow Up Investigation for Injury of Unknown Etiology. Nursing staff will be educated on the new form</p>	09/01/2012	

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	<p>assessment was completed and new bruises were found on the resident's right and left hands and right lower extremity and skin assessment sheets were completed. An entry made on 5/24/12 at 12:40 p.m. indicated area of purpura was noted the the resident's right forearm and the resident had no complaints of pain.</p> <p>The Non-Pressure Ulcer Skin Conditions sheets were reviewed. There were three sheets initiated on 5/14/12. The first sheet indicated a bruise measuring 4 cm (centimeters) x 1.2 cm was observed to the resident's left hand. The second sheet indicated a bruise measuring 5cm x 5.6cm was observed to the resident's right hand. The third sheet indicated a purple bruise measuring 1.6cm x 2.4cm was observed to the resident's right lower extremity. There was one sheet initiated on 5/24/12. This sheet indicated an onset purpura area measuring 7cm x 4cm was observed on the residents right forearm and the date of onset was 5/24/12.</p> <p>The first Non Pressure Ulcer Skin Condition report was dated 5/14/12. This report was for a bruise to the right lower extremity. The initial assessment indicated the bruise was to the right lower extremity and measured 1.6 cm x 2.4 cm. The following weekly assessments were as follows:</p>		<p>prior to September 1, 2012. IV. Monitoring: The unit managers will audit compliance by completing the Weekly Skin Sheet Audit on a weekly basis and submit the audit to the DNS on Fridays. This audit will be done weekly for at least eight (8) months. [Form: Investigation for Injury of Unknown Etiology]</p>				

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	<p>5/17/12 -bruise remains purple in color and measures 1.6 cm x 2.7 cm.</p> <p>5/24/12- bruise red/pink, fading, and measures 1.5 cm x 2.5 cm.</p> <p>6/06/12- purple bruise remains and measures 1 cm x 1.5 cm.</p> <p>6/21/12-bruise remains and measures 0.8 cm x 1.2 cm.</p> <p>There was no assessment or measurements of the bruise between 6/6/12 and 6/21/12.</p> <p>There were no further assessments or measurement of the bruise after 6/21/12.</p> <p>The second Non Pressure Ulcer Skin Condition report was dated 5/14/12. This report was for a red bruise to the left hand. The bruise measured 4 cm x 1.2 cm. The following weekly assessments were as follows:</p> <p>5/17/12-bruise remains present and measures 4.2 cm x 1.2 cm.</p> <p>5/24/12-red bruise noted and measures 3 cm x 2.1 cm.</p> <p>6/06/12-light bruise remains and measures 3 cm x 2 cm.</p> <p>6/21/12-bruise remains and measures 2.1cm x 1.5 cm.</p> <p>There was no assessment or measurements of the bruise between 6/6/12 and 6/21/12.</p> <p>There were no further assessments or measurement of the bruise after 6/21/12.</p>			

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	<p>The third Non Pressure Ulcer Skin Condition report was dated 5/14/12. This report was for a red bruise to the right hand. The bruise measured 5cm x 5.6 cm. The following weekly assessments were as follows: 5/17/12- bruise dark purple and measures 5.3 cm x 5.6 cm. 5/24/12- brown bruise measures 4.2 cm x 3 cm. 6/06/12- bruise red and purple and measures 4.2 cm x 2.5 cm. 6/02/12- healed</p> <p>When interviewed on 8/1/12 at 11:40 a.m., the Director of Nursing indicated the facility protocol is for bruises to be measured and assessed on the Non Pressure Ulcer Skin Condition report at the time they are first identified. The Director of Nursing also indicated all bruises should be assessed and measured weekly until they are healed. The Director of Nursing indicated assessment of the bruises for Resident #F was not completed weekly.</p> <p>This federal tag relates to Complaint IN00111937.</p> <p>3.1-37(a)</p>						

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation record review, and interview the facility failed to provide adequate supervision and implement interventions to prevent accidents, related to floor mats not in place, medications left unattended, lack of follow up assessment and interventions after a choking episode, and lack of interventions put in place for repeated bruising, for 4 of 6 residents reviewed for accidents and supervision in the sample of 11. (Residents #F, #G, #J, and #N)</p> <p>Findings include:</p> <p>1. On 7/31/12 at 1:30 p.m., a Medication Cart was observed next to the white fence rail outside of the Nursing Station of the Special Care unit. There was a prescription bottle on top of the medication cart. The label on the bottle indicated the medication was Risperdal (an antipsychotic medication) 0.25 milligrams. There were no staff members in view of the Medication Cart at this time. Resident #N was observed sitting on bench near the elevator. The resident</p>	F0323	<p>F323 It is the policy of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. I. Specific Corrective Actions: 1. RN #1 was given a staff education regarding leaving medications unattended. 2. The floor mat was immediately placed on floor next to the bed for resident G. 3. The physician was notified of the coughing episode.</p> <p>II. Identification and correction of others: All residents have the potential to be affected by the environment having accident hazards, inadequate supervision and residents not having assistance devices. The 24 hour report was updated to include condition changes, refusals, and new skin issues. The unknown etiology form was revised and now includes interventions put in place. All staff were re-educated to check the tray card before serving a meal to a resident.</p> <p>III. Systemic Changes: The floor nurses will complete two rounds per shift to ensure all devices are in place. The CNA sheets will include adaptive equipment</p>	09/01/2012	

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	<p>was approximately 12-14 feet from the Medication Cart. A few minutes later the Program Director walked past the Medication Cart. At 1:35 p.m., RN #1 walked to the Medication and picked the medication bottle up. When interviewed at this time, the RN indicated she had left the container out as she she needed to reorder the medication. The label on the pill bottle indicated it was Risperdal .25 milligrams. The RN opened the bottle and verified there was one pill in the bottle at this time. RN#1 indicated she thought the container was empty.</p> <p>The record for Resident #N was reviewed on 8/1/12 at 10:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer disease and weakness. An entry in the 7/13/12 Nurses' Notes made at 3:00 p.m. indicated the resident had been exit seeking and attempting to get on the elevator.</p> <p>When interviewed on 8/1/12 at 11:40 a.m., the Director of Nursing indicated the medication should not have been left on top of the Medication Cart.</p> <p>2. The closed record for record for Resident #F was reviewed on 7/31/12 at 12:45 p.m. The resident's diagnoses included, but were not limited to, dementia, cerebral vascular disease, and</p>		<p>devices to ensure proper placement for each resident. Nurses will be re-educated on proper documentation and assessment including the use of updated 24 hour report and revised skin etiology investigation form. All staff were re-educated regarding therapeutic diets and tray cards. IV. Monitoring: Nurses are to date and initial daily round flow sheet. The clinical team will review the updated 24 hour report daily (Mon-Fri) and audit the charts listed on the report for proper documentation and follow through. The flow sheet is to be done twice daily for three (3) months, then once daily for five (5) months. [Form: Daily round flow sheet] The Dietary manager or designee will perform meal service audits for tray accuracy. An audit will consist of reviewing five residents' meal trays for accuracy with the results recorded on the "Meal Service Audit" form. The audit will include but is not limited to breakfast, lunch, and dinner. The audit will be performed during five meals each week for four weeks. Any deficiencies will be documented on the "Tray Accuracy Intervention" form with corrective actions noted. After four weeks the meal service audit will be completed at three meals for four weeks then weekly thereafter for at least another six (6) months. [see F365 for form]</p>		

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	<p>neuropathy.</p> <p>The 1/17/12 Minimum Data Set (MDS) quarterly assessment indicated the resident required only supervision of staff for bed mobility, transfers, walking in her room and the corridors.</p> <p>Review of the 5/2012 Nurses' Notes indicated an entry was made on 5/14/12 at 1:50 p.m. This entry indicated a skin assessment was completed and new bruises were found on the resident's right and left hands and right lower extremity and skin assessment sheets were completed. An entry made on 5/24/12 at 12:40 p.m. indicated area of purpura was noted the the resident's right forearm and the resident had no complaints of pain.</p> <p>The Non-Pressure Ulcer Skin Conditions sheets were reviewed. There were three sheets initiated on 5/14/12. The first sheet indicated a bruise measuring 4 cm (centimeters) x 1.2 cm was observed to the resident's left hand. The second sheet indicated a bruise measuring 5cm x 5.6cm was observed to the resident's right hand. The third sheet indicated a purple bruise measuring 1.6cm x 2.4cm was observed to the resident's right lower extremity. There was one sheet initiated on 5/24/12. This sheet indicated an onset purpura area measuring 7cm x 4cm was observed</p>			

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	<p>on the residents right forearm and the date of onset was 5/24/12.</p> <p>A "Follow Up Investigation for Injury of Unknown Etiology" form was initiated on 5/14/12 for the above bruises. The form indicated the CNA noted the skin areas and brought them to the attention of the Nurse. The form also indicated the CNAs were interviewed and a CNA indicated the resident may have bumped on the table when scooting her chair in at the table. Actions taken were to monitor the areas weekly and to assist the resident in pushing the stationary chair to the table. There was no form available related to the 5/24/12 right forearm bruise. There was no documentation of any further interventions being put into place after the 5/24/12 purpura noted to the resident's right forearm. There was no care plan available related to resident's bruises or fragile skin.</p> <p>When interviewed on 8/1/12 at 11:40 a.m., the Director of Nursing indicated there was no follow up investigation completed on 5/24/12. The Director of Nursing also indicated there was not care plan to address further interventions related to the resident sustaining the bruises.</p> <p>3. On 7/31/12 at 12:40 p.m., Resident G was observed in bed, lying on his side,</p>			
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	<p>asleep. The floor mat was observed behind the head board of the resident's bed. During this time, the Unit Program Director indicated the floor mat should have been on the floor and not behind the head board.</p> <p>At 1:50 p.m., Resident G's record was reviewed. Resident G's diagnoses included, but were not limited to, femoral fracture of the right hip and dementia.</p> <p>A Fall Risk Assessment on 7/14/12 indicated the resident is High Risk for the potential of falls. A care plan regarding "Risk for Falls" had interventions dated on 7/14/12 "PSA (personal sensor alarm) bed/chair and low bed with (c with line above it) mat.</p> <p>During an interview with the DON on 8/1/12 at 11:40 a.m., she confirmed the resident should have had the mat on the floor next to the resident's bed when he was lying down.</p> <p>On 8/2/12 at 10:40 a.m., the resident was observed in lying in bed with the sensor alarm on the floor under the bed. Interview with CNA #4 at this time indicated there was not another CNA on the unit to make the bed up while she was providing care in the bathroom. The resident got back into bed before the bed</p>			

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	<p>was made and sensor placed under the sheets.</p> <p>4. On 7/31/12 at 11:55 a.m., Resident J's record was reviewed. Resident J's diagnoses included, but not limited to, dysphagia (difficulty swallowing), GERD (gastro-esophageal reflux disease), malaise, and ischemia.</p> <p>A signed Physician order on 12/21/11 and 1/9/12 indicated the resident was to have a mechanical soft diet with nectar thick liquids.</p> <p>A "Nutritional Risk" care plan initiated on 11/12 and updated on 1/9/12, indicated the resident was to be on a mechanically altered diet related to dysphagia and the resident had a history of choking. Interventions (no date) indicated the resident was to receive a mechanical soft and nectar thick liquids.</p> <p>A nursing note dated 6/25/12 at 5:20 p.m. indicated "Res (resident) eating cole slaw, started coughing-able to clear throat with (c with line above it) cough. Four min (minutes) later, drinking nectar thick coffee & (and) began to cough..."</p> <p>A modified barium swallow study on 8/11/2011 indicated the resident had "multiple episodes of coughing during the study which could have indicated a small</p>			

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	<p>aspiration beyond the vocal folds...pt (patient) with aspiration with mixed consistency. Pt unable to coordinate chewing and swallowing to effectively/safely..."</p> <p>The 12/22/11 Speech therapy note indicated therapy spoke with the resident and her family regarding supervision at meals and following strategies to clear her oral cavity. The family agreed to moving the resident to the day room for meals.</p> <p>On 7/31/12 at 12:10 p.m., Resident J was observed in the main dining room eating lunch. A small bowel of cubed jello was observed in front of the resident.</p> <p>At 2:50 p.m., LPN (Licensed Practical Nurse) #1 was interviewed. She verified the resident used to be in the day room but due to her cognitive status and enjoying having meals with friends, she eats in the main dining room. She indicated she wasn't sure if the resident should have had the jello. LPN #1 was observed utilizing the phone and spoke with someone in the kitchen and asked the about the resident having jello. LPN #1 indicated she was told it was alright for the resident to have the jello.</p> <p>There was no recommendation from Speech Therapy nor was there a waiver</p>			

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	<p>signed for resident to return to the main dining room available.</p> <p>On 8/1/12 at 11:40 a.m., the DON was interviewed and she confirmed the resident should not have had the jello for lunch. She further indicated the Nurses and the CNAs should have checked what was on the tray card before giving the meal to the resident. She also indicated there should have been more documentation follow up on monitoring the resident from the coughing on cole slaw and fluids.</p> <p>This federal tag relates to Complaints IN00111937 and IN00112652.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident remained free of unnecessary drugs related administering anti anxiety medications and narcotic medications without adequate indications for their use and without adequate monitoring of the medications, for 1 of 3 residents reviewed for psychotropic medications in the sample of 11. (Resident #G)</p> <p>Findings include:</p>	F0329	F329 It is the policy of this facility to ensure each resident's drug regimen is free from unnecessary drugs. It is also the policy of this facility, based on a comprehensive assessment of residents, to 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	09/01/2012

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	<p>On 7/31/12 at 12:40 p.m., Resident G was observed in bed, lying on his side, asleep.</p> <p>At 1:50 p.m., Resident G's record was reviewed on 7/31/12 at 1:50 p.m. The resident's diagnoses included, but were not limited to, status post femoral fracture of the right hip and dementia.</p> <p>The Physician Recapitulation Orders upon return from the hospital dated 7/14/12 to 7/31/12 indicated the resident was to receive the following medications: Namenda (a medication for dementia symptoms) 10 mg (milligrams) by mouth daily; Seroquel (an antipsychotic medication) 25 mg by mouth twice a day; Seroquel 200 mg by mouth at bedtime; Zoloft (an antidepressant) 50 mg by mouth daily; Elavil (an antidepressant) 10 mg by mouth at bedtime; Aricept (a medication for dementia symptoms) 5 mg by mouth at bedtime; Ativan (an anti anxiety medication) 1mg by mouth every four hours prn (as needed) for anxiety; and Norco (a narcotic pain medication) 5/325 mg one tab every 4 hours prn for pain 1-5 (pain scale mild to moderate pain); and Norco 7.5 mg two tabs by mouth every four to six hours prn for pain 6-10 (pain scale moderate to severe pain).</p>		<p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>I. Specific Corrective Actions: An order clarification was immediately obtained regarding the resident's orders for Norco and Ativan including specific signs and symptoms to be used in determining dosage and frequency. Will review all resident charts currently on PRN psychotropic's, if they have not been used in seven days the PRN medication will be discontinued.</p> <p>II. Identification and correction of others: All residents have the potential to be affected by incomplete documentation related to the use of anti anxiety and/or pain medication; and inadequate monitoring of same medications. All charts for residents receiving anti anxiety and/or pain medication were reviewed for proper indications for the medication and monitoring of the medication(s).</p> <p>III. Systemic Changes: All nurses will be educated regarding appropriate documentation related to indications for medication usage and proper monitoring of said mediations prior to September 1, 2012.</p> <p>IV. Monitoring: The nurse manager or designee will audit MARs weekly for any prn anti-anxiety or prn pain medication given, that will be placed on the prn medication audit and those charts will be</p>				

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	<p>The narcotic flow sheet on 7/15/12 at 12:30 a.m. indicated two tablets of 0.5 mg of Ativan were signed out. The Behavior Intervention Log did not indicate any behaviors of anxiety or agitation during this shift.</p> <p>Nursing note on 7/15/12 at 2:30 a.m. indicated, "s/s (signs and symptoms of pain observed. prn Norco (pain medication) given..." The narcotic flow sheet did not indicate the pain medication had been signed out.</p> <p>Nursing note on 7/16/12 at 10:00 a.m. indicated, "...prn Norco given at 8 a.m. d/t (due to) s/s (signs/symptoms) of pain with mild relief noted..." The narcotic flow sheet did not indicate the pain medication had been signed out.</p> <p>The narcotic flow sheet on 7/16/12 at 3:00 p.m., two 7.5 mg of Norco and 0.5 mg of Ativan were signed out. There was no nursing documentation indicating the resident was in pain or having behaviors. The Behavior Intervention Log did not indicate any behaviors of anxiety or agitation during this shift.</p> <p>The narcotic flow sheet at 9:00 p.m. indicated two 7.5/325 mg tablets of Norco and 0.5 mg of Ativan were signed out. The Behavior Intervention Log did not</p>		<p>audited for appropriate documentation. Audits to be turned in on Fridays to DNS. After three months the audits will decrease to monthly for at least another five months.</p>		

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	<p>indicate any behaviors of anxiety or agitation during this shift.</p> <p>The narcotic flow sheet on 7/17/12 at 6:00 a.m. indicated two 7.5/325 mg tablets of Norco and 0.5 mg of Ativan were signed out. There was no nursing documentation indicating the resident was in pain. The Behavior Intervention Log did not indicate any behaviors of anxiety or agitation during this shift.</p> <p>On 7/17/12 at 6:30 p.m. indicated, "...hold ativan 0.5 mg 1 tab po q (every) 4* (hours) prn (as needed, Seroquel 25 mg 1 tab po BID (twice daily) and Seroquel 200mg 1 tab po @ (at) bedtime, re eval in 3 days." There was no documentation indicating why medications were on hold.</p> <p>The narcotic flow sheet on 7/18/12 at 4:00 a.m. indicated two 7.5/325 mg tablets of Norco were given. There was no nursing documentation indicating the resident was pain.</p> <p>The narcotic flow sheet on 7/18/12 at 2:00 p.m. indicated two 7.5/325 mg tablets of Norco were given. There was no nursing documentation indicating the resident was in pain.</p> <p>The narcotic flow sheet on 7/19/12 at 12:30 p.m. indicated two 7.5/325 mg</p>						

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	<p>tablets of Norco were given. There was no nursing documentation indicated the resident was in pain.</p> <p>The narcotic flow sheet on 7/19/12 at 7:00 p.m. indicated two 7.5/325 mg tablets of Norco were signed out. There was no nursing documentation indicating the resident was in pain.</p> <p>The narcotic flow sheet on 7/20/12 at 10:00 a.m. indicated two 7.5/325 mg tablets of Norco were signed out. An order to restart Seroquel 25mg BID was received.</p> <p>The narcotic flow sheet on 7/21/12 at 1:00 p.m. indicated two 7.5/325 mg tablets of Norco were signed out. There was no nursing documentation indicating the resident was in pain.</p> <p>A nursing note on 7/22/12 at 1:00 a.m. indicated, "Res awake yelling out jibberish attempting to get out of bed unassisted. facial [sic] grimacing noted res [sic] fidgeting. prn [sic] Norco ii tabs give r/t s/s pain 8/10." The narcotic flow sheet did reflect the dose signed out.</p> <p>A nursing note on 7/23/12 at 1:00 a.m. indicated, "Res sitting up (arrow pointing up) in hallway, speaking jibberish, facial grimacing, fidgeting s/s pain 8/10-- res</p>			

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	<p>given prn Norco 7.5mg ii tabs." The narcotic flow sheet did reflect the dose signed out.</p> <p>A nursing note on 7/23/12 at 10:45 a.m. indicated, "Status report called in to Dr. (physician's name) per orders with (c with line above it) N.O. (new order) to restart Seroquel 8 pm dose and and get tabs on Wed..." The physician order written during this time indicated to "restart Seroquel @ 8 p.m. 200 mg po @ HS (bedtime)."</p> <p>A physician order on 7/24/12 at 11:35 a.m. indicated, "May restart Ativan 1 mg po prn q 4 hours. for increase anxiety and agitation." A physician order at 5:32 pm indicated, "Clarification: D/C prn Ativan 0.5mg. Change PRN Ativan 1mg i tab po q 6 hrs for increase (arrow pointing up) anxiety, or increase (arrow pointing up) agitation [sic] instead of q 4 hrs."</p> <p>A nursing note on 7/24/12 at 6:05 p.m. indicated, "Late entry 7/24/12 4:15 pm, Res not grimacing @ this time reposition [sic]." The narcotic flow sheet 4:30 p.m. indicated two 0.5 mg tabs of Ativan were signed out.</p> <p>The narcotic flow sheet on 7/25/12 at 9:00 a.m. indicated two 0.5 mg of Ativan were signed out. The Behavior</p>			

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	<p>Intervention Log did not indicate any behaviors of anxiety or agitation during this shift.</p> <p>A nursing note at 7/25/12 at 1:00 p.m. indicated, "PRN Ativan given with (c with line over it) relief." The narcotic flow sheet did not indicate the medication was signed out at this time.</p> <p>A nursing note on 7/25/12 at 10:45 p.m. indicated, "...From 3p to 6p resident was slightly lethargic probably in response to PRN Ativan at 9 a today. Resident ate no supper due to his refusal..."</p> <p>The narcotic flow sheet on 7/26/12 at 1:00 a.m. indicated one 7.5/325 mg of Norco was signed out. There are no nursing documentation to indicate the resident was in pain but there was documentation at this time indicating, "no (o with line through it) A/R (adverse reactions) to PRN ativan."</p> <p>The narcotic flow sheet on 7/26/12 at 9:00 a.m. indicated one 7.5mg of Vicodin was signed out. At 10:15 a.m., a nursing note indicated, "Resident continues to seem in pain. guarding (R) leg. mumbling. unable to determine exact site of pain. Sleeping off and on this am..."</p> <p>On 7/31/12 at 3:00 p.m. during an</p>			

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	<p>interview with the DON, she indicated the nursing staff were giving the resident both Norco and/or Ativan without distinguishing what was pain and what was anxiety. On 8/1/12, the DON provided an order clarification dated 7/31/12 at 6:00 p.m. "1. Norco 5/325 mg (milligrams) i (one) tab P.O. (by mouth) every four hours prn (as needed) for s/sx (signs and symptoms) pain i.e.. (such as) wincing, guarding of the right hip. 2. Norco 7.5/750 mg, 2 tabs P.O. every 6 hours prn for pain s/sx of thrashing, hitting, limping. 3. Ativan 1 mg i P.O. every 6 hours prn for s/sx of increased agitation not relieved with prn analgesics."</p> <p>On 8/2/12 at 10:45 a.m., Resident G was observed lying in bed asleep. During this time, CNA #4 was interviewed and had indicated the resident used to be independent in walking and was known to "get into things" before his fall/hip fracture. Since the resident returned from the hospital with the hip fracture, "all he wants to do is sleep. If he gets up for breakfast and lunch, he wants to go right back to bed after the meals."</p> <p>The Unit Program Director was interviewed on 8/2/12 at 11:00 a.m. and indicated the resident the resident had been sleeping more.</p>			

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	<p>On 8/2/12 at 1:45 p.m. during an interview with the DON regarding the resident's decline in condition, his increased sleeping habits, poor appetite and the cycle of pain meds, antipsychotic, anti anxiety medication, she indicated the correlation they may have with the resident's symptoms.</p> <p>This federal tag relates to Complaint IN00111937.</p> <p>3.1-48(a)(6) 3.1-48(b)(1)</p>			

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F0365 SS=D	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, record review, and interview, the facility failed to provide and assure a dessert was served in an appropriate form, according to assessment and care plan, for 1 of 3 residents reviewed for swallowing difficulties in the sample of 11. (Resident #J)</p> <p>Findings include:</p> <p>On 7/31/12 at 12:10 p.m., Resident J was observed in the main dining room eating lunch. A small bowel of cubed jello was observed in front of the resident.</p> <p>On 7/31/12 at 11:55 a.m., Resident J's record was reviewed. Resident J's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), GERD (gastro-esophageal reflux disease), malaise, and ischemia.</p> <p>A modified barium swallow study on 8/11/2011 indicated the resident had "multiple episodes of coughing during the study which could have indicated a small aspiration beyond the vocal folds...pt (patient) with aspiration with mixed</p>	F0365	<p>F365 It is the policy of this facility to ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. I. Specific Corrective Actions: The staff involved on 7/31/12 with Resident J receiving the wrong food related to his/her diet were educated regarding checking the tray card for correct food forms before giving the meal to the resident. II. Identification and correction of others: All residents have the potential to be affected by receiving the wrong food related to his/her diet. All staff were re-educated to check the tray card before serving the meal to the resident. III. Systemic Changes: All staff will attend a mandatory in-service related to appropriate foods for residents on special diets, i.e. thickened liquids and mechanical soft diets; also staff will be reminded to always check the individual resident's tray card before serving a meal to ensure the correct food form is being served. A "Therapeutic Diet" in-service will be conducted by the dietitian for dietary staff and will be completed by 8/31/12. IV. Monitoring: The Dietary manager or designee will perform</p>	09/01/2012			

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	<p>consistency. Pt unable to coordinate chewing and swallowing to effectively/safely..."</p> <p>A "Nutritional Risk" care plan initiated on 11/12 and updated on 1/9/12, indicated the resident was to be on a mechanically altered diet related to dysphagia and the resident had a history of choking. Interventions (no date) indicated the resident was to receive a mechanical soft and nectar thick liquids.</p> <p>A signed Physician order on 12/21/11 and 1/9/12 indicated the resident to have a mechanical soft diet with nectar thick liquids.</p> <p>At 2:50 p.m., LPN #1 was interviewed and indicated she wasn't sure if the resident should have received the jello.</p> <p>On 8/1/12 at 11:40 a.m., the DON was interviewed and she confirmed the resident should not have had the jello for lunch. She further indicated the Nurses and the CNAs should have checked what was on the tray card before giving the meal to the resident.</p> <p>This federal tag relates to Complaint IN00111937.</p> <p>3.1-21(a)(3)</p>		<p>meal service audits for tray accuracy. An audit will consist of reviewing five residents' meal trays for accuracy with the results recorded on the "Meal Service Audit" form. The audit will include but is not limited to breakfast, lunch, and dinner. The audit will be performed during five meals each week for four weeks. Any deficiencies will be documented on the "Tray Accuracy Intervention" form with corrective actions noted. After four weeks the meal service audit will be completed at three meals for four weeks then weekly thereafter for at least another six (6) months. [Forms: Meal Service Audit & Tray Card Intervention]</p>				

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