

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN46750		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 18, 19, 20, and 21, 2011</p> <p>Facility number: 000463 Provider number: 155444 AIM number: 100290910</p> <p>Survey team: Vicki Bickel, RN-TC DeAnn Mankell, RN (7/18, 7/20, & 7/21, 2011) Delinda Easterly, RN (7/19, 7/20, & 7/21, 2011) Karen Lewis, RN (7/19, 7/20, & 7/21, 2011) Ginger McNamee, RN (7/20/11)</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 6 Medicaid: 33 Other: 23 Total: 62</p> <p>Sample: 15</p>	F0000	<p>This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider to the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</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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F0225 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/26/11 by Suzanne Williams, RN The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>						

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	<p>Based record review and interview, the facility failed to report a verbal statement of abuse to the administrator for 1 of 1 resident with a verbal statement of abuse in a sample of 15 (Resident #6).</p> <p>Findings include:</p> <p>1. Resident #6's clinical record was reviewed on 7/18/11 at 2:20 P.M. and 7/20/11 at 2:00 P.M.</p> <p>Resident #6's diagnoses included, but were not limited to, cerebral vascular disease, diabetes mellitus, legally blind, thrombocytopenia, and conduct disturbances.</p> <p>Resident #6's nurses' notes indicated he was admitted on 5/6/11. Further review of the nurses' notes indicated on 5/15/11 he began refusing care. On 5/18/11 he refused to be shaved, refused his medications and treatments, and became physically aggressive with staff.</p> <p>Resident #6's admission MDS (minimum data set) assessment dated 5/17/2011 indicated he was moderately impaired for cognitive ability. He was assessed as having no behaviors, needing two person assistance for transfers from his bed to his wheelchair, needing extensive of 1 person for dressing and needing physical help</p>	F0225	F 225 Investigate/Report Allegations/Individuals It is the practice of this facility to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with State law through established procedures. Corrective Action for Resident's Affected: Abuse investigation executed immediately after reported to Administrator 7/20/11 and found to be unsubstantiated. Other Resident's having the potential to be affected: All residents have the potential to be affected. All staff was inserviced/educated by Administrator concerning resident abuse policy, the definitions of abuse and immediate correct response/reporting by staff to all allegations or witness of abuse of a resident on 7/26/11. Measures to ensure practice does not reoccur: All staff was inserviced/educated by Administrator concerning resident abuse policy, the definitions of abuse and immediate correct response/reporting by staff to all allegations or witness of abuse of a resident on 7/26/11. All new employees are educated concerning immediate action if abuse is suspected, what constitutes abuse, and immediate reporting of abuse. Abuse	08/20/2011	

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	<p>with bathing.</p> <p>The nurses' notes for 6/11/11, 6/13/11, 6/15/11 indicated Resident #6 was physically and verbally abusive with staff, by screaming and hitting at staff and refusing treatment and medications. The notes indicated the family, physician, and social services were aware of the behaviors.</p> <p>The nurses' notes for 6/16/11 indicated while staff provided peri-care for Resident #6, he became "physically and verbally aggressive when staff tried to provide peri-care @ hs (bedtime). Began screaming 'No!' and tried hitting staff repeatedly."</p> <p>The nurses' notes indicated these behaviors continued on a daily basis. On 6/23/11 at 1:00 P.M., the doctor was notified of the resident's continued refusal of treatments, medications, accuchecks, and dressing change to the left heel. The doctor ordered a psych evaluation.</p> <p>The nurses' notes continued to note the resident's behaviors of physical and verbal aggression on a daily basis.</p> <p>The psychologist saw Resident #6 on 6/29/2011 for an initial evaluation for physical aggression and behavior</p>		<p>prohibition inservicing completed bi-annually for all staff. This correction action will be monitored by: DON/Designee will review the facility Abuse Policy with 5 employees weekly for 4 weeks. Monitoring will continue for 6 months or until compliance is achieved. See Attachment A1 Monthly questioning of random employees concerning abuse policy is reported during QA meeting for continued compliance. Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>				

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	<p>problems and noncompliance with treatment and care. This form indicated Resident #6 "claims the staff beats him up. He can not or will not see helping him out of bed and the accompanying discomfort of being touched as help and not an accack (sic).... he feels he is being hit when staff help him out of bed etc...."</p> <p>The social service notes dated 7/17/11 indicated "Writer notified this AM of behaviors earlier this week & continuing. Writer provided visit c (with) res. (resident). Res. stated 'They hit me.' When asked about hitting staff. Res. unable to tell writer which staff, unable to describe staff & unable to tell writer when it has happened. Writer asked res. if has pain & that this could be pronounced during care & interpreted as 'hitting.' Res. denied having any pain. Writer discussed the need to let nsg. (nursing) provide care and he will not hit anymore...."</p> <p>During an interview with Resident #6 on 7/20/11 at 10:45 A.M., he indicated the staff had "beat me up" that morning. He said "They beat the hell out of me." He further said this happened once in awhile. When asked to describe what happened, he said, "They grabbed my arms so hard that they hurt me."</p> <p>During an interview with the psychologist</p>				

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	<p>on 7/20/11 at 11:00 A.M., she indicated the resident was angry and belligerent and confrontational with staff and he doesn't want any help. She further indicated she didn't think he was being hit and that he just doesn't want any help.</p> <p>During an interview with the Administrator on 7/20/11 at 2:40 P.M., he indicated, no one had ever told him of any allegations of abuse toward this resident and he had not investigated any allegations of abuse.</p> <p>During an interview with the Social Worker on 7/20/11 at 2:45 P.M., she indicated she had talked to the resident about the statement he had made to the psychologist. She had talked with the psychologist and she thought it was just pain. She had talked with the resident physician and he had said the resident had always been this way. She indicated she had not told the Administrator as she didn't think the resident had been hit. She further indicated as she had talked with the staff she had no reason to believe the resident had been hit by the staff.</p> <p>Review of the "Abuse, Prevention, Intervention, Investigation, & Reporting Policy" dated March 2001 and provided by the DON on 7/18/11 at 1:30 P.M. indicated "It is the responsibility of</p>						

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F0226 SS=D	<p>employees to promptly report to the facility administrator any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors: including injuries of unknown source...."</p> <p>3.1-28(c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to develop a written policy for all allegations of abuse to be reported immediately to the Administrator. The facility, also, failed to follow written policy for the prohibition of mistreatment, neglect, and a abuse for the report of a verbal statement of abuse for 1 of 1 resident with a verbal statement of abuse in a sample of 15. (Resident #6).</p> <p>Findings include:</p> <p>1. Review of the "Abuse, Prevention, Intervention, Investigation, & Reporting Policy" dated March 2001 and provided by the DON on 7/18/11 at 1:30 P.M. indicated "It is the responsibility of employees to promptly report to the facility administrator any incident of suspected or alleged neglect or resident abuse from other residents, staff, family,</p>	F0226	F226 Develop/Implement Abuse/Neglect, ETC PoliciesIt is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. Corrective action for resident's affected: The facility policy Abuse Prevention, Intervention, Investigation, and Reporting policy was revised 7/20/11. Abuse investigation executed immediately after reported to Administrator 7/20/11 and found to be unsubstantiated. All staff was inserviced/educated by Administrator concerning resident abuse policy, the definitions of abuse, and immediate response/reporting by staff to all allegations or witness of abuse of a resident on 7/26/11. Other resident's having the potential to be affected: All resident's have the potential to be affected. All staff was	08/20/2011	

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	<p>or visitors: including injuries of unknown source...."</p> <p>This policy lacked a provision to immediately report any allegations of abuse to the Administrator.</p> <p>2. Resident #6's clinical record was reviewed on 7/18/11 at 2:20 P.M. and 7/20/11 at 2:00 P.M.</p> <p>Resident #6's diagnoses included, but were not limited to, cerebral vascular disease, diabetes mellitus, legally blind, thrombocytopenia, and conduct disturbances.</p> <p>The psychologist saw Resident #6 on 6/29/2011 for an initial evaluation for physical aggression and behavior problems and noncompliance with treatment and care. This form indicated Resident #6 "claims the staff beats him up. He can not or will not see helping him out of bed and the accompanying discomfort of being touched as help and not an accack (sic).... He said he feels he is being hit when staff help him out of bed etc...."</p> <p>The social service notes dated 7/17/11 indicated "Writer notified this AM of behaviors earlier this week & continuing. Writer provided visit c (with) res.</p>		<p>inserviced/educated by Administrator concerning resident abuse policy, the definitions of abuse and immediate correct response/reporting by staff to all allegations or witness of abuse of a resident on 7/26/11.Measures to ensure practice does not reoccur: All staff was inserviced/educated by Administrator concerning resident abuse policy, the definitions of abuse and immediate correct response/reporting by staff to all allegations or witness of abuse of a resident on 7/26/11. All new employees are educated concerning immediate action if abuse is suspected, what constitutes abuse, and immediate reporting of abuse. Abuse prohibition inservicing completed bi-annually for all staff.This corrective action will be monitored by: DON/Designee will review abuse policy with 5 employees weekly for 4 weeks. Monitoring will continue monthly for 6 months or until compliance achieved. See attachment A1Monthly questioning of random employees concerning abuse policy is reported during QA meeting for continued compliance.Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.Addendum: Monitoring</p>		

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F0250 SS=D	<p>(resident). Res. stated 'They hit me.' When asked about hitting staff. Res. unable to tell writer which staff, unable to describe staff & unable to tell writer when it has happened. Writer asked res. if has pain & that this could be pronounced during care & interpreted as 'hitting.' Res. denied having any pain. Writer discussed the need to let nsg. (nursing) provide care and he will not hit anymore...."</p> <p>During an interview with Resident #6 on 7/20/11 at 10:45 A.M., he indicated the staff had "beat me up" that morning. He said "They beat the hell out of me." He further said this happened once in awhile. When asked to describe what happened, he said, "They grabbed my arms so hard that they hurt me."</p> <p>During an interview with the Administrator on 7/20/11 at 2:40 P.M., he indicated, no one had ever told him of any allegations of abuse toward this resident and he had not investigated any allegations of abuse.</p> <p>3.1-28(a)</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</p>	F0250	<p>results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p> <p>F250 Provision of Medically Related Social Servicelt is the</p>	08/20/2011			

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	<p>facility failed to provide effective behavior interventions for a resident who refused care, including medications and treatments, and had with persistent verbal and physical aggression toward staff for 1 of 1 resident reviewed for behaviors in a sample of 15 (Resident #6).</p> <p>Findings included:</p> <p>1. Resident #6's clinical record was reviewed on 7/18/11 at 2:20 P.M. and 7/20/11 at 2:00 P.M.</p> <p>Resident #6's diagnoses included, but were not limited to, cerebral vascular disease, diabetes mellitus, legally blind, thrombocytopenia, and conduct disturbances.</p> <p>Resident #6's nurses' notes indicated he was admitted on 5/6/11. Further review of the nurses' notes indicated on 5/15/11 he began refusing care. On 5/18/11 he refused to be shaved and became physically aggressive with staff and treatments along with medications.</p> <p>Resident #6's admission MDS (minimum data set) assessment dated 5/17/2011 indicated he was moderately impaired for cognitive ability. He was assessed as having no behaviors. He was assessed as needing 2 person assistance for transfers</p>		<p>practice 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. Corrective Action for Resident Affected: The behavior management program for resident #6 was revised immediately with new approaches/interventions documented on the plan of care for resident #6 and Social Service Designee reviewed changes with direct-care staff. Other resident's having the potential to be affected: All resident behavior management plans of care were reviewed per Social Service Designee and adjusted as indicated. Measures to ensure practice does not reoccur: All employees will be inserviced/educated on correct procedure for behavior management on 8/9/11. DON/Designee will monitor 24 hour report sheets daily for behavior findings and report such findings in the morning meeting to Social Services Designee for adjustments to the behavior plan of care. This corrective action will be monitored by: DON/Designee will monitor 24 hour report sheets daily for behavior findings and report such findings in the morning meeting to Social Service Designee for adjustments to the behavior plan of care. Monitoring will continue monthly for 6 months or until compliance</p>		

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	<p>from his bed to his wheelchair. He was assessed as needing extensive of 1 person for dressing. He was assessed as needing physical help with bathing.</p> <p>The nurses' notes for 6/11/11, 6/13/11, 6/15/11 indicated Resident #6 was physically and verbally abusive with staff, by screaming and hitting at staff and refusing treatment and medications. The notes indicated the family, physician, and social services were aware of the behaviors.</p> <p>There was a care plan dated 6/13/2011 for the need of "Resident occasionally becomes agitated during hands-on care and will yell and hit out at staff. Resident had a Dx (diagnoses) of DM II (type 2 diabetes mellitus), Diabetic Retinopathy, Legal Blindness, Degen (degenerative) Joint Disease." The Approaches/Interventions were "1. Inform resident of care to be provided. 2. Approach in a calm, slow, friendly manner. 3. Use visual prompts to aid in understanding i.e. shampoo, towel, soap etc... tell res what you have. 4. Place a warm wash cloth in resident's hand for resident to participate in care. 5. Observe for signs of agitation such as increased physical movements, increase in tone of voice, anger, etc.... 6. Consider alternate staff if necessary. 7. Assure resident's</p>		<p>achieved. Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>		

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	<p>safety and approach at later time. 8. Allow resident opportunity to choose time of care and to participate in decision making of care."</p> <p>The nurses' notes for 6/16/11 indicated while staff provided peri-care for Resident #6, he became "physically and verbally aggressive when staff tried to provide peri-care @ hs (bedtime). Began screaming 'No!' and tried hitting staff repeatedly."</p> <p>The nurses' notes indicated these behaviors continued on a daily basis. On 6/23/11 at 1:00 P.M., the doctor was notified of the resident's continued refusal of treatments, medications, accuchecks, and dressing change to the left heel. The doctor ordered a psych evaluation.</p> <p>The nurses' notes continued to note the resident's behaviors of physical and verbal aggression on a daily basis and refusals of medications and treatments.</p> <p>The care plan dated 6/13/2011 for the need of "Resident occasionally become agitated during hands-on care and will yell and hit out at staff" was updated on 6/27/11 with a notation of "Res refusing tx (treatment) per ngs (nursing). (Name of resident's physician) states res has been this way for years, very independent &</p>				

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	<p>private, wanting to do things his (res') way." There was an additional intervention of "9. Observe for s/s (signs/symptoms) of pain R/T (related to) Dx. of Degen (degenerative) Joint Dis. (disease)."</p> <p>The psychologist saw Resident #6 on 6/29/2011 for an initial evaluation for physical aggression and behavior problems and noncompliance with treatment and care. This form indicated Resident #6 "claims the staff beats him up. He can not or will not see helping him out of bed and the accompanying discomfort of being touched as help and not an accack (sic).... The patient management recommendations: Patient was told he could not threaten or strike at care givers. He cannot raise his fist to them. He was told hat (sic) cooperation was what was desired. The consequences of inappropriate behavior was discussed thorough relatiy (sic) testing. Three simple instructions that staff can continue to reinforce: 1. No threatening. 2. No hitting 3. Be cooperative He said he feels he is being hit when staff help him out of bed etc...."</p> <p>There was an additional Care Plan dated 6/29/2011 for the problem of "Resident has a hx (history) of persistent anger directed toward peers and staff. Resident</p>				

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	<p>becomes verbally aggressive, cursing and threatening other, and yelling. Resident's Doctor (name) states he has been this way for years." The approaches were "1. Keep resident's routine and caregivers as consistent as possible. 2. Be aware of possible 'triggers', i.e. fatigue, hunger, pain etc... Meet need when possible. 3. Do not rush resident. 4. If behavior occurs, call resident's name and state to resident to stop. Be firm, but kind. 5. Remove resident from area, take to quiet environment. Remind resident how words affect others. Do not argue with resident. 6. When resident is calm, return to original location."</p> <p>The Behavior Assessment completed on 7/1/11 indicated "Res. is very combative during any hands-on care. Hits, kicks, scratches staff screaming "You'll do it my way!!!" Staff have asked numerous times how he wants care to be done. Res. is angry about placement.... CP (care plan) developed staff aware of need to follow behavior interventions in place since 6/13/11."</p> <p>The psychiatrist saw Resident #6 on 7/5/11 for an initial evaluation for "significant verbal and physical aggression toward staff. At times refuses medication and often refuses treatments." The psychiatrist indicated, "This is a ...</p>				

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	<p>male... who had been very irritable and showing aggression toward staff. When asked why he strikes out at staff he states 'Because they hit me.' He is getting wound care on his buttocks and (l) (left) heel and to him they are 'hitting' him. I told him he needs to take his medication so his wounds won't get worse instead of refusing care. Angry he is not home." This evaluation had a recommendation for the resident to "start Celexa (antidepressant) for aggression and irritability...."</p> <p>The psychologist saw the resident on 7/6/11 and 7/14/11. There were no changes in the resident's behaviors. He continued to hit staff and claim the staff him so he hits back. There were no new interventions except the possible use of a lift for getting him out of bed.</p> <p>The social service notes dated 7/17/11 indicated "Writer notified this AM of behaviors earlier this week & continuing. Writer provided visit c (with) res. (resident). Res. stated 'They hit me.' When asked about hitting staff. Res. unable to tell writer which staff, unable to describe staff & unable to tell writer when it has happened. Writer asked res. if has pain & that this could be pronounced during care & interpreted as 'hitting.' Res. denied having any pain. Writer discussed</p>				

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F0282 SS=D	<p>the need to let nsg. (nursing) provide care and he will not hit anymore."</p> <p>During an interview with the psychologist on 7/20/11 at 11:00 A.M., she indicated the resident was angry and belligerent and confrontational with staff and he doesn't want any help.</p> <p>During an interview with CNA #1 on 7/21/11 at 10:30 A.M., she indicated Resident #6 hits, bites, cusses, and screams every time you touch him. He calls the staff names and says they are "Stupid B-----s." She said even when they reapproach him, he does the same and he won't let the staff wash him. She said he seemed to quiet down when he was sat up on the side of the bed and gotten dressed. She indicated she had filled out behavior forms in the past, but nothing was ever done to help stop his behaviors, so she stopped filling out the behavior forms.</p> <p>3.1-34(a)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to provide care in accordance with physician orders and monitor blood pressures twice a day, prior</p>	F0282	F282 Services by Qualified Persons/Per Care Planit is the practice of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance	08/20/2011	

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	<p>to medication administration, for 1 of 15 residents reviewed for following physician orders in a sample of 15. (#41)</p> <p>Findings include:</p> <p>The clinical record for Resident #41 was reviewed on 7/19/11 at 2:00 p.m. Resident #41's current diagnoses included, but were not limited to, hypertension and bipolar disorder.</p> <p>Resident #41 had current physician's orders for the following,</p> <p>A. Lisinopril 5 milligrams orally once daily for hypertension. (hold if B/P (blood pressure) less than 105/60)</p> <p>B. Triamterene HCTZ 37.5 -25 milligrams give one capsule every morning for hypertension. (hold if B/P less than 105/60)</p> <p>C. Monitor blood pressure and pulse twice daily at 8 a.m. and 8 p.m.</p> <p>Resident #41 had a health care plan, dated 5/11, which indicated the resident had a problem listed as, the resident has a diagnosis of hypertension and is at risk for complications associated with it. Interventions for this problem included, administer medications as ordered, monitor blood pressure as ordered and</p>		<p>with each resident's written plan of care. Corrective action for resident affected: Resident #41's physician clarified B/P parameters 7/19/11 and the plan of care was updated accordingly. Other resident's having the potential to be affected: All residents with hypertensive medications were reviewed for B/P parameters and the plan of care adjusted accordingly. Measures to ensure practice does not reoccur: Nurses will be inserviced/educated on following physician's orders on 8/9/11. DON/Designee will monitor MARs for B/P documentation weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately and included in the monthly QA meetings. This corrective action will be monitored by: DON/Designee will monitor MARs for B/P documentation weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately. Monitoring will continue monthly for 6 months or until compliance achieved. See Attachment C1 Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>		

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	<p>observe for signs of hypertension such as: vertigo, headache, bloody nose, nausea, vomiting, confusion, or elevated blood pressure.</p> <p>The June and July 2011 Medication Administration Record for Resident #41 indicated the following B/P results for 8:00 p.m.</p> <p>June 2, 97/54</p> <p>June 3, 99/63</p> <p>June 6, 101/56</p> <p>June 8, 111/55</p> <p>June 9, 106/56</p> <p>June 15, 88/62</p> <p>June 19, 97/53</p> <p>June 21, 97/55</p> <p>June 23, 99/55</p> <p>July 1, 95/54</p> <p>July 13, 97/64</p> <p>July 16, 85/55</p>						

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	<p>The Medication Administration Record for the dates noted above indicated the anti-hypertension medications were administered and not held as ordered by the physician.</p> <p>During an interview with the Director of Nursing on 7/19/11 at 2:30 p.m. additional information was requested related to the resident having received the medications with an order to hold according to low B/P results.</p> <p>During an interview with the Director of Nursing on 7/19/11 at 4:40 p.m. she indicated the nursing staff had called Resident #41's physician and received a clarification of the order to hold B/P medication. The clarification order, dated 7/19/11 indicated,</p> <p>B/P parameter order clarification:</p> <p>Hold B/P medications if systolic B/P less than 100 or Diastolic B/P less than 60.</p> <p>During an interview with the Director of Nursing on 7/19/11 at 4:40 p.m. she indicated the nursing staff should have clarified the original B/P medication orders when the order was originally received in the facility on 1/16/09.</p> <p>3.1-35(g)(2)</p>						

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F0309 SS=D	<p>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 observation, interview and record review, the facility failed to ensure interventions were provided for residents experiencing constipation for 3 (Resident's #10, #54, & #57) of 3 residents reviewed for constipation in a sample of 15.</p> <p>Findings include:</p> <p>Resident #10's clinical record was reviewed on 7/19/11 at 9:45 a.m. Diagnoses included, but were not limited to: hypertension , congestive heart failure, renal insufficiency, depression, osteoarthritis, hypokalemia, and osteoarthritis.</p> <p>The facility "BM report", received and reviewed on 7/19/11, indicated Resident # 10 had a bowel movement on 6/29/11. No further bowel movement was indicated until a "smear" on 7/7/11. The resident did not have a bowel movement for 8 days. A "medium" bowel movement was indicated on 7/8/11</p> <p>The facility "Alerts Report" for 6/30/11 -</p>	F0309	F309 Provide Care/Services for Highest Well-BeingIt is the practice of this facility to ensure each resident receive and the facility to 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. Corrective Action for Resident's Affected: Residents #10, #54, #57 were not harmed. Nurses were inserviced/educated on ensuring all residents have a bowel movement every 3 days and that the appropriate interventions are provided in accordance with the physician's orders 7/26/11. Other resident's having the potential to be affected: All residnets have the potential to be affected. Nurses were inserviced/educated on ensuring all residents have a bowel movement every 3 days and that the appropriate interventions are provided in accordance with the physician's orders 7/26/11. Charge nurse has been monitoring the daioly BM alerts via the Accunurse Computer System and providing the appropriate interventions as	08/20/2011	

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	<p>7/8/11 indicated a laxative was given on 6/29/11, 7/5/11, and 7/8/11.</p> <p>The facility "Medication Administration Record" (MAR) indicated Milk of Magnesia (laxative) was given on 7/3/11, 7/6/11, and 7/7/11 with no results reported. No other interventions were found.</p> <p>Physician order recaps for June 2011, indicated the resident had an order for soap suds enema "as needed" for constipation, if milk of magnesia is ineffective.</p> <p>"Nurses Notes", received and reviewed on 7/20/11, indicated from 6/30/11 through 7/7/11, no mention of the resident having a bowel movement or assessment of the abdomen.</p> <p>An interview with the Director of Nursing on 7/21/11 at 10:00 a.m. indicated she did not know why the resident went so long without having a "BM" without other interventions being tried.</p> <p>The policy "Laxative use to prevent constipation" received and reviewed on 7/18/11 indicated "1. will monitor the resident care record daily to monitor for any resident who has not had a bowel movement in three days. 3.resident</p>		<p>directed per physician orders.Measures to ensure practice does not reoccur: All nursing staff will be inserviced/educated on BM policy and procedure 8/9/11. DON/Designee will monitor Accunurse alerts daily for 4 weeks, then monthly until compliance is achieved. See attachment B1All findings will be addressed immediately and included in the monthly QA meetings.This corrective action will be monitored by: DON/Designee will monitor Accunurse alerts daily for 4 weeks and then monthly for 6 months or until compliance achieved. See attachment B1 All findings will be addressed immediately and included in the monthly QA meetings.Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>		

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	<p>will be given a laxative per doctors order... 5. ...if a resident has a problem with constipation, an evaluation of health status, medications, etc, will be completed".</p> <p>2.) The clinical record for Resident #54 was reviewed on 7/19/11 at 10:30 a.m. Resident #54's current diagnoses included, but were not limited to, morbid obesity, anxiety and constipation.</p> <p>A quarterly minimum data set assessment, dated 6/6/11, indicated the resident required extensive assistance from the staff with toilet use.</p> <p>A health care plan, dated 4/11, indicated the resident had a problem listed as, the resident suffers from constipation due to: a diagnosis of constipation, decreased mobility and medication use. Interventions for this problem included, monitor bowel movements, administer medications as ordered, and advise the charge nurse if the resident does not have a bowel movement every three days, for further evaluation and possible as needed medication administration.</p> <p>Resident #54 had current physician's orders for the following,</p> <p>A. Methadone (a narcotic pain medication) 2.5 milligrams routinely</p>						

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	<p>twice daily for pain.</p> <p>B. Hydrocodone 10/325 milligrams give 1/2 tablet every 4 hours as needed for pain.</p> <p>C. Miralax 17 grams daily for constipation</p> <p>D. Bisacodyl 5 milligram tablet once daily as needed for constipation</p> <p>The June and July 2011 Medication Administration Record indicated the resident received the as needed pain medication Hydrocodone at least 1 time daily.</p> <p>Review of the 2010 Nursing Drug Handbook indicated the Hydrocodone and Methadone medications had a potential side effect listed as constipation.</p> <p>Review of the April, May June and July 2011 "BM [bowel movement] Report" printed from the facility computer system indicated the resident had no BM recorded on the following dates:</p> <p>April</p> <p>April 26, 27, 28, 29</p> <p>May</p>				

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	<p>May 12, 13, 14, 15</p> <p>May 27, 28, 29, 30, 31, and June 1</p> <p>June</p> <p>June 8, 9, 10, 11</p> <p>The clinical record lacked any documentation of the resident having received the as needed Bisacodyl medication as ordered by the physician..</p> <p>During an interview with the Director of Nursing on 7/20/11 at 3:45 p.m. she indicated she had no information to provide to indicate the resident had any BM on the dates noted above.</p> <p>3.) Resident #57's clinical record was reviewed on 7/20/11 at 9:50 a.m. Resident #57's current diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, weakness, anxiety, dementia, and dyslipidemia.</p> <p>Resident #57 had a health care plan, dated 2/8/10, which indicated a "problem" of risk for constipation. One intervention for this problem was to advise charge nurse if the resident does not have a bowel movement every three days, for further evaluation and possible as needed medication administration and /or</p>				

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	<p>physician and responsible party notification.</p> <p>A significant change MDS (Minimum Data Set) assessment dated 6/1/11, indicated Resident #57 needed extensive assistance from the staff with toileting needs.</p> <p>Resident #57's bowel movement documentation indicated resident did not have a bowel movement on May 28, 29, 30 and 31, 2011.</p> <p>The "Medication Administration Record" for May 2011 indicated the resident had an as needed physician's order for milk of magnesia once a day for constipation. Resident #57's MAR (Medication Administration Record) for May indicated no as needed medications had been given after May 27, 2011.</p> <p>During an interview with the DoN on 7/21/11 at 8:30 a.m., she indicated she had no further information to provide regarding Resident #57 having had a bowel movement on the above dates.</p> <p>3.1-37(a)</p>				

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F0328 SS=D	<p>The facility must ensure that residents 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 a resident had oxygen saturations completed as ordered by the physician for 1 of 3 residents reviewed with physician's orders for oxygen in a sample of 15. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 7/20/11 at 10:00 a.m. Resident #21's current diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and pulmonary hypertension.</p> <p>Resident #21 had a health care plan, dated 4/11, which indicated the resident had a problem listed as, resident has COPD and is risk experiencing respiratory distress which includes low oxygen saturations. Interventions for this problem included, administer oxygen as ordered, and observe for signs and symptoms of</p>	F0328	<p>F 328 Treatment/Care for Special NeedsIt is the practice of this facility to ensure that residents receive proper treatment and care for the following services: Injections, Parental and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy; Tracheal Suctioning; Respiratory care; Foot care; and Prostheses. Corrective action for resident's affected: Resident #21 was not harmed. Nurses will be inserviced/educated on ensuring oxygen saturations are obtained and physician's orders are followed 8/9/11. Other resident's having the potential to be affected: All residents with oxygen saturation orders were reviewed and the plan of care adjusted accordingly. Nurses will be inserviced/educated on ensuring oxygen saturations are obtained and physician's orders are followed 8/9/11. Measures to ensure practice does not reoccur: Nurses will be inserviced/educated on ensuring oxygen saturations are obtained and physician's orders are</p>	08/20/2011			

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	<p>respiratory distress.</p> <p>Resident #21 had current physician's orders for the following,</p> <p>A. Oxygen at 3 liters per nasal cannula continuously.</p> <p>B. Check oxygen saturations every shift.</p> <p>During observation on 7/19/11 at 11:30 a.m. Resident #21 was up in her wheelchair and was wearing oxygen per nasal cannula. The resident had a portable oxygen tank on her wheelchair.</p> <p>The May and June 2011 Treatment Administration Records for Resident #21 lacked any information related to the oxygen saturation levels having been completed on the following dates and shifts,</p> <p>May 14, 15, 20, 24, and 27 no oxygen saturation was documented for 7-3 shifts.</p> <p>May 14, no oxygen saturation was documented on 3-11 shift.</p> <p>June 13 no oxygen saturation was documented on 7-3 shift.</p> <p>During an interview with the Director of Nursing on 7/20/11 at 9:00 a.m. additional</p>				<p>followed 8/9/11. DON/Designee will monitor MARs weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately and included in the monthly QA meeting. This corrective action will be monitored by: DON/Designee will monitor MARs weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately. Monitoring will continue for 6 months or until compliance is achieved. See Attachment C1Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>		

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	<p>information was requested related to the resident not having oxygen saturation levels documented on the dates and shifts noted above.</p> <p>During an interview with the Director of Nursing on 7/20/11 at 3:15 p.m., she indicated she had no additional information to provide related to the lack of documentation of the above oxygen saturation levels. She further indicated if no oxygen saturation level was documented, this would indicate no testing was completed.</p> <p>Review of the current undated facility policy, titled, "Pulse Oximetry Monitoring", provided, by the Director of Nursing on 7/21/11 at 10:00 a.m., indicated:</p> <p>"Basic Responsibility, Licensed Nurse</p> <p>Policy It is the policy of this facility to adequately monitor oxygenation (Sao2) and heart rate of respiratory compromised residents per physician's order.</p> <p>Purpose To determine blood oxygen saturation level...</p>				

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F0425 SS=D	<p>Documentation Oxygen saturation level..."</p> <p>3.1-47(a)(6)</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on interview and record review, the facility failed to ensure their pharmacy provided medications for 1 (Resident # 2) of 15 residents reviewed for medications provided, in a sample of 15.</p> <p>Findings include:</p> <p>Resident # 2's clinical record was reviewed on 7/19/2011 at 1:55 p.m. Diagnoses included, but were not limited to: diabetes mellitus, coronary artery disease, anemia, chronic kidney disease</p>	F0425	F425 Pharmacuetical SVC-Accurate Procedures, RPHIt is the practice of this facility to provide pharmaceutical services to meet the needs of each resident and to employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provisionof pharmacy services in the facility. Corrective action for resident's affcted: Resident #2 was unharmed. The back-up pharmacy (PRN) provided internal training of staff to ensure error was corrected. In addition,	08/20/2011	

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	<p>and urinary tract infection.</p> <p>The resident's Medication Administration Record (MAR) indicated on 6/9/11, she was started on an antibiotic for 8 days and pyridium (lower urinary tract pain medication) for 5 days, for a urinary tract infection.</p> <p>The MAR further indicated the pyridium was given on 6/9/11, 6/10/11, 6/11/11 and 6/13/11. The record indicated no pyridium was given on 6/12/11.</p> <p>The "Nurses Notes" dated 6/12/11 at 4:50 p.m. indicated the resident complained of burning with urination.</p> <p>The "Nurses Notes" dated 6/12/11 at 4:50 p.m. further indicated that the "pyridium not available this shift. Pharmacy aware".</p> <p>An interview with the Director of Nursing on 7/20/11 at 1:30 p.m. indicated she would be receiving a copy of the medication error report indicating the pharmacy called in the wrong number of doses to the PRN (as needed) pharmacy.</p> <p>A "captured issue" (med error report) dated 7/20/11, from the primary pharmacy indicated "back-up pharmacy (PRN) called pyridium to (local pharmacy) for (Resident #2)." "They</p>		<p>Omnicare Pharmaceuticals has implemented new "Double Check" policy to decrease the incidence of human error. Nurses will be inserviced/educated 8/9/11 on ensuring that they verify the correct number of medications when receiving from the back-up pharmacy. Other resident's have the potential to be affected: All resident's have the potential to be affected. The back-up pharmacy (PRN) provided internal training of staff to ensure error was corrected. In addition, Omnicare Pharmaceuticals has implemented new "Double Check" policy to decrease the incidence of human error. Nurses will be inserviced/educated 8/9/11 on ensuring correct number of medications when receiving from back-up pharmacy. Measures to ensure practice does not reoccur: The back-up pharmacy (PRN) provided internal training of staff to ensure error was corrected. In addition, Omnicare Pharmaceuticals has implemented new "Double Check" policy to decrease the incidence of human error. Nurses will be inserviced/educated on 8/9/11 on ensuring that they verify the correct number of medications when receiving from the back-up pharmacy. DON/Designee will monitor each back-up pharmacy delivery to ensure correct amount</p>		

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F0514 SS=D	<p>documented that they called in for 5, but they only called in 3, which caused 2 missed doses which facility contact" (primary pharmacy) to send." "Root cause...documentation of wrong quantity from back-up pharmacy."</p> <p>3.1-25(a)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview the facility failed to ensure blood sugar results and sliding scale insulin were documented in the clinical record for 1 of 3 residents reviewed with physician's orders for blood sugar monitoring with sliding scale insulin (resident #54) and failed to ensure resident weights were accurately documented for 1 of 4 residents reviewed</p>	F0514	<p>of medications delivered. This corrective action will be monitored by: DON/Designee will moniotr each back-up pharmacy delivery to ensure correct amount of medications delivered. All findings will be addressed immediately. Moniotring will continue monthly for 6 months or until compliance achieved. See Attachment D1 and D2Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p> <p>F514 Complete/Accurate/Accessiblett is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized and containing sufficient information to identify the resident; a record of the</p>	08/20/2011	

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	<p>for weights (Resident #25) in a sample of 15.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #54 was reviewed on 7/19/11 at 10:30 a.m.</p> <p>Resident #54's current diagnoses included, but were not limited to, morbid obesity, anxiety, diabetes mellitus and constipation.</p> <p>Resident #54 had current physician's orders for the following,</p> <p>A. Blood sugar monitoring 4 times daily.</p> <p>B. Administer sliding scale insulin coverage 4 times daily according the blood sugar results.</p> <p>C. Administer Lantus insulin subcutaneously 25 units daily at bedtime.</p> <p>D. Administer Novolog insulin subcutaneously 5 units three times daily before meals</p> <p>The June and July 2011 Medication Administration Records for Resident #54 lacked documentation of blood sugar monitoring and or insulin administration on the following dates and times,</p>		<p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Corrective action for resident's affected: Resident #54 was unharmed. Nurses will be inserviced/educated on ensuring blood sugars are monitored per the physician's orders and accurately documented on the MAR 8/9/11. Resident #25 was unharmed. Weekly and Monthly weights are to be conducted per Restorative C.N.A.s, effective 7/27/11 to ensure accurate, concise weight measurements be obtained. Restorative C.N.As were inserviced on new weight procedure 7/27/11. All nursing staff was inserviced on new weight procedure 7/26/11. Other resident's having the potential to be affected: DON/Designee reviewed all Diabetic plans of care to ensure accurate documentation and physician's orders followed. All resident's weights were reviewed and any variances corrected by adding the resident to weekly weights until weight stability ensured. Weekly and Monthly weights are to be conducted per Restorative C.N.A.s, effective 7/27/11. All nursing staff was inserviced on new weight procedure 7/26/11. Measures to ensure practice does not reoccur: Nurses will be inserviced/educated on ensuring</p>		

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	<p>A. June 11, at bedtime, no routine insulin was documented as having been administered.</p> <p>B. June 20 at bedtime, no blood sugar was documented as having been completed.</p> <p>C. July 17, at bedtime, no blood sugar result was documented as having been completed.</p> <p>During an interview with the Director of Nursing on 7/19/11 at 2:30 p.m. additional information was requested related to the lack of insulin and blood sugar documentation noted above.</p> <p>During an interview with the Director of Nursing on 7/19/11 at 4:45 p.m. she indicated she had found the insulin and blood sugar results requested. she indicated the information was on the "24 Hour Report Sheets". She indicated the "24 Hour Report Sheets" were not a part of the resident's clinical record. She further indicated the insulin and the blood sugar results should have been documented in the Medication Administration Record.</p> <p>2.) Review of the current undated facility policy, titled "Blood Sugar Monitoring", provided by the Director of Nursing on</p>		<p>blood sugars are monitored per the physician's orders and accurately documented on the MAR 8/9/11. DON/Designee will monitor MARs weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately and included in the monthly QA meetings. Weekly and Monthly weights are to be conducted per Restorative C.N.As, effective 7/27/11. All nursing staff was inserviced on new weight procedure 7/26/11. This corrective action will be monitored by: Nurses will be inserviced/educated on ensuring blood sugars are monitored per the physician's orders and accurately documented on the MAR 8/9/11. DON/Designee will monitor MARs weekly for 4 weeks, then monthly and will indicate this by initialing the MAR above the date. All findings will be addressed immediately. Monitoring will continue monthly for 6 months or until compliance achieved. Weekly and Monthly weight are to be done per Restorative C.N.A.s, effective 7/27/11 to ensure accurate, concise weight measurements obtained. All nursing staff were inserviced on new weight procedure 7/26/11. DON/Designee will monitor weekly/monthly weights per the Accunurse Computer System with the Dietary Manager until</p>				

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	<p>7/21/11 at 10:00 a.m. indicated the following,</p> <p>"Basic Responsibility Licensed Nursing</p> <p>Purpose To monitor blood glucose level...</p> <p>Documentation Guidelines</p> <p>Date, time, blood glucose level Method of testing If insulin is ordered based on sliding scale document the type and amount of insulin administered and the site of injection..."</p> <p>2. The clinical record of Resident #25 was reviewed on 7/20/11 at 9:50 a.m. Diagnosis included but were not limited to: depression, congestive heart failure, diabetes mellitus, neuropathy, anemia constipation and hip fracture.</p> <p>The facilities "Nursing Admission Assessment" dated 7/1/11 indicated the resident's weight was 246.4 pounds.</p> <p>The "Treatment Administration Record" indicated the resident to be weighed weekly on Wednesday's times 4. The weight recorded for 7/6/11 was 159.8. The weight recorded for 7/13/11 was 157.6.</p>		<p>compliance achieved. All findings will be addressed immediately. Monitoring will continue monthly for 6 months or until compliance achieved. Addendum: Monitoring results will be reviewed in QA meetings monthly for 6 months or until a pattern of substantial compliance is achieved with a subsequent plan developed and implemented as indicated.</p>		

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	<p>An interview with the Director of Nursing on 7/20/11 at 1:23 p.m. indicated the resident's weight at the local hospital on 6/28/11 was 223 pounds. She further indicated she was unsure of how the resident was weighed..with or without wheelchair and/or which wheelchair. She also indicated she had previously been aware there were issues regarding weights.</p> <p>The facility policy "Weight Management Process" received and reviewed on 7/20/11 indicated "Assign weight schedule for residents at time of admission, readmission, and at least monthly. Facility will have a program for obtaining weights which will include same time of the month for routine weights, consistent staff involvement and standard for similar conditions for each resident when being weighed (same chair, scale clothing attire, dry brief)."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				