

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2014
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NAME OF PROVIDER OR SUPPLIER  NEW HAVEN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 22, 23, 24, 25, 26 and 29, 2014</p> <p>Facility number: 000114 Provider number: 155207 AIM number: 100266640</p> <p>Survey team: Julie Call, RN, TC Sue Brooker, RD Martha Saull, RN Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 4 Medicaid: 57 Other: 23 Total: 84</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 3,</p>	F000000	<p>This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal law and not because Genesis Healthcare New Haven Center agrees with the allegations and citations listed on pages 1-62 of this statement of deficiencies. Genesis Healthcare New Haven Center maintains that the alleged/ deficiencies do not jeopardize the health/ and safety of the residents, nor are they of such by character so as to constitute substandard quality of care or limit our capability to render adequate care. Please accept this plan of correction as our credible allegation of compliance.</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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F000241 SS=D	<p>2014 by Randy Fry RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility staff failed to sit when feeding a resident (Resident #100) and also failed to administer eye medication in a dignified manner to 1 resident (Resident #47)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #100 on 9/29/14 at 2:47 p.m., indicated the following: diagnoses included, but were not limited to, dementia, chronic pain syndrome, and encounter for palliative care.</p> <p>A Minimum Data Set assessment for Resident #100, dated 6/13/14, indicated he required supervision with set-up help only from staff for eating.</p> <p>During an observation of the lunch meal on 9/22/14 at 12:00 p.m., Resident #100</p>	F000241	<p><b>IF 241483.15 (a) Dignity and Respect of Individuality What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p><b>1.Standing while feeding a Resident</b>  <b>RN # 1</b> received immediate re-education and disciplinary action on 09/26/2014 South Unit Manager for not providing dignity to resident #100 while assisting with his lunch meal service. Center staff were re-educated on the Dignity of residents and remaining seated while feeding residents 09/26/2014-10/12/2014 by the NPE and DON. No other residents were found to be affected by the alleged deficient practice. Resident #100 has been monitored daily during meal service to ensure that staff is being seated during meal time to assist with the consumption of meals.</p> <p><b>1.Administering eye drops in</b></p>	10/20/2014			

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	<p>was observed seated in his high back wheelchair at a dining table in the main dining room. His meal tray had been delivered and set up in front of him. RN #1 was observed to approach the resident and stand next to his high backed wheelchair. She began feeding him his meal standing next to him, and continued to feed him at least 1/2 half of his meal while standing next to him. At 12:04 p.m. she was notified by the Director of Nursing (DON) she needed to sit when feeding a resident. RN #1 was heard to reply to the DON, "Who said?"</p> <p>The Nurse Practice Educator was interviewed on 9/29/14 at 3:38 p.m. During the interview she indicated staff were absolutely not to stand when feeding a resident.</p> <p>2. On 9/23/14 at 1:07 p.m., the 400 hall was observed. On the left side of the hall near the nurses ' station, were two medication carts. On the right side of the hall, directly across from the medication carts, residents were observed to be lined up in the hall in their wheelchairs. At the time, an anonymous resident was heard to comment it was "time for a smoke break." LPN #20 was observed to be standing in the hall beside a medication cart. She had a vial of eye drops which she was attempting to administer to a</p>		<p><b>a public area.</b> LPN # 20 Received disciplinary action on 09/29/2014 for administering eye drops in the hallway, not following rules for Mediation Administration. Nursing staff was re-educated on proper Medication Administration related to the administering of any medications residents 09/26/2014-10/12/2014 by the NPE and DON, including eye drops/ointments to residents in a private setting to assure that personal dignity and well-being are maintained. Staff was re-educated on proper positioning of residents 09/26/2014-10/12/2014 by the NPE and DON while administering eye drops <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A.</b> Residents, who reside at the facility and require assistance with meal consumption, have the potential to be affected by the deficient practice. No other Residents were found to be affected. <b>B.</b> Residents who reside at the facility and receive medications have the potential to be affected by the alleged deficient practice. No other residents were found to be affected by the deficient practice. A. Facility staff was re-educated on 09/26/2014 through 10/12/2014 by the Nurse Practice</p>		

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	<p>resident who was in the hall, also beside the medication cart. The resident was observed to be standing with both knees bend and his torso flexed backwards at a 30 degree angle, in an attempt to bring the level of his eyes closer to the nurse, who was attempting to administer the eye drops, as he stood in the hallway. LPN #20 was observed to be putting eye drops in Resident #47's eyes. The eye drops were observed to be running down the resident's left cheek and the nurse asked the resident "want me to do it again?" The resident shook his head and said "no." At the time, Resident # 47, then straightened his knees and torso, to stand upright. At the time, LPN #20 indicated to the resident "I'll walk you to your room." LPN #20 was observed to take a medication cup with pills in it as she walked with the resident to his room.</p> <p>On 9/26/14 at 10:50 a.m. the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Medication Administration: Eye (Drops and Ointments). This policy was dated 1/2/14 and included, but was not limited to, the following: "Instruct/assist patient to sit or lie in supine position with head tilted back and toward side of affected eye..."</p> <p>On 9/29/14 at 9:20 a.m., the medication</p>		<p>Educator and DON for Dignity of Resident's, Staff was re-educated on remaining seated at all times while assisting residents with meals. B .Facility Staff were also re-educated on Dignity and well-being of our residents and to ensure their Privacy and Dignity is maintained at all times. Even when administering any type of medication. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Facility has implemented an audit tool to ensure staff will remain seated anytime they are assisting residents with meals. And to ensure resident dignity is maintained while administering medications. <b>How will the corrective actions be monitored to ensure the deficient practice will not recur?</b> Facility managers will conduct audits to make sure that staff remains seated while feeding residents Audits will be conducted daily (five days a week) x (4) weeks, twice-weekly x (4) weeks, then weekly thereafter x 4 months to validate that we are meeting the standard of Medication Administration. Audit findings will then be reported to the IDT team through the PI process Meeting weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies..</p>				

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	<p>administration record of Resident #47 was reviewed. This indicated the resident had received artificial tears during the observation of the administration of the eye drops on 9/23/14 at 1:07 p.m.</p> <p>On 9/29/14 at 11:52 a.m. the DON (Director of Nursing) was interviewed. She indicated the resident should have been given his eye drops in a private place.</p> <p>On 9/29/14 at 4 p.m. the NPE (Nurse Practice Educator) was interviewed. She indicated the manner in which the resident had to bend while standing in the hall to accommodate the nurse to instill eye drops, was not in a dignified manner.</p> <p>A current facility policy "Patient's Bill of Rights and Responsibilities", revised on 8/4/14 and provided by the Director of Social Services on 9/26/14 at 9:55 a.m., indicated "...To assure that the patient's personal dignity, well-being, and self-determination is maintained...."</p> <p>This deficiency was cited on the annual Recertification on 11/15/13, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-3(t)</p>		<p>Administrator/Director of Nursing and the Nurse Practice Educator to monitor for compliance through QA process. with results forwarded to the PI Committee for additional interventions as a need is identified. <b>Date of Compliance: 10/20/2014</b></p>				

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure an exposed, unused needle was transported by the nurse in a safe manner to the resident for 1 of 1 insulin administrations.</p> <p>Findings include:</p> <p>On 9/24/14 at 11:45 a.m., LPN #21 was observed to prepare a syringe of insulin for a resident. The medication cart was directly outside the room of the resident LPN #21 was preparing insulin for. At the time, she was observed to uncap the insulin syringe and puncture the needle into the insulin vial and withdrawn the amount of insulin. She was observed to lay the uncapped insulin syringe on the MAR (medication administration record). The needle was observed to be laying on the MAR and the uncapped needle was observed to not have touched the MAR. The cap to the syringe which LPN #21 had removed, was observed to be laying also on the MAR. LPN #21 had gathered additional items to take into the resident's room and then was observed to pick up the uncapped syringe and walk</p>	F000281	<p><b>F 281 483.20 (k), (3), (i) Services provided to meet Professional Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? LPN #21 Received Counseling and re-education for proper medication preparation and administration On 09/29/2014 by the North Unit Manager Education was also provided on safe delivery of transporting an uncovered needle and administering medications requiring injectable administration from a needle. Physician was made aware of nurse not following proper procedure for transporting medication in a needle uncapped. Nursing staff was re-educated by the Nurse Practice Educator and DON on 09/26/2014 through 10/12/2014 on the proper procedure for safe handling and transport of any medication requiring a needle, including how to activate the safety mechanism. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who reside at</b></p>	10/20/2014			

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	<p>into the resident's room. The resident was sitting in his wheelchair on the far side of the room. No other residents were in the room at the time. While LPN #21 wiped off the area on the resident's arm to be injected, she positioned the uncapped syringe between her index and middle finger, and then injected the resident with insulin. LPN #21 was then observed to leave the room. At the time, LPN #21 was interviewed as to the insulin syringe being a safety syringe. She indicated that it was a safety syringe and as she had already disposed of the used syringe, she opened a new syringe package. The syringe did have a protective sheath on the barrel of the syringe. LPN #21 indicated after she injects the resident she pulls the protective sheath up to the end of the syringe to cover the needle. At the time, LPN #21 was interviewed regarding her practice of transporting an uncovered needle from the medication cart to a resident. She indicated this was usually her practice because "more often than not, I pull the protective cover too far and it clicks in place" and is then not useable.</p> <p>On 9/26/14 at 10:58 a.m. the DON (Director of Nursing) and NPE (Nurse Practice Educator) were interviewed. They indicated it was not the facilities' practice for nurses to walk around with uncapped/unprotected needles and the</p>		<p>the facility and require medications that are delivered through a needle have the potential to be affected by the deficient practice. No other Residents were found to be affected by the deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Competencies for medication administration will be conducted on current nursing staff and will be conducted on newly hired nursing staff to validate understanding of policy and procedures of medication administration before passing medications. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Audits will be conducted daily (five days a week) x (4) weeks, twice-weekly x (4) weeks, then weekly thereafter x 4 months to validate that we are meeting the standard of proper medication administration and safety related to the proper use of safety syringes. Audit findings will then be reported to the IDT team through the PI process meeting weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies. Administrator/Director of nursing to monitor for compliance through the PI Process with results forwarded to the PI Committee for</p>				

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F000323 SS=E	<p>needle should have been covered with the safety sheath.</p> <p>On 9/26/14 at 10:57 a.m. the NPE provided a current copy of the facility policy and procedure for "Medication Administration: Injectable..." This policy was dated 1/2/14 and included, but was not limited to, the following: "...safety syringe with appropriate needle...prior to disposal, activate syringe safety mechanism..."</p> <p>3.1-35(g)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on interview and record review, the facility failed to ensure effective interventions were in place prior to a fall which resulted in a fracture and/or implement new interventions after a fall for 1 of 3 residents reviewed for falls. (Resident # 74)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure staff medications, alcohol prep pads, Sani-Cloth Plus Germicidal cloths,</p>	F000323	<p>additional interventions as a need is identified. <b>Date of Compliance: 10/20/2014</b></p> <p><b>3.1-35 (g), (1) F 323 483.25 (h) Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>1. Resident # 74 is no longer a resident at the facility. 2. Storage Containers with secured locks were mounted on the walls in the shower rooms for secure placement of chemicals</p>	10/20/2014

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	<p>Epi-Clenz hand sanitizer, Med Spa shave cream, roll on antiperspirant, shampoo and body wash containers, and Vitamin A &amp; D ointment packets were secured and out of reach of confused and mobile residents who resided in 2 of 2 units (North and South) in the facility. This deficient practice had the potential to affect 28 confused and mobile residents of the 84 residents who resided in the facility.</p> <p>Findings include:</p> <p>A. The clinical record of Resident #74 was reviewed on 9/25/14 at 10 a.m. Diagnoses included, but were not limited to, the following: muscle weakness, difficulty walking, and lack of coordination, Alzheimer ' s disease, cognitive communication deficit, abnormal posture, peripheral autonomic neuropathy and personal history of falls. The MDS (Minimum Data Set) assessment dated 4/18/14 included, but was not limited to, the following: independent cognition; extensive assistance required for transferring and walking in room; balance was not steady, only able to stabilize with human assist. The MDS dated 5/22/14 included but was not limited to the following: independent cognition; extensive assist with transfers; walking in the room did not occur; and</p>		<p>used in those areas. Items were collected and secured and locked. Staff was re-educated on proper storage of hand sanitizers, placement for personal products for residents, and germicidal cloths.</p> <p>3.RN #1 was given disciplinary action on 09/26/2014 by the South Unit Manager and re-educated on policy and procedure for securing personal items/ medications in the facility.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who reside at the facility and are mobile and confused have the potential to be affected by the deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> A. Residents who are at risk or sustain a fall will have an immediate intervention put into place to reduce the potential for the resident to sustain another fall while addressing potential causes for the fall. B. Staff were re-educated on residents 09/26/2014-10/12/2014 by the NPE and DON securing all potential chemical hazards and ensuring they are not out where they can be obtained by confused residents who are mobile within the facility. . Administrative staff</p>		

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	<p>balance seated to standing required human assistance to stabilize and walking did not occur.</p> <p>A Fall risk Evaluation, dated 4/11/14 indicated the following: "the resident did have a fall in the last month; was on an antidepressant and an antihypertensive medication and was oriented to person/place/time; and mild alteration in judgment/insight. On the form, the numerical value assigned to the "mild alteration" selection was "2", however 1 was written in the score portion of the form. The total for the indicators was calculated to be 11 (with "1" being utilized for the judgment/insight portion of the form.) The form indicated a total of 12 or above indicated a "high risk for fall."</p> <p>A plan of care with an initial date of 4/16/14 and a revision date of 6/1/14, addressed the focus of "Potential for falls related to...impaired balance, unsteady gait, history of multiple falls and non compliance with turning alarms off, and walking unassisted. Last fall 5/11/14 with ankle fx (fracture)..." The goal was "no significant injury related to a fall" and Interventions included but were not limited to, the following: "pressure sensor alarm when in bed (4/16/14); RFA (restraint free alarm) to wheelchair for</p>		<p>will conduct rounds to ensure no chemicals, or potentially hazardous chemicals are left unsecured. C. Staff was re-educated per facility handbook of proper storage of personal items while in the facility residents on 09/26/2014-10/12/2014 by the NPE and DON and the use of lockers available to them. Staff was re-educated that no medications are to be out within resident reach, including personal medications. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Audits will be conducted daily by the Administrator/DON and Department managers throughout the facility Audits will be conducted daily (five days a week) x (4) weeks, twice-weekly x (4) weeks, then weekly thereafter x 4 months to validate that we are ensuring that the facility is free of accidents related to hazards/supervision and devices used in the facility. Audit findings will then be reported to the IDT team through the PI process meeting weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies. Administrator/Director of nursing to monitor for compliance through ther PI process, with results forwarded to the PI Committee for additional interventions as a need is identified. <b>Date of</b></p>				

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	<p>safety and fall prevention; check placement and function every shift (5/18/14); 5/11/14 remind resident to use call light prior to ambulating or transfer (5/11/14)."</p> <p>Nurses notes (NN) from 4/11/14 - 6/15/14 were reviewed on 9/25/14 at 11 a.m. They included, but were not limited to, the following:  4/11/14 at 3:15 p.m.: admitted from home, ambulates with walker, forgets easily  4//12/14 at 5 p.m.: very forgetful  4/13/14 at 2:30 a.m.: bed alarm in place and functional  4/14/14 at 10 a.m.: personal alarm in place and working  4/15/14 at 6:15 p.m.: bed and chair alarm in place and working  4/20/14 at 9 p.m.: "turns alarms off before she gets out of bed, amb (ambulate) with walker..."  4/21/14 at 12:30 a.m.: "Alert with memory issues...turns bed alarm off and ambulates to BR (bathroom) then pulls emergency cord in BR..."  4/29/14 at 7 p.m.: "...forgetful..."  5/1/14 at 12 p.m. "...very forgetful. Up in room per self. Enc (encouraged) to call for assistance..."  5/5/14 at 12 p.m. "...forgetful. Up in room/self..."  5/11/14 at 6 p.m.: "...bed/chair alarm in</p>		<b>Compliance: 10/20/2014</b>		

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	<p>place and functioning..."</p> <p>5/11/14 at 9 p.m.: "increased confusion..."</p> <p>5/11/14 at 10:30 p.m.: "Resident in 200 hallway. Resident has no shoes or other footwear on. Resident was on floor in 200 hallway had been incont (incontinent) of urine and slid in it...Resident had not turned on call light but had turned her bed alarm off..."</p> <p>5/12/14 at 9 a.m.: "n.o. (new order) X-ray R (right) foot/ankle d/t (due to) swelling, bruising et (and) tenderness..."</p> <p>5/12/14 at 8 p.m.: "...resident admitted (to hospital) with pneumonia, UTI (urinary tract infection) et (and) rt (right) ankle fracture..."</p> <p>5/15/14 at 5 p.m.: "Arrived at facility...R ankle with splint and ace bandage...bed/chair alarms in place and functioning..."</p> <p>5/16/14 at 12 a.m.: "...RLE (right lower extremity) has splint...dependent on staff for ADL (activities of daily living) and transfers..."</p> <p>5/18/14 at 6 a.m.: Bed alarm on and functional.</p> <p>5/25/14 at "6a - 2p: Res alert and confused, x 1 assist with ADLs et transfers...."</p> <p>5/29/14 at 1 a.m.: "...alert, oriented to self only...right boot in place...bed alarm in place and functioning."</p> <p>6/1/14 at 6:30 a.m.: "Res on floor in</p>			

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	<p>room, forgot she couldn't get up by herself to the bathroom..."</p> <p>The "Falls-72 hours" report, dated 6/1/14 at 6:30 a.m. included but was not limited to, the following: "Immediate intervention: helped up into w/c (wheelchair), RFA (restraint free alarm) re applied." The "Next shift follow up" dated 6/1/14 at 2-10 p.m. through 6/3/14 2-10 (sic) lacked documentation of the following area: "intervention at time of fall, effective and/or not effective, specify new intervention..." with the exception of the follow up dated 6/2/14, 2-10 (sic) indicated the intervention at the time of the fall was effective.</p> <p>6/5/14 at 2-10 (sic): "...alarms intact, check and functioning."</p> <p>6/12/14 at 11 a.m.: "Res (resident) non-compliant with weight bearing status. Res ambulated to et from BR unassisted. Res had turned alarm off. Will cont (continue) to monitor..."</p> <p>6/15/14 10p-6a : "...non compliant with weight bearing status...is alert but very confused, requires redirection frequently...continues to turn off her alarms. Was informed that these were for her safety. I don't care." [sic]</p> <p>On 9/26/14 at 8:47 a.m., the DON provided a copy of the facility fall investigation for the 5/11/14 fall and the</p>						

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	<p>6/1/14 fall. This form included, but was not limited to, the following: Circumstances of the event and what actions, if any, have been taken currently: "amb (ambulated) to hallway and slipped on floor feet wet (urine) assessed...2 assist when amb her back to bed, bed alarm off which (resident name) knows how to turn off, no apparent injuries...to obtain UA (urinalysis) if ok from MD." What preventative measures were in place prior to this fall? "alarms in place." Was the alarm assigned to this resident? "yes"; was the alarm set up properly "Yes"; Was alarm turned on "no"; did the alarm sound "no"; was there a change in cognition/behavior in last 7 days: "yes, resident appeared confused and agitated"; root cause/conclusion: obtaining UA C&amp;S (culture and sensitivity) to r/o (rule out) UTI"; cognitive/behavior factors prior to fall: "alert, confused, restless" The option for poor safety awareness was not checked. Care plan update dated (was left blank).</p> <p>A Urinalysis report was dated as collected on 5/11/14 at 11:45 (sic) and was received on 5/12/14 at 5:24 a.m. The report was printed on 5/12/14 at 7:20 a.m. and indicated a culture was "not indicated."</p> <p>On 9/29/14 at 12:09 p.m. the DON was</p>			

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	<p>interviewed. She indicated the immediate intervention implemented after the 5/11/14 fall, was the NP (Nurse Practitioner) having been notified and to rule out an infectious process due to the resident being confused, a urinalysis was ordered. She indicated the bed alarm was off at the time of the fall, as the resident knew how to turn the alarm off. The DON indicated at the time, the resident did not have a UTI (urinary tract infection) which required treatment of antibiotics.</p> <p>A consultation note, dated 5/12/14, included but was not limited to, the following: "...who sustained a fall...brought to the emergency department diagnosed with a right ankle fracture dislocation..."</p> <p>Nurses notes dated 5/15/14 at 5 p.m. indicated the resident returned to the facility from the hospital. This note indicated the resident had a right ankle splint.</p> <p>A Fall Risk Evaluation, was dated 5/15/14 and indicated the resident was a high risk for falls, with a total score of 19. The form indicated a total over 12 indicated a high risk for falls.</p> <p>The MAR (medication administration</p>			

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	<p>record) for May and June 2014 indicated the following, dated 5/15/14: "RFA (restraint free alarm) to wheelchair for safety and fall prevention; check placement and function every shift." The May and June 2014 MAR also indicated the following dated 5/15/14: "Bed sensory alarm for safety and fall prevention; check placement and function every shift."</p> <p>On 9/26/14 at 8 18 a.m. the DON was interviewed. The DON indicated the resident had a fall at home prior to admission and on admission, the resident had a pressure pad alarm to the bed only. The DON was interviewed regarding the resident being able to turn the alarm off and get out of bed unassisted and her response was the resident had a care plan for non compliance with the alarm. The NPE (Nurse Practice Educator) indicated the there was an order for a restraint free chair alarm while up in wc (date 5/15/14) in the Dr. orders.</p> <p>The NPE indicated the intervention after the fall was a UA as the resident had not prior been incontinent of urine.</p> <p>On 9/26/14 at 8:47 a.m. the DON provided a copy of the facility fall investigation dated 6/1/14. This form included, but was not limited to, the following: "Circumstances of the event</p>						

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	<p>and what actions, if any, have been taken currently: Resident attempted to get up without assistance; care plan updated (was left blank); Has the resident fallen before "yes"; Previous number of falls: past 30 days: zero and past 31-180 days was 1; What preventative measures were in place prior to this fall: "sensor alarm while in bed and wc"; Interventions added immediately after fall and care plan updated "yes"; was an alarm set up properly "yes"; was alarm turned on "yes"; did the alarm sound "yes"; was there a change in the cognition/behavior in last 7 days: "no"; root cause/conclusion: resident unassisted transfer. currently on therapy services."</p> <p>A Fall Risk Evaluation, dated 6/18/14 indicated the resident remained at a high risk for falls with a total score of 17.</p> <p>On 9/26/14 at 10:50 a.m. the DON provided a current copy of the policy and procedure for "Accidents/Incidents", dated 5/15/14. The policy included, but was not limited to, the following: "Purpose:...to define causative/contributing factors and institute preventative measures to avoid further occurrences...Follow up/Investigation:...Interventions to prevent further accidents/incidents have been identified and implemented...initiate</p>			

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	<p>actions to prevent further accidents/incidents..."</p> <p>On 9/29/14 9 a.m. the NPE (Nurse Practice Educator) was interviewed. She indicated when they get an order for a UA (urinalysis) once they obtain the order, they get a preliminary report but physicians don't like to treat the infection until they have a final report. She indicated the microbiology report can take an additional 48-72 hours and it can take up to 4 days to get a final result to let the physician know.</p> <p>On 9/29/14 at 1:10 p.m. the South Unit Manager was interviewed. At the time, the "neurological assessment flow sheet" was reviewed. The initial date on this form was 5/10/14 at 10:30 p.m. The South Unit Manager indicated the following: the resident fell 5/11/14 at 10:30 p.m. and the facility started neuro (neurological) checks on 5/11/14 but documented them as having started on 5/10/14. She indicated the resident already had alarms on her wc and bed alarm and the intervention after the fall was to get a UA and also to remind her to call for assistance. She indicated the neuro check were done every 15-30 minutes. At this time, the form was reviewed and indicated the following: neuros were documented every 30</p>			

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	<p>minutes from 5/10/14 at 10:30 p.m. until 5/12/14 at 2:30 a.m. The next neuro check after this was not until 6:30 a.m. Documentation was lacking of a 6:30 a.m. neuro check having been completed. The 10:30 a.m. neuro check was completed. The resident was transferred to the hospital on 5/12/14 at 12:15 p.m. with a fracture to the right ankle. The unit manager indicated they didn't implement any different fall prevention interventions to the resident when she returned from the hospital on 5/15/14. She indicated on 5/18/14 the facility did add an alarming seatbelt to the resident's wheelchair.</p> <p>B.1. An observation in the North hall unlocked, unattended shower room on 9-22-2014 at 9:58 a.m., indicated a 4 ounce bottle of Epi-Clenz hand sanitizer and two packets of Vitamin A &amp; D ointment were on top of a linen cart, an 11 ounce Med Spa shave cream can and a 1.5 fluid ounce Med Spa roll on antiperspirant were on a window sill by the shower entrance.</p> <p>2. An observation of the 400 hall unattended medication cart on 9-22-2014 at 10:16 a.m., indicated an alcohol prep pad was out on top of the medication cart.</p>			

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	<p>3. An observation in the South hall unlocked, unattended shower room on 9-22-2014 at 10:28 a.m., indicated a packet of Vitamin A &amp; D ointment on top of a covered linen cart. Further observations indicated 2 unsecured 3 drawer plastic containers which contained the following:</p> <ul style="list-style-type: none"> <li>-The right side container top drawer contained an 8 ounce perineal wash spray bottle, Med Spa roll on antiperspirant and 4 packets of Vitamin A &amp; D ointment.</li> <li>-The bottom drawer contained 9 Vitamin A &amp; D ointment packets, Med Spa roll on antiperspirant and a 4 ounce bottle of Epi-Clenz hand sanitizer.</li> <li>-The left side container top drawer contained 2 packets of Vitamin A &amp; D ointment, 2 Med Spa roll on antiperspirants, two 8 ounce perineal wash spray bottles, 1 Epi-Clenz hand sanitizer and 2 Med Spa shampoo and body wash bottles.</li> <li>-The 2nd drawer contained a Med Spa roll on antiperspirant and shave cream.</li> </ul> <p>4. An observation of the unlocked and unattended North hall shower room on 9-24-2014 at 10:08 a.m., indicated the following:</p> <ul style="list-style-type: none"> <li>-One 4 ounce Epi-Clenz hand sanitizer and 2 packages of Vitamin A &amp; D ointment were out on top of one of the 3 drawer plastic containers.</li> </ul>						

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	<p>-One Med Spa shave cream can was on the shelf in shower on the left.</p> <p>-Ten packages of Vitamin A &amp; D ointment were on the shelf of one of the linen carts.</p> <p>5. An observation of the 200 hall unattended medication cart on 9-26-2014 at 8:58 a.m., indicated 2 alcohol prep pads and a Bisacodyl suppository were out on top of the cart.</p> <p>6. An observation of the 400 hall treatment cart on 9-26-2014 at 9:22 a.m. indicated a container of PDI Sani Cloth Plus Germicidal disposable cloth container was out on top of the treatment cart.</p> <p>7. An observation of the unlocked and unattended North hall shower room on 9-26-2014 at 9:24 a.m., indicated a bottle of White Rain shampoo in one shower stall, a Med Spa roll on antiperspirant in the other shower stall, 1 packet of Vitamin A &amp; D ointment on a linen cart shelf and a 4 ounce bottle of Epi-Clenz hand sanitizer was in the top drawer of one of the 3 drawer plastic containers.</p> <p>8. An observation of the unattended and unlocked South hall shower room on 9-26-2014 at 9:31 a.m., indicated the unlocked plastic 3 drawer containers</p>			

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	<p>included the following:</p> <ul style="list-style-type: none"> <li>-The right cart top drawer contained one 8 ounce perineal wash spray bottle, a Med Spa shave cream and roll on antiperspirant and 5 Vitamin A &amp; D ointment packets.</li> <li>-The left cart top drawer contained 2 Med Spa shampoo and body wash bottles, two 8 ounce perineal wash spray bottles, 2 Med Spa roll on antiperspirants and 5 Vitamin A &amp; D ointment packets; the 2nd drawer contained a can of Med Spa shave cream and a roll on antiperspirant.</li> </ul> <p>9. An observation of the medication cart for rooms 210 - 219 in the South hall on 9-26-2014 at 9:33 a.m., indicated an unzipped black mesh bag with colorful stripes was unattended and out on top of the unattended medication cart. Further observations of the bag indicated an amber color prescription type container with tablets was inside the bag.</p> <p>An observation with the South hall Unit Manager of the unzipped black mesh bag with colorful stripes on 9-26-2014 at 9:38 a.m., indicated the South hall Unit Manager removed the following:</p> <ul style="list-style-type: none"> <li>-an amber color unlabeled prescription bottle full of rust colored, round pills with the marking "I-2"</li> <li>-a blister pack of 10 and another pack of 4 Spiriva capsules</li> </ul>				

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	<p>-a Spiriva Inhaler -an albuterol/ventolin inhaler.</p> <p>An interview with the South hall Unit Manager and Nurse #1 was observed on 9-26-2014 at 9:42 a.m. and indicated the unzipped black mesh bag with colorful stripes was the property of Nurse #1. Nurse #1 indicated the black mesh bag contained her allergy medications. Nurse #1 was observed to ask the South hall Unit Manager about securing her medications in the resident medication cart or the medication storage room. The response of the South hall Unit Manager indicated the personal items were to be stored in the locked breakroom.</p> <p>During an interview with Nurse #1 on 9-26-2014 at 10:00 a.m., Nurse #1 indicated she forgot she was not supposed to keep her personal medications out on the top of the resident medication cart. Further interview with Nurse #1 indicated she was aware the Bisacodyl suppository was left out on top of the other medication cart. Nurse #1 indicated she didn't put it in a drawer because she was afraid she would have forgotten the suppository.</p> <p>An interview with the DON (Director of Nursing) on 9-26-2014 at 10:09 a.m., indicated staff was not to leave their</p>			

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	<p>personal medications out on top of the medication carts. Further interview with the DON indicated the Bisacodyl suppository, alcohol prep pads and the PDI Sani-Cloth Germicidal cloths wipes should not be left out unattended.</p> <p>On 9-26-2014 at 10:15 a.m., a list was provided by the South Hall Unit Manager which indicated 10 confused and mobile residents resided in the South hall.</p> <p>On 9-26-2014 at 12:02 p.m., a list was provided by the DON which indicated 18 confused and mobile residents resided in the North hall.</p> <p>An interview with the Medical Records staff, who also ordered supplies on 9-26-2014 at 11:38 a.m., indicated personal hygiene products were not to be stored in the showers and each resident had their own supplies which were kept in the resident rooms.</p> <p>The Medical Record staff provided the following containers on 9-26-2014 at 11:38 a.m. with "Keep out of Reach of Children" on the label: -"PDI Sani-Cloth Plus Germicidal Disposable Cloth" 1 lb. (pound) 13.3 oz (ounce) -"Epi-Clenz instant Hand Sanitizer" 7-% Ethyl alcohol 4 oz.</p>			

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	<p>-"Med Spa roll on antiperspirant" 1.5 Fl (fluid) oz.</p> <p>-"Med Spa shampoo and body wash" 8 fl. oz. bottle</p> <p>-"Med Spa shave cream" 11 oz. can</p> <p>-"Perineal Wash" 8 oz spray bottle had only "external use only" on the label.</p> <p>A MSDS (Material Safety Data Sheet) for Sani-Cloth Plus Germicidal Disposable Cloth was provided by Medical Records staff on 9-26-2014 at 11:38 a.m. and indicated the following under "Hazards...combustible...causes moderate eye irritation...vapor concentrations above recommended exposure levels are irritating to the eyes and the respiratory tract; may cause headaches and dizziness, and other central nervous system effects...."</p> <p>A copy of the Vitamin A &amp; D ointment package was provided by Medical Records on 9-26-2014 at 11:38 a.m. and indicated "...warnings...for external use only...KEEP OUT OF REACH OF CHILDREN...."</p> <p>A copy of the "Medium Prep Pad" package was provided by Medical Records on 9-26-2014 at 11:38 a.m. and indicated "Alcohol Antiseptic...keep out of reach of children...."</p>				

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	<p>An interview with CNA #9 on 9-29-2014 at 9:36 a.m., indicated each resident has their personal hygiene supplies stored in a drawer in their room and the personal hygiene products were not stored in the shower rooms.</p> <p>A policy Storage and Expiration Dating of Drugs, Biological, Syringes, and Needles dated 8-1-2012 and provided by the DON on 9-29-2014 at 1:42 p.m., indicated "Drugs, biological, syringes and needles are stored under proper conditions with regard to...safety, security...as directed by state and federal regulations and manufacturer/supplier guidelines...to prevent theft, loss or access by non-authorized staff or patients...all drugs and biologicals, including treatment items are securely stored in a locked cabinet/cart or locked medication inaccessible by patients and visitors...."</p> <p>A copy of the Genesis Employee Handbook dated June 2014 and provided by the Nurse Practice Educator on 9-29-2014 at 3:45 p.m., indicated on page 32 "...bags you carry into or out of work may be inspected by any supervisor...you may be provided with a locker to secure your...personal items...advised to place personal items in the trunk of your car...."</p>			

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F000329 SS=E	<p>3.1-45(a)(2) 3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure justification for an increase in an antipsychotic medication and/or rationale to not attempt a GDR (gradual dose reduction) of an antianxiety medication for 1 of 5 residents reviewed for unnecessary medication. The facility further failed to attempt a gradual dose reduction for psychotropic medications for 4 residents</p>	F000329	<p><b>3.1-45 (a). (2) 3.1-45 (a), (1) F 329 Drug Regimen is Free from Unnecessary Drugs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The Behavioral management IDT will monitor these resident's behaviors and medication changes, documenting monthly/PRN on</p>	10/20/2014

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	<p>(Resident #45, Resident #81, Resident #102, and Resident #60) of 5 residents reviewed for unnecessary medication.</p> <p>Findings include:</p> <p>1. On 9/25/14 at 1 p.m., the clinical record of Resident #45 was reviewed. Diagnoses included, but were not limited to, the following: depressive disorder, Alzheimers disease, cognitive deficits, senile dementia with delusional features and anxiety state. The MDS (Minimum Data Set) assessment dated 4/12/14 included, but was not limited to, the following: total cognition score was zero, which indicated severely impaired cognition; resident did not have any hallucinations and/or delusions.</p> <p>The March 2014 Behavior Monitoring and Intervention Flow Record was reviewed on 9/26/14 at 10 a.m. This form included but was not limited to, the following: behaviors monitored included itching, anxiousness, tearfulness and delusions. The resident was documented on this form to have had no incidents of anxiousness; a total of 4 incidents of tearfulness, 1 each on 3/15, 3/26, 3/28 and 3/29. Documentation indicated the interventions attempted to resolve the behavior were unsuccessful. One incident of delusions was documented on</p>		<p>any reports of behaviors or outbursts. Nursing Management will ensure daily documentation by staff is in place to capture any behaviors that are exhibited.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Residents who reside at the facility and take psychotropic medications have the potential to be affected by the deficient practice. Residents identified in the 2567 were reviewed with Physician and pharmacist and no harm was identified to these individuals. Other residents on psychotropic medications will be reviewed daily with reports of inappropriate behaviors, and monthly at the behavioral management meeting to ensure that individual review of concerns are addressed timely. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Facility will ensure that all behaviors are appropriately documented and reviewed by nursing managers daily. If behavior needs immediate intervention, staff is required to call the DON/Administrator/DSS for immediate intervention. Documentation of behaviors requiring administration of a medication will be captured on the behavioral flow record</p>		

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	<p>3/29/14 with the intervention improving the behavior. Documentation was lacking on the Behavior Monitoring form of the intervention that was attempted, even though the form indicated there was an improvement. At the time, the nurses notes (NN) for March 2014 were reviewed and documentation was lacking of a delusional behavior or symptom on 3/29/14.</p> <p>The April 2014 Behavior Monitoring and Intervention Flow Record was reviewed on 9/26/14 at 10:20 a.m. This form included but was not limited to, the following: monitoring behaviors of pacing and mood changes. The documentation indicated the above behaviors did not occur.</p> <p>On 9/26/14 at 9 a.m. the nurse notes from March - April 2014 were reviewed. Documentation was lacking of any incidents of hallucinations, delusions, anxiousness and or tearfulness until the following entry on 4/14/14 at 2 p.m.: "N.O. (new order) noted dc (discontinue) Zyprexa 2.5 mg, start Zyprexa 5 mg, hallucinations et (and) delusions. Res (resident) has seen children outside in hall children not seen by staff..."</p> <p>A Psychotherapeutic Medication Use Evaluation (PMUE) form dated 4/14/14</p>		<p>documented on by nursing staff. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Audits will be conducted by the NPE/DON/Designee daily (five days a week) x (4) weeks, twice-weekly x (4) weeks, weekly times (4) weeks and monthly x 4 months to validate that we are meeting the requirement ensuring the residents drug regimen is free from unnecessary drugs and that the facility maintains accurate review and adheres to gradual dose reductions bi-annually if appropriate for those residents. Nurse management team will also document monthly in the behavioral management meeting to support any changes or reductions made. Administrator/Director of Nursing/ Designee to monitor for compliance through the PI process weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies.. , with results forwarded to the PI Committee for additional interventions if a need is identified. <b>By what date the systemic changes will be completed. Date of Compliance: 10/20/2014</b></p>				

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	<p>included, but was not limited to, the following: "Interdisciplinary Team Summary:...increase in hallucinations, failed reduction of Zyprexa, put back to 5 mg at HS.</p> <p>A physician order, dated 4/14/14 indicated the following: "D/C (discontinue) Zyprexa (used to treat psychotic conditions such as schizophrenia and bipolar disorders) 2.5 mg; start Zyprexa 5 mg 1...every HS (bedtime), failed GDR (gradual dose reduction) increase in hallucinations."</p> <p>A plan of care with an initiation date of 8/15/14 addressed the focus of "...hallucinates as evidenced by sees people not seen by staff..." The goal was documented as will have less than 2 episodes of hallucinations in one week. The interventions included but were not limited to, the following: observe for signs and symptoms of hallucinations; medications per MD order.</p> <p>A plan of care with an initiation date of 7/11/14 addressed the focus of "...exhibits distressed mood symptoms as evidenced by anxiety." Interventions included but were not limited to, the following: "...observe for changes in mood, behavior...observe for signs and symptoms of depression or anxiety."</p>			

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	<p>A plan of care, with an initiation date of 8/15/14, addressed the focus of "...at risk for complications related to the use of psychotropic drugs." The goal was "resident will have the smallest most effective dose without side effects." The interventions included, but were not limited to, the following: "...complete behavior monitoring flow sheet; gradual dose reduction as ordered; monitor for continued need of medication as related to behavior and mood."</p> <p>On 9/25/14 at 1:45 p.m. the DON (Director of Nursing) was interviewed. She indicated the facility Behavior Committee included the following representatives: Consultant pharmacist, DON, NPE (Nurse Practice Educator), the unit managers from each of the north and south units, Social Service Director (SSD), the Psychiatrist (either the Nurse Practitioner (NP) and/or the physician) and the Activity Director. She indicated each resident was reviewed at least every other month but as of September 2014, each resident will be reviewed quarterly for appropriateness of psychoactive medications.</p> <p>On 9/25/14 at 1:45 p.m., the DON indicated the Behavior Management teams reviewed the following documents</p>			
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	<p>at the behavior meetings: the residents chart, documentation in the NN (nurses notes), behavioral tracking records (which the DON indicated contained charting by exception). She also indicated the pharmacy "keeps up when a gradual dose reduction is due." She indicated the team discussed whether medication was beneficial to the resident and if the reduction was indicated. She indicated the goal was to have the resident be on the least dose possible.</p> <p>On 9/29/14 at 8 a.m. the DON was interviewed. She indicated the resident had the dose of Zyprexa reduced to 2.5 mg at hs (bedtime) on 8/12/13 and due to an increase in hallucinations, which was considered a failed GDR (gradual dose reduction) the resident's Zyprexa was increased to 5 mg at hs on 4/14/14.</p> <p>Documentation was lacking of justification of the Zyprexa being increased on 4/14/14 from 2.5 mg to 5 mg, other than the one incident of delusions on 3/19/14,</p> <p>2. On 9/25/14 at 11 a.m. the clinical record of Resident #81 was reviewed. Diagnoses included but were not limited to, the following: Status post stroke, depression, anxiety and obsessive/compulsive personality</p>			

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	<p>disorder. The MDS dated 7/18/14 included but was not limited to, the following: total cognition score indicated independent cognition; no mood or behaviors were identified; and the psychiatric/mood disorder was identified as depression.</p> <p>A PMUE (Psychotherapeutic Medication Use Evaluation) form, dated 7/14/14 included, but was not limited to, the following: "psychotherapeutic medication...Buspar 10 mg...last dosage change date 4/8/13, increase, other concurrent clinical concerns:...depression, OCD (obsessive compulsive disorder), "Behavior Trends since last evaluation; no change in behavior symptoms"; Interdisciplinary Team Summary: "still has episodes of depression et (and) perseverating obsessive thoughts"; "Gradual dose reduction NOT Recommended: state the rationale why an attempt at GDR will likely impair this patient's function..."stable at this time."</p> <p>The June 2014 and July 2014 Behavior Monitoring and Intervention Flow Records were reviewed on 9/26/14 at 10 a.m. They included the following: in June 2014 the behaviors monitored for were withdrawn and obsessive thoughts. Documentation was lacking on the entire</p>						

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	<p>form of any behaviors having occurred. The July 2014 behavior monitoring flow record included the following behaviors monitored for: withdrawn and agitation. Documentation was lacking on the entire form of any behaviors having occurred. Documentation was also lacking of monitoring of a behavior or symptom justification for an antianxiety medication, Buspar 10 mg bid (twice a day) the resident was receiving, related to an obsessive compulsive personality disorder diagnosis, anxiety and perserverating thoughts.</p> <p>A plan of care, dated 7/28/14, addressed the focus of "Resident exhibits behavior: Obsessive compulsive disorder. The goal was to "will attempt to not have episodes of obsession within the next review."</p> <p>A plan of care, dated 7/28/14, addressed the focus of "Resident is at risk for complications related to the use of psychotropic drugs...receives an...antianxiety medication for dx (diagnosis) of personality disorder with history of perserverating and obsessive thoughts." The goal was to "have the smallest most effective dose without side effects." Interventions included, but were not limited to, the following: "Monitor for continued need of medication as related to behavior and mood at behavior</p>			

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	<p>management meeting and prn (as needed)."</p> <p>A PMUE form, dated 9/8/14, included but was not limited to, the following: "Buspar 10 mg bid (twice a day) -OCD, start date 2/11//13 and last dose change was 4/8/13, decrease...Resident increased teariness [sic], periods of anxiety, perseverating of thought..Interdisciplinary Team Summary (was left blank); Interdisciplinary Team Recommendation:...Gradual Dosage Reduction NOT recommended: State the rationale why an attempt at GDR will likely impair this patient's function..."CCI (clinically contraindicated) Buspar..."</p> <p>The August and September 2014 Behavior Monitoring Intervention Flow Records were reviewed on 9/26/14 at 10:20 a.m. They included the following: The August Behavior record indicated the targeted behaviors of "Anxiety and Withdrawn." Documentation was lacking of any behaviors having occurred. The September 2014 Behavior records indicated the targeted behaviors of "Tearfulness" and "Anxiety." Documentation was lacking of any behaviors having occurred. Documentation was also lacking of the tracking of the "perseverating thoughts" which the PMUE form documented the</p>			

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	<p>resident had an increase in.</p> <p>The August and September 2014 nurse notes, dated 8/2/14 - 9/17/14, were reviewed on 9/26/14 at 11 a.m. Documentation was lacking of any behaviors occurring during the time period.</p> <p>A physician order, dated 9/8/14, included the following: "Contraindicate GDR of Buspar at this time. Any decrease would negatively impact her psychiatric/mental health status. She continues to have episodes of Perseverating thoughts."</p> <p>A note dated 9/8/14 at 1:15 p.m. indicated the following: "Res reviewed per IDT during behavior management for CCI on Buspar usage. Will continue as res continues with periods of anxiety et perseverating thoughts..."</p> <p>On 9/25/14 at 2:20 p.m. the DON was interviewed. She indicated the resident was on Buspar (used to treat anxiety and depressive disorder) and the resident's diagnosis to support this medication was obsessive compulsive personality disorder and depressive disorder. The DON indicated this medication was started on 4/9/13, at a dose of 10 mg bid (twice a day). The DON indicated another indication for the medication</p>			

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	<p>which the resident exhibited was perseverating (keeps repeating the same things over and over again) thoughts and obsessive thoughts. She indicated a GDR of the medication was CCI (clinically contraindicated) in 10/14/13 and the next GDR review was on 9/8/14. She indicated the GDR on 9/8/14 was also clinically contraindicated.</p> <p>3. Review of the clinical record for Resident #102 on 9/24/14 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, depressive disorder and anxiety state.</p> <p>Resident #102 was admitted to the facility on 4/8/13.</p> <p>A physician's order for Resident #102, dated 6/10/13, indicated to increase Lexapro (antidepressant) from 10 mg (milligrams) daily to 20 mg daily.</p> <p>A physician's order for Resident #102, dated 7/13/13, indicated to increase Ativan (antianxiety) 0.25 mg daily to Ativan 0.25 mg TID (three times a day).</p> <p>A Behavior Monthly Flowsheet for Resident #102, dated for the month of October, 2013, indicated he was receiving the medications of Ativan for agitation/anxiety state and Lexapro for anxiety state. The flowsheet also</p>			

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	<p>indicated the facility was tracking the behaviors of agitation, anger, and anxiety. No behaviors were documented on the flowsheet.</p> <p>A Behavior Monthly Flowsheet for Resident #102, dated for the month of November, 2013, indicated he was receiving the medications of Ativan for agitation/anxiety state and Lexapro for anxiety state. The flowsheet also indicated the facility was tracking the behaviors of anxiety and mood changes. No behaviors were documented on the flowsheet.</p> <p>A Behavior Monthly Flowsheet for Resident #102, dated for the month of December, 2013, indicated he was receiving the medications of Ativan for agitation/anxiety state, and Lexapro for anxiety state. The flowsheet also indicated the facility was tracking the behaviors of anxiety, agitation, and anger. No behaviors were documented on the flowsheet.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #102, dated 1/13/14, indicated he was receiving Lexapro 20 mg q (every) day and Ativan 0.25 mg TID. The note also indicated staff reported he was still having some episodes of severe anxiety. The note</p>			

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	<p>further indicated a contraindicated gradual dose reduction (GDR) of Lexapro and Ativan. The note indicated any decrease would negatively impact his Psychiatric/Mental Health status as he continued to have episodes of anxiety.</p> <p>A Psychotherapeutic Medication Use Evaluation for Resident #102, dated 1/23/14, indicated he received Lexapro 20 mg and Ativan 0.25 mg TID. The evaluation also indicated there were no behaviors, but a GDR was not recommended.</p> <p>An Interdisciplinary Progress Notes for Resident #102, dated 1/30/14, indicated he "...refuses to stay in w/c (wheelchair) very long...resident is not motivated he wants to lay in bed all the time...."</p> <p>An Interdisciplinary Progress Notes for Resident #102, dated 1/31/14, indicated he "...continues to be incont (incontinent) of bowel but refuse (sic) to alert nurse + caregiver he has to have a bowel movement, this is a behavior that needs to be address (sic) since it's additional work...."</p> <p>A Psychotherapeutic Medication Use Evaluation for Resident #102, dated 1/31/14, indicated he received Lexapro 20 mg for anxiety and Ativan 0.25 mg</p>			

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	<p>TID for anxiety. The evaluation also indicated Resident #102 did not have any change in behavior symptoms. The evaluation further recommended a GDR was not recommended.</p> <p>A Behavior Monthly Flowsheet for Resident #102, dated for the month of January, 2014 indicated he was receiving the medications of Ativan for agitation/anxiety state and Lexapro for anxiety state. The flowsheet also indicated the facility was tracking the behaviors of agitation, and anger. One episode of anxiety was documented on 1/18/14.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of February, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>An Interdisciplinary Progress Notes for Resident #102, dated 3/17/14, indicated he yelled at a Certified Nursing Assistant.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of March, 2014, did not indicate what behaviors the facility was</p>				

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	<p>monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>An Interdisciplinary Progress Notes for Resident #102, dated 4/24/14, indicated he was "very stubborn."</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of April, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #102, dated 5/12/14, indicated he was receiving Lexapro 10 mg daily and Ativan 0.25 mg TID. The note also indicated staff reported he was still having some episodes of severe anxiety. No changes in medication were made.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of May, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were</p>			

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	<p>documented on the flow record.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #102, dated 6/9/14, indicated he was receiving Lexapro 10 mg daily and Ativan 0.25 mg TID. The note also indicated staff reported he was still having some episodes of severe anxiety. No changes in medication were made.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of June, 2014, indicated the facility was monitoring the behaviors of anxiety and being withdrawn. Instructions for completion of the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>An Interdisciplinary Progress Notes for Resident #102, dated 7/2/14, indicated he refused AM care and breakfast times 3 attempts.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #102, dated 7/14/14, indicated he received Lexapro 10 mg daily and Ativan 0.25 mg TID. The note also indicated the staff reported he was still having some episodes of severe anxiety. The note further indicated a GDR of Ativan and</p>			

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	<p>Lexapro was contraindicated due to resident having episodes of anxiety. The note indicated any decrease would negatively impact his Psychiatric/Mental Health status.</p> <p>A Psychotherapeutic Medication Use Evaluation for Resident #102, dated 7/14/14, indicated he received Lexapro 20 mg daily and Ativan 0.25 mg TID. A GDR was not recommended due to the resident was stable and no behaviors were noted.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of July, 2014, indicated the facility was monitoring the behaviors of anxiety and being withdrawn. Instructions for completion of the record indicated to document daily by exception only. The record indicated he refused care on 7/2/14.</p> <p>An Interdisciplinary Progress Note for Resident #102, dated 8/29/14, indicated he was non-compliant with alarms.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #102, dated for the month of August, 2014, indicated the facility was monitoring the behaviors of anxiety and being withdrawn. Instructions for competing the record</p>			

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	<p>indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>The Director of Nursing (DON) was interviewed on 9/26/14 at 9:30 a.m. During the interview she indicated Resident #102's Lexapro was increased from 10 mg daily to 20 mg daily, with a clinically contraindicated (CCI) GDR on 1/13/14 and 7/14/14. She also indicated Resident #102's Ativan was increased from 0.25 mg daily to 0.25 mg TID, with a CCI GDR on 1/13/14 and 7/13/14. When queried, she indicated CCI indicated the gradual dose reduction was contraindicated since he was doing well.</p> <p>A facility care plan for Resident #102, revised on 8/5/14, indicated the focus area of resident has a diagnosis of depression and antidepressant medication use. Interventions to the focus included, but were not limited to, allow the resident time to verbalize anger and frustration, observe for changes on mood and behavior, observe for signs/symptoms of depression or anxiety, administer medications per MD orders, and gradual dose reduction as ordered.</p> <p>A facility care plan for Resident #102, revised on 8/21/14, indicated the focus area of resident exhibits behavior:</p>						

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	<p>physical and verbal aggression towards staff, resists care or treatment and meals at times. Interventions to the focus included, but not limited to, approach resident in a calm friendly manor (sic) , assess and manage unmet needs, identify behavior triggers and reduce exposure to triggers, offer resident choices as able, and remove resident from environment.</p> <p>A facility care plan for Resident #102, revised on 8/21/14, indicated the focus area of resident at risk for complications related to the use of psychotropic medication: antianxiety. Interventions to the focus included, but were not limited to, encourage resident to discuss feelings as needed, observe/monitor for continued need of medication as related to behavior and mood, administer medication per MD order, and gradual dose reduction as ordered.</p> <p>4. Review of the clinical record for Resident #60 on 9/24/14 at 8:33 a.m., indicated the following: diagnoses included, but were not limited to, senile dementia, unspecified psychosis, depressive disorder, unspecified episodic mood disorder, and diabetes mellitus.</p> <p>A physician's order for Resident #60, dated 10/14/13, indicated to decrease Risperdal (antipsychotic) from 0.5 mg</p>			

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	<p>BID (twice a day) to 0.25 mg AM and 0.5 mg HS (hour of sleep). The order also indicated Cymbalta (antidepressant) 30 mg BID.</p> <p>A Social Services Progress Notes for Resident #60, dated 10/10/13, did not indicated any problems with behaviors.</p> <p>A Social Services Progress Notes for Resident #60, dated 10/14/13, indicated a Behavior Management meeting was held. The note also indicated the times for the Risperdal were being changed to help with sleeping patterns. The note further indicated no further concerns were noted.</p> <p>A physician's order for Resident #60, dated 10/14/13, indicated to discontinue Risperdal 0.5 mg BID and to start Risperdal 0.25 mg q AM and Risperdal 0.5 mg q HS as an attempted GDR due to somnolence. The order also indicated a contraindicated GDR of Cymbalta due to attempt of GDR of Risperdal.</p> <p>A Behavior Monthly Flowsheet for Resident #60, dated for the month of October, 2013, indicated he was receiving Risperdal for mood disorder and psychosis and Cymbalta for depression. The flowsheet indicated the facility was monitoring the behaviors of mood changes, anger, and anxiety. No</p>			

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	<p>behaviors were documented on the flowsheet.</p> <p>A Behavior Monthly Flowsheet for Resident #60, dated for the month of November, 2013, indicated he was receiving Risperdal for mood disorder and psychosis and Cymbalta for depression. The flowsheet indicated the facility was monitoring the behaviors of mood changes, anger, and depression. No behaviors were documented on the flowsheet.</p> <p>An Interdisciplinary Progress Notes for Resident #60, dated 12/14/13, indicated 2 episodes of cursing at staff and yelling at another resident.</p> <p>A Behavior Monthly Flowsheet for Resident #60, dated for the month of December, 2013, indicated he was receiving Risperdal for mood disorder and psychosis and Cymbalta for depression. The flowsheet indicated the facility was monitoring the behaviors of mood changes, anger, and depression. No behaviors were documented on the flowsheet.</p> <p>A Psychotherapeutic Medication Use Evaluation for Resident #60, dated 1/9/14, indicated he received Cymbalta 60 mg daily and Risperidone 0.25 mg</p>			

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	<p>AM and 0.5 mg HS. The evaluation also indicated his behavior symptoms were not present prior to the review.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #60, dated 1/13/14, indicated he received Cymbalta 30 mg BID and Risperdal 0.25 mg q AM and Risperdal 0.5 mg q HS. The note also indicated the resident reported he was less aggressive and less delusional, but the staff reported he was still anxious, irritable, easily provoked and fretful. The note further indicated to increase Cymbalta to 60 mg BID for depression and mood irritability. A GDR of Risperdal was contraindicated since the Risperdal was decreased in October, 2013 and the resident still had episodes of mood irritability.</p> <p>A physician's order for Resident #60, dated 1/13/14, indicated to increase Cymbalta from 30 mg BID to 60 mg BID.</p> <p>An Interdisciplinary Progress Notes for Resident #60, dated 1/13/14, indicated he received Cymbalta 30 mg BID and Risperdal 0.25 mg q AM and 0.5 mg q HS. The note also indicated the resident had an increase in behaviors, yelling at staff and others. The note further indicated Cymbalta would be increased to 60 mg BID.</p>			

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	<p>A Behavior Monthly Flowsheet for Resident #60, dated for the month of January, 2014, indicated the facility was monitoring the behaviors of mood changes and depressed and withdrawn. No behaviors were documented on the flowsheet.</p> <p>An Interdisciplinary Progress Notes for Resident #60, dated 2/2/14, indicated he was yelling and cursing at staff.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of February, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of March, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of April, 2014, did not indicate</p>			

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	<p>what behaviors the facility was monitoring. Instruction for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavioral Medicine Evaluation &amp; Management Note for Resident #60, dated 5/12/14, indicated the resident was receiving Cymbalta 60 mg BID and Risperdal 0.25 mg q AM and Risperdal 0.5 mg q HS. The note also indicated the resident reported he was less aggressive and less delusional. The staff reported he was less anxious, less irritable and less easily provoked and fretful. No changes in medication were made.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of May, 2014, did not indicate what behaviors the facility was monitoring. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of June, 2014, indicated the facility was monitoring the behaviors of mood changes and withdrawal. Instructions for completing the record indicated to document daily by exception</p>			

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	<p>only. No behaviors were documented on the flow record.</p> <p>A Psychotherapeutic Medication Use Evaluation for Resident #60, dated 7/14/14, indicated he received Cymbalta 60 mg BID and Risperdal 0.25 mg q AM and 0.5 mg HS. The evaluation also indicated the resident was stable, but still had some episode of delusional thinking and depression.</p> <p>An Interdisciplinary Progress Note for Resident #60, dated 7/14/14, indicated he was reviewed during the Behavior Management meeting. The note also indicated a CCI GDR of Risperdal and Cymbalta at this time due to resident continuing to have episodes of delusional thinking. The note further indicated the resident may be effected negatively by medication decrease.</p> <p>A Behavior Monitoring and Interventions Flow Record for Resident #60, dated for the month of July, 2014, indicated the facility was monitoring the behaviors of anxiety, being withdrawn, and verbally aggressive. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>A Behavior Monitoring and Interventions</p>						

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	<p>Flow Record for Resident #60, dated for the month of August, 2014, indicated the facility was monitoring the behaviors of being withdrawn and cursing at others. Instructions for completing the record indicated to document daily by exception only. No behaviors were documented on the flow record.</p> <p>The Director of Nursing (DON) was interviewed on 9/26/14 at 9:30 a.m. During the interview she indicated Resident #60's Risperdal was decreased from 0.5 mg q AM and 0.5 mg q HS, with a CCI GDR on 3/10/14, a deferred GDR on 6/9/14, and a CCI GDR on 7/14/14. She also indicated Resident #60's Cymbalta was increased from 30 mg BID to 60 mg BID, with a CCI GDR on 7/14/14. When queried, she indicated CCI indicated the gradual dose reduction was contraindicated since he was doing well.</p> <p>The DON was interviewed on 9/26/14 at 10:15 a.m. During the interview she indicated Social Service was to identify what behaviors the facility was monitoring on the monthly behavior flow records. She also indicated the blank records were during the time the facility did not have a Director of Social Services. She further indicated the behavior meetings were a round table</p>			

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	<p>discussed among the staff and Pharmacist. A white board was at each nursing station where staff wrote about resident behaviors. The DON indicated it was as the responsibility of the unit manager to confirm the behavior and to make certain it was recorded on the behavior flow record. The behavior flow record was to chart by exception only.</p> <p>The DON was interviewed on 9/29/14 at 11:49 a.m. During the interview she indicated the facility had no additional documentation to validate the continued need for the psychotropic medications.</p> <p>A facility care plan for Resident #60, created on 6/19/14, indicated the focus area of resident exhibits behavior: resists care or treatment. Interventions to the problem included, but were not limited to, approach resident in a calm friendly manor (sic), assess and manage unmet needs, if first refused care re-approach resident at a later time, and offer resident choices as able.</p> <p>A facility care plan for Resident #60, created on 7/11/14, indicated the focus area of resident exhibits distressed mood symptoms as evidenced by: sadness/depression. Interventions to the focus included, but were not limited to, allow the resident time to verbalize anger</p>			

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	<p>and frustration, allow time for expression of feelings with empathy and reassurance, and allow time for verbalization of feelings/needs and attempt to resolve area of being upset.</p> <p>A facility care plan for Resident #60, revised on 8/20/14, indicated the focus area of resident exhibits behavior;verbal aggression related to cognitive impairment. Interventions to the focus included: allow resident time to vent feelings/needs, approach resident in a calm friendly manor (sic), assess and manage unmet needs, and document interventions and resident's response.</p> <p>A facility care plan for Resident #60, revised on 8/20/14, indicated the focus area of resident exhibits behavior: agitation related to minor changes in routine-frustration. Interventions to the focus included, but were not limited to, allow resident time to vent feelings/needs, approach resident in a calm friendly manor (sic), assess and manage unmet needs, document interventions and resident's response, and encourage and teach resident calming techniques.</p> <p>A facility care plan for Resident #60, revised on 8/20/14, indicated the focus area of resident exhibits psychosocial</p>				

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	<p>distress about own well-being and or social relationships as evidenced by: grief over loss status/roles. Interventions to the focus included, but were not limited to, allow resident the opportunity to share/vent feelings, allow resident to make decisions independently and provide verbal praise, and approach resident in a calm, friendly manner.</p> <p>A current facility policy "Behaviors: Management of Challenging", revised on 5/15/14 and provided by the DON on 9/26/14 at 10:50 a.m., indicated "...5. Initiate the use of the Psychotherapeutic Medication Use Evaluation...5.1 Complete the form monthly for each patient prescribed and antipsychotic...5.2 The interdisciplinary team will use the form to evaluate and monitor for effectiveness and potential for gradual dose reduction (GDR)...."</p> <p>A current facility policy "Psychotherapeutic Medication Use", revised on 5/15/14 and provided by the DON on 9/29/14 at 1:17 p.m., indicated "...Tapering should be attempted during at least two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated...."</p>				

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F000364 SS=E	<p>A current facility policy "Psychopharmacological Medication Use", revised on 1/1/13 and provided by the DON on 9/29/14 at 1:17 p.m., indicated "...1. Facility should comply with the Psychopharmacological Dosage Guidelines created by the Centers for Medicare and Medicaid Services ("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacological medications including gradual dose reductions...."</p> <p>This deficiency was cited on the annual Recertification on 11/15/13, the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-48(b)(1) 3.1-48(a)(2) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure palatable food for 6 of 20 residents confidentially interviewed for food taste.</p>	F000364	<b>F 364 483.35 (1), (2) Nutritive Value/Appear, Palatable/PreferTemp What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b>	10/20/2014

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	<p>Findings include:</p> <p>During the Stage 1 resident interviews, the following confidential comments were indicated in response to the question "does the food taste good and look appetizing":</p> <p>-On 9-23-2014 at 2:17 p.m., the resident indicated "sometimes it does and sometimes it doesn't; has scrambled egg everyday and doesn't mix it up; don't serve what's on the menu and has the same thing every week."</p> <p>-On 9-22-2014 at 3:03 p.m., the resident indicated "doesn't like the fish or chicken."</p> <p>-On 9-23-2014 at 1:30 p.m., the resident indicated "a lot of foods are tough, so they chopped them up but the resident indicated it doesn't help the taste."</p> <p>-On 9-22-2014 at 2:37 p.m., the resident indicated "food isn't the greatest; previous food service manager added more pizzazz to the food."</p> <p>-On 9-22-2014 at 2:15 p.m., the resident indicated "mostly get raw vegetables, the potatoes are hard, meat is tough and at noon today the beef was tough...cannot cut meat..."</p> <p>On 9-23-2014 at 11:13 a.m., the resident indicated "they could do better...need more meats for choices and limited choices."</p>		<p><b>practice?</b> Dietary staff was re-educated on Menus, Recipes, and Spices and encouraged to season to taste on 10/08/2014 by Interim Dietary Manager.. The Dietary Manager/Designee will be required to sample foods before serving at each meal to ensure satisfaction with the meal being served. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents residing at Genesis Healthcare New Haven Center have the potential to be affected by the deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> The Dietary Manager /Designee will visit one(1)to two (2) alert and oriented residents (5 times a week) at two (2) separate meals x's two (2) weeks. Then 2 residents twice weekly x's two (2) weeks (2 days a week) and weekly/PRN after for 5 months to address resident's response to appearance, taste and texture of their meal. Dietary manager will document and record resident feedback, immediately addressing any concerns verbalized. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur;</b> The Dietary Manager/Designee will be</p>				

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	<p>A confidential resident interview on 9-24-2014 at 9:05 a.m., indicated the resident was eating breakfast in her room. The resident indicated she did not like fried eggs and the eggs were cold.</p> <p>A test tray provided by the CDM (Certified Dietary Manager) on 9-25-2014 at 11:43 a.m., indicated the test tray was tasted by 3 of 4 surveyors and included the following:</p> <ul style="list-style-type: none"> <li>-The meat served was pork. It was plain, white, without breading, tough to cut and dry to taste.</li> <li>-The broccoli stems and florets were soft, pale green in appearance and bland in taste.</li> <li>-The mashed sweet potatoes were light orange in color, smooth and bland for 1 surveyor.</li> <li>-The pink color drink identified as pink lemonade had no taste (was tasted by 4 surveyors).</li> <li>-The carmel color cake had a plain, unidentified taste.</li> </ul> <p>An interview with the CDM on 9-25-2014 at 12:05 p.m., indicated the cake was peanut butter. The CDM indicated she did not taste the cake, was not aware the pink lemonade had no taste, the pork was tough or the broccoli was bland. The CDM indicated they did follow the recipes except for the cake as</p>		<p>required to sample foods before serving at each meal to ensure satisfaction with the meal being served. Interim Dietary Manager/Designee will be in the kitchen to monitor meal service two(2) meals a day, five (5x's) a week x's (4) weeks, Twice weekly (2x) times a week x's(4) four weeks and Weekly thereafter and PRN times four (4) months to ensure meals are palatable and presentable. Audit findings will then be reported to the IDT team through the PI process Meeting weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies.. . Administrator/Dietary Manager to monitor for compliance monthly, with results forwarded to the PI Committee for additional interventions as a need is identified. <b>By what date the systemic changes will be completed. 10/20/2014</b></p>				

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	<p>the menu was changed from peanut butter bar to peanut butter cake.</p> <p>An interview with the CDM on 9-25-2014 at 1:00 p.m., indicated the Menu Calendar Report had the following menu for lunch for 9-25-2014: "Breaded Pork Chop Mashed Sweet Potatoes Broccoli Florets or Rotisserie Spice Chicken Poultry Gravy Mashed Sweet Potatoes Roasted Brussels Sprouts Tomato Garnish Dinner Roll Margarine Peanut Butter Bar Milk Coffee Sugar Packet Pepper Packet"</p> <p>Confidential interviews with residents who were served the lunch on 9-25-2014 indicated the following: On 9-25-2014 at 1:05 p.m., the resident indicated a thumbs down for the lunch meal and stated the "pork roast was dry." On 9-25-2014 at 1:08 p.m., the resident indicated the "pork chop was tasteless...couldn't cut the meat...vegetable was raw...had Brussels</p>			

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	<p>sprouts...unsure of the kind of cake that was served and the green beans yesterday were raw."</p> <p>On 9-25-2014 at 1:17 p.m., the resident indicated a request for the pink lemonade was made because it looked good. The resident indicated the pink lemonade was "not good and tasteless" and the resident "did not like the taste of the meat."</p> <p>On 9-25-2014 at 1:15 p.m., the CDM provided recipes for the lunch meal. The ingredients included the following:</p> <ul style="list-style-type: none"> <li>-The breaded pork chop recipe had a note that indicated "sliced pork loin after it was cooked." The ingredients used for 50 servings were, 12-1/2 lb (pound) BRT, C Cut Pork Loin, 2 sprays of food release, 15 cups corn flakes cereal, 2-1/4 cup all purpose flour, 4 tsp (teaspoon) iodized salt, 1 tbsp (tablespoon) black pepper, 1-1/2 cup liquid pasteurized eggs and 1-1/2 cup of 2% lowfat milk</li> <li>- The broccoli florets recipe indicated 10 lb of broccoli florets, fzn (frozen), 4 oz (ounces) solid margarine, 1 tsp iodized salt and 2 tsp of black pepper were used for fifty 1/2 cup servings.</li> <li>-The mashed sweet potatoes recipe indicated 2 - 1/2 #10 cans of LS yams, 8 oz of solid margarine, 1-1/2 qt (quart) lowfat 2% milk and 1/4 tsp ground nutmeg were used for fifty 1/2 cup servings.</li> </ul>						

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	<p>-There was not a recipe provided for the pink lemonade.</p> <p>-The peanut butter cake recipe indicated 2-1/2 cup cold water #1, 5 lb yellow cake mix, 4 cups creamy peanut butter, 4 cups cold water #2 and 1 spray food release for 64 servings. The topping included 4-3/8 tbsp all purpose flour, 2-5/8 cup granulated sugar, 1-1/4 cup creamy peanut butter. After the topping was sprinkled over the batter, 3 cups of semi-sweet chocolate chips were spread evenly on the topping.</p> <p>An interview with the CDM on 9-26-2014 at 9:05 a.m., indicated she made rounds daily with residents on each unit and after each meal to make sure the residents were satisfied with the taste. The CDM indicated she tracked the results on a scrap piece of paper and did not keep the paper. The CDM indicated only if there was a big concern with a resident's meal, the concern would have been documented in the resident's record.</p> <p>A policy on Food Preferences revised on 5-5-2013 and provided by the CDM on 9-26-2014 at 9:34 a.m., indicated the purpose was "...to enhance patient/resident meal satisfaction...."</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p>						

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to ensure staff washed their hands for the recommended amount of time and at the appropriate time. The facility also failed to ensure staff who entered the facility kitchen wore hair restraints. This deficient practice had the potential to affect 79 of 84 residents who ate meals prepared by the facility.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the main dining room on 9/22/14, the following was observed:</p> <p>- At 11:45 a.m., RN #1 was observed to lather her hands for 7 seconds prior to rinsing. She then was observed to serve meal trays to residents.</p> <p>- At 11:50 a.m., RN #1 was observed to lather her hands for 10 seconds prior to</p>	F000371	<p><b>F 371 483.35 (i) Food Procure, Store/Prepare/Serve-Sanitary</b></p> <p><b>1.Hand washing</b></p> <p><b>2.Hair Nets</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>1.Staff were re-educated 09/22/2014 through 10/12/2014 and dietary staff on 10/07/2014 by the NPE and Interim Dietary Manager on proper hand washing technique of wetting hands, scrubbing for 20 seconds. Competencies conducted on those individuals listed as not properly washing their hands.</p> <p>2.Center staff was re-educated on 09/26/2014 – 10/12/2014 by the DON/NPE that no one is allowed in the kitchen or dish room area without donning a hair net at any time. Disciplinary action was taken with those individuals who did not meet this expectation.</p> <p><b>How will you identify other residents having the potential to be affected by the same</b></p>	10/23/2014
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	<p>rinsing. She then was observed to serve meal trays to residents.</p> <p>- At 11:56 a.m., RN #1 was observed to lather her hands for 9 seconds prior to rinsing. She then was observed to serve meal trays to residents.</p> <p>2. During an observation of the lunch meal in the main dining room on 9/24/14, the following was observed:</p> <p>- At 11:22 a.m., Speech Language Pathologist #2 was observed to enter the dining room and place soap on her hands. She immediately placed her hands under running water and lathered her hands.</p> <p>- At 11:30 a.m., Speech Language Pathologist #2 was observed to lather her hands for 12 seconds prior to rinsing. She then was observed to serve meal trays to residents.</p> <p>- At 11:32 a.m., Speech Language Pathologist #2 was observed to touch her hair and clothing and then continue to assist resident with their beverages without washing her hands.</p> <p>- At 11:38 a.m., Physical Therapy Assistant #3 was observed to prepare a mug of hot chocolate for a resident she had just escorted into the dining room by</p>		<p><b>deficient practice and what corrective action will be taken?</b> Resident's residing at Genesis Healthcare New Haven Center has the potential to be affected by the deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A. B. Hair nets will be made available inside of the dietary entrances to accommodate staff. Signage placed outside of entrance doors to remind staff before entering the kitchen or dish areas. How the corrective actions will be monitored to ensure the deficient practice will not recur;</b> A. Managers assigned to the main dining room, and Unit managers/Designees for those residents who consume meals on the units will observe staff hand washing for (3) employees per shift for the proper Audits will be conducted daily (five days a week) x (2) weeks, bi-weekly x (2) weeks, then weekly thereafter x 4 months to ensure deficient practice has been resolved.. B. Signage will be placed at kitchen entrances reminding staff not to enter without the proper hairnet in place. Dietary Manager/Designee will report any violations to the Administrator for further action. Audits will be conducted daily (five days a week) x (4) weeks,</p>	

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	<p>touching the clothing of the resident. She was observed to open a package of hot chocolate mix and run her index finger around the inside of the package prior to pouring the contents into the mug. She was not observed to wash her hands.</p> <p>- At 11:40 a.m., LPN #4 was observed to lather her hands for 16 seconds prior to rinsing. She then was observed to serve meal trays to residents.</p> <p>- At 11:43 a.m., LPN #4 was observed to lather her hands for 18 seconds prior to rinsing. She then was observed to serve meal trays to residents.</p> <p>3. During an observation of the lunch meal in the assisted dining room on 9/24/14, the following was observed:</p> <p>- At 12:07 a.m., Certified Nursing Assistant #5 was observed to move a stool on wheels over to a table between 2 residents by using her index finger on her right hand. She immediately placed a clean clothing protector on a resident.</p> <p>- At 12:10 p.m., LPN #6, was observed to wash her hands for the recommended amount of time. She then was observed to move a chair closer to a dining table with her clean hands and started to feed a resident.</p>		<p>twice-weekly x (4) weeks, then weekly thereafter x (4) months to validate that we are meeting handwashing criteria. Audit findings will then be reported to the IDT team through the PI process meeting weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies.</p> <p>Administrator/Director of Nursing and the Nurse Practice Educator to monitor for compliance through the PI process, with results forwarded to the PI Committee for additional interventions as a need is identified Administrator/Dietary Manager / Designee to monitor for compliance monthly, with results forwarded to the PI Committee for additional interventions if a need is identified. <b>By what date the systemic changes will be completed. 10/23/2014</b></p>				

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	<p>4. During an observation of the lunch meal in the facility kitchen on 9/25/14, the following was observed:</p> <ul style="list-style-type: none"> <li>- At 10:36 a.m., RN #7 was observed to enter the facility kitchen without a hair restraint.</li> <li>- At 10:38 a.m., Human Resources #8 was observed to enter the facility kitchen without hair restraint.</li> </ul> <p>The staff were observed to walk past open carts of clean mugs and glasses, an open clear plastic bin of clean fruit bowls, and clean steam table pans and servings utensils on a sideboard.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 9/26/14 at 8:56 a.m. During the interview she indicated any staff who entered the facility kitchen were to wear a hair restraint. She also indicated staff were to lather their hands for 20 seconds before rinsing and were to wash their hands after touching anything soiled.</p> <p>A current facility policy, "Hand Washing", revised on 12/14/09 and provided by the CDM on 9/25/14 at 1:16 p.m., indicated "...Hand washing is performed after:...1.2 Touching hair, ears,</p>			
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	<p>nose, or mouth;...1.6 Before touching any clean utensils, plates, cups, or pans;...."</p> <p>A current facility policy, "Hand Hygiene", revised on 10/1/13 and provided by the CDM on 9/26/14 at 9:30 a.m., indicated "...Adherence to hand hygiene practices is maintained by all Center personnel...To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms...1.6 Before and after handling food;...2.7 After contact with inanimate objects in the immediate vicinity of the patient;...2.8 Before and after assisting patient with meals;...3.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously for at least 15 to 20 seconds covering all surfaces of the hands and fingers...."</p> <p>A current facility policy, "Personal Hygiene", revised on 10/1/14 and provided by the CDM on 9/25/14 at 12:00 p.m., indicated "...Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food...."</p> <p>This deficiency was cited on the annual recertification on 11/15/13, the facility failed to implement a plan of correction to correct the deficiency.</p>			

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F000431 SS=E	<p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the</p>	F000431	<b>F 431 483.60(b), (d), (e) Drug Records, Label/Store Drugs &amp;</b>	10/23/2014

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	<p>facility failed to ensure expired medications were not in use and/or over the counter (OTC) medications were properly labeled and/or medications carts were maintained in a clean manner for 2 of 6 medication carts observed and 1 of 2 treatment carts observed.</p> <p>Findings include:</p> <p>On 9/29/14 at 1:46 p.m. the North Hall cart was reviewed with RN #22. The second drawer from the top, was observed to have a bottle of over the counter multi vitamins (MVI). This bottle of MVI was observed to have the resident's name written on the bottle but lacked documentation of the ordering physician. Also observed was a bottle of over the counter Cranberry Extract 300 mg. This bottle also had the resident's name on it but lacked documentation of the ordering physician. RN #22 indicated the resident whose name was on the over the counter medications, was currently receiving them. Observed in the larger drawers of the cart, in which the bubble packets of pills were kept, was observed to be an accumulation of crushed pill residue and/or medication type beads along with dust, debris and dried spills in the base of the drawers. Also observed on the outside of the cart, in the open compartment on the side of the cart,</p>		<p><b>Biologicals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A.</b> Staff was re-educated on the proper storage of OTC medications on 09/26/2014 through 10/12/2014 by the Nurse Practice Educator. All OTC medications were labeled with Resident and Physician names. <b>B.</b> Medication Carts were put on a weekly cleaning schedule. Nursing staff will ensure carts are cleaned and the end of their shift, prior to next shift taking over. <b>C.</b> No other residents were found to be affected by the deficient practice as medication and treatment carts were checked for expired medications. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents who reside at Genesis Healthcare New Haven Center have the potential to be affected by the deficient practice. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur;</b> A. Nursing Staff will ensure any OTC medications have the Resident's name, and Physician name on them. Audits will be conducted daily by the Unit Managers/Designee (five days a week) x (4) weeks, the twice weekly x (4) weeks, then weekly thereafter x 4 months to ensure</p>				

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	<p>where the water glasses, med cups and spoons were kept the following was observed: dust, debris and dried spills. The cups were stored in the compartment with the lip of the cup resting on the soiled base of the compartment.</p> <p>On 9/29/14 at 1:55 p.m. the treatment cart on the North Hall was reviewed with RN #22. Observed in this treatment cart was a tube of "Lidocaine Cream 4%." The expiration date on the tube was observed to be 5/2014. At the time, LPN #21 was interviewed. She indicated the resident receives the cream every 2 weeks prior to getting an injection. LPN #21 indicated the resident most recently had the last dose of Lidocaine cream applied today. At the time, the resident's MAR (medication administration record) was reviewed and indicated the resident received Lidocaine cream 4%, apply topically one time a day every 14 days, with a start date of 6/9/14.</p> <p>On 9/29/14 at 2:05 p.m. the NPE (Nurse Practice Educator) reviewed the South Hall medication cart. The NPE indicated she had just cleaned the carts about 1- 1/2 weeks ago. She indicated the facility tries to clean the carts at least monthly. She indicated they don't have the medication/treatment carts on a routine cleaning schedule. At this time, on the</p>		<p>deficient practice has been resolved. B. Nursing Staff were given a cleaning schedule that will ensure weekly cleaning of each indivulized medication carts and treatment carts. Audits will be conducted daily by the Nurse Practice Educator/Designee (five days a week) x (4) weeks, twice weekly x (4) weeks, then weekly thereafter x (4) months to ensure deficient practice has been resolved. C. Audits for the Medication and Treatment carts will be conducted (3)three times weekly times (4) weeks, twice weekly times (4) weeks and weekly thereafter times (4) months to ensure there are no expired medications will be given. Administrator/Director of Nursing/ Designee to monitor for compliance through the PI process weekly times (4) weeks, bi-weekly times (2) weeks and monthly thereafter to ensure compliance of alleged deficiencies with results forwarded to the PI Committee for additional interventions if a need is identified. <b>By what date the systemic changes will be completed. Date of Compliance: 10/23/2014</b></p>				

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	<p>outside compartment of the carts where the drinking cups, medication cups and spoons were housed, there was observed dried spills, dust and debris in the base of the compartment. The lip of the overturned cups was observed to be base with the dried spills, dust and debris. The NPE indicated when she cleaned the medication carts, she pulled everything out of them, wiped all the cart surfaces down inside and outside but not the outside bin.</p> <p>On 9/29/14 at 2:52 p.m. the NPE provided current copies of the policy and procedure for "Storage and Expiration Dating of Drugs..." This policy and procedure was dated 5/16/11 and included but was not limited to, the following: "Drugs...are stored under proper conditions with regard to sanitation...and expiration dates as directed by the state and federal regulations...drugs and biologicals that have an expiration date on the label...are stored separately, away from use, until destroyed or returned to the provider..."</p> <p>On 9/29/14 at 3:20 p.m. the North Hall Unit Manager was interviewed. She indicated she had just cleaned the medication carts last week. She indicated (name of pharmacy) had just been here last Tuesday. She indicated they audit</p>			

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F000441 SS=D	<p>the treatment and medication carts monthly. She indicated the facility cleans the carts once a week but this is not documented anywhere.</p> <p>On 9/29/14 at 4:05 p.m. the NPE was interviewed. She indicated the over the counter medications should be labeled with the physician's name. She also indicated the cleaning of the medication carts was not on a schedule. She indicated the nurses "maintain their carts." She indicated that (name of the pharmacy) also come to the facility and they check for and remove expired medications from the medication cart and/or treatment carts.</p> <p>3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>			

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate handwashing by 3 of 3 nursing staff (Nurse #12, CNA #13 and CNA #14) for the appropriate amount of time and/or after removing disposable gloves during wound care for 1 of 1 observation of wound care. (Resident # 44)</p> <p>Findings include:</p> <p>During an observation of wound care on</p>	F000441	<p><b>F441 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Center Staff were re-educated 09/22/2014 through 10/12/2014 by the NPE/DON on proper hand washing technique. DON/Designee will observe Nurse #12 while providing wound care and the technique for the compliance with the P&amp;P of hand washing and glove changes during wound care. Center staff were re-educated on P&amp;P of</p>	10/23/2014

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	9/26/14 at 8:40 a.m., Nurse #12 prepared supplies for wound care of Resident #44's Stage IV Pressure Ulcer on the coccyx. CNA (Certified Nursing Aide) #13 stood at the head of the bed with disposable gloves on her hands. CNA #14 was observed to expelled flatus from the colostomy bag with gloved hands and tissues and then replaced the clip onto the colostomy bag. CNA #14 removed the disposable gloves and proceeded to wash and rinse her hands for 10 seconds before drying her hands with paper toweling and donning new disposable gloves. CNA #13 and CNA #14 assisted Nurse #12 to position Resident #44 onto to their right side. Both CNAs were wearing disposable gloves and held the Resident while Nurse #12 removed the Resident's brief and old dressing from the coccyx wound. Nurse #12 placed the trash in plastic bags and then removed the disposable gloves and washed her hands with soap and water, lathering her hands for 15 seconds before rinsing her hands with water, dried her hands with paper toweling and turned the water off with the toweling. Nurse #12 donned new disposable gloves and washed the Resident's buttocks and rectal area (perineal area) with a clean washcloth, bath gel and water. The Nurse then placed the dirty washcloth in a separate plastic bag for laundry. Nurse #12		glove use within the facility. Unit Managers/Designee will observe staff for proper handwashing and glove usage while in the facility. Competencies were conducted on those individuals listed as not properly washing their hands/changing gloves. Competency was conducted on Nurse #12 for hand washing, donning and doffing of gloves while providing wound care on 09/26/2014 by NPE. Aides #13 and aide #14 had competencies performed for proper hand washing technique and donning and doffing of gloves at the appropriate times. <b>How the corrective actions will be monitored to ensure the deficient practice will not recur;</b> Audits will be conducted daily on one resident who is receiving wound care to ensure proper hand washing, and changing of gloves is done properly to ensure infection control practices are in place. Audits will be conducted daily (five days a week) x (4) weeks, twice-weekly x (4) weeks, then weekly thereafter x 4 months to ensure deficient practice has been resolved. Administrator/Director of Nursing/ Designee to monitor for compliance throught the PI process weekly times (4) weeks, bi-weekly times two(2) and monthly thereafter to ensure compliance of alleged deficiencies with results		

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	removed the disposable gloves and placed them in the plastic trash bag and took 20 seconds to wash, rinse and dry her hands before donning new disposable gloves. The Nurse used a clean washcloth to rinse the resident's buttocks and rectal area with water and patted the area dry with a clean bath towel. Nurse #12 put the soiled linens into the plastic bag and removed the disposable gloves and put them in the plastic trash bag. She proceeded to wash her hands, lathering for 12 seconds before rinsing with water; she dried her hands with paper toweling and turned off the water with the toweling and donned new disposable gloves. Nurse #12 performed wound care to a Stage IV Pressure Ulcer coccyx wound after irrigating the wound with NS (Normal Saline). The Nurse removed the disposable gloves and put the dirty gloves into the plastic trash bag and then donned new disposable gloves and did not wash her hands; she proceeded with the wound care procedure. When the wound care procedure was completed, the Nurse and both CNA's repositioned the resident in bed. The nurse removed her disposable gloves and washed her hands, lathering for 15 seconds before rinsing and drying her hands. CNA #13 removed her disposable gloves and took 20 seconds to wash, rinse and dry her hands and CNA #14 removed the dirty linens and trash		forwarded to the PI Committee for additional interventions if a need is identified. <b>By what date the systemic changes will be completed. Date of Compliance: 10/20/2014</b>	

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	<p>bags from the room with gloved hands.</p> <p>During an interview with RN, NPE (Registered Nurse, Nurse Practice Educator) on 9/26/14 at 10:57 a.m., she indicated the staff should lather their hands for 20 seconds during handwashing. She indicated all staff were in-serviced on handwashing techniques at the Facility's Health Fair earlier in the month of September.</p> <p>During an interview with Nurse #6 on 9/26/14 at 11:15 a.m., she indicated handwashing should be done for the length of time it takes to sing "ABC's" or "Happy Birthday" or count 1001, 1002. She indicated the entire procedure should take 30 seconds. She indicated handwashing should be done before putting on and after taking off disposable gloves. She indicated disposable gloves were to be changed after touching anything considered dirty.</p> <p>During an interview with CNA #14 on 9/26/14 at 11:35 a.m., she indicated the hands should be lathered for 20 seconds during handwashing, she indicated she counts 1:1000, 2:1000, 3:1000 when washing her hands. She indicated gloves needed to be changed between resident contacts and after contact with a dirty surface. She also indicated handwashing</p>			

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	<p>needed to be done before putting on gloves and after the gloves were taken off.</p> <p>During an interview with Nurse #12 on 9/26/14 at 11:35 a.m., she indicated the hands should be lathered 10 to 15 seconds during handwashing and indicated the entire handwashing process should take 20 seconds.</p> <p>During an interview with Nurse #15 on 9/29/14 at 2:50 p.m., she indicated the hands should be lathered for 20 seconds during handwashing and indicated handwashing should be completed before putting on gloves and after removing the gloves. She indicated gloves should be changed whenever touching anything contaminated.</p> <p>A current facility policy "Hand Hygiene", with revision date of 10/01/13 and provided by the NPE on 9/26/14 at 10:27 a.m., indicated, "...1. Wash hands with soap and water in the following situations: 1.1 after removing gloves and other personal protective equipment (PPE); 1.2 Before and after direct patient care; Immediately after contact with blood, body fluids or other potentially infectious materials....2. Decontaminate hands using an alcohol based hand rub or wash hands with soap and water in the</p>			

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F000520 SS=E	<p>following clinical situations: 2.1 Before any direct contact with patient; 2.2 before putting on gloves;...After contact with patient's skin; 2.5 After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings (if visibly soiled, must wash hands);...2.9 After removing gloves....3. Follow proper technique for hand hygiene practices. To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands and rub hands vigorously for at least 15 to 20 seconds covering all surfaces of the hands and fingers...."</p> <p>3.1-18(I)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require</p>			

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	<p>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility QAA (Quality Assurance Committee) failed to implement an adequate action plan for the identified concerns which included the following: not treating residents with respect and dignity, not ensuring the safety of residents, not ensuring gradual dose reductions of antipsychotic medication, not providing quality palatable and flavorful food, not keeping the medication and treatment carts clean and free of expired treatment medication, and inadequate handwashing during meal service and wound care. These deficiencies had the potential to affect 84 of 84 Resident who reside at the facility.</p> <p>Findings include:</p> <p>An interview with the DON on 9/29/14 at 3:30 p.m., indicated the QAA committee was aware of many of the identified concerns and the concerns had been addressed in the monthly "All Staff Meetings", the concerns addressed at the meetings included: Resident's Rights,</p>	F000520	<p><b>F-520 – QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A.</b> The Center Performance Improvement Committee has developed the center action plans for identified quality deficiencies as listed in the 2567. B. The Center performance Improvement Committee will meet one time weekly for (4) weeks, bi-weekly for two (1) month, and Monthly thereafter to review the action plans and audits to ensure compliance of the centers policies and procedures with * Treating residents with Dignity and Respect, ensuring the safety of resident's, ensuring GDR of psychotropic medications are made, serving palatable and flavorful food, not keeping personal medication on top of medication/treatment carts and keeping them clean and free of expired medications and inadequate hand washing during meal service and wound care, hair net usage. The action plans and audit tools will be reviewed by the Administrator and DON to maintain compliance. <b>Date of Compliance: 10/20/2014</b></p>	10/20/2014

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NAME OF PROVIDER OR SUPPLIER  NEW HAVEN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DALY DR NEW HAVEN, IN 46774
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>which including respect, dignity and privacy of the residents, handwashing, fall prevention and safety of the residents. She indicated the QAA committee had developed actions plans for falls and infection control and indicated the facility had a reduction in falls and infections. She also indicated the behavior team reviews the residents who take psychotropic medication and indicated they have had a reduction in the use of these medications.</p> <p>The QAA committee consisted of the Administrator, the DON (Director of Nursing), the NPE (Nurse Practice Educator) and Infection Control, the Medical Director and the Pharmacist. The Committee also included the managers of each of the Facility's departments including, the 2 Unit Managers, Maintenance, Human Resources, Activities, Social Services, MDS Coordinator and the Dietary Manager. The committee met monthly and failed to implement adequate action plans to correct the identified concerns which included the following: not treating residents with respect and dignity, not ensuring the safety of residents, not ensuring gradual dose reductions of antipsychotic medication, not providing quality palatable and flavorful food, not keeping the</p>			

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	<p>medication and treatment carts clean and free of expired treatment medication, and inadequate handwashing during meal service and wound care.</p> <p>On 9/22/14 at 9:00 a.m., the DON provided the Facility's current policy "Center Quality Improvement Process" with revision date on 4/1/03, which indicated the following, "...will implement an ongoing Quality Improvement Process...Process monitoring: Data collection on key process of care and services that demonstrate what we do...Process evaluation: Data analysis to define how we do what we do...that produce good or poor outcomes...Process improvement: The action we take to enhance and improve what we do and how we do it....The Quality Improvement Plan is evaluated annually to determine it's effectiveness in improving quality cost effectiveness and customer satisfaction...to fulfill the Genesis HealthCare [sic] goal of providing a full life for it customers...."</p> <p>This deficiency was cited on the annual Recertification on 11/15/13, and the facility failed to implement a plan of action to correct the deficiency.</p> <p>3.1-52(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2014

FORM APPROVED

OMB NO. 0938-0391

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