

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2016
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NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00210526.</p> <p>Complaint IN00210526 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F323, F353 and F425.</p> <p>Survey dates: September 28 and 29, 2016.</p> <p>Facility number: 000079 Provider number: 155159 AIM number: 100256160</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 04 Medicaid: 55 Other: 05 Total: 64</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after October 24th, 2016.	

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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F 0282 SS=D Bldg. 00	<p>Quality Review completed by 14454 on October 5, 2016.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure the care plan related to fall prevention was followed for 1 of 3 residents reviewed for falls. (Resident D)</p>	F 0282	<p>F282 – Services by Qualified Persons/Per Care Plan</p> <p>It is the practice of this provider that all services provided or arranged by the facility are provided by qualified persons in accordance with each resident's</p>	10/24/2016

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	<p>Finding includes:</p> <p>The clinical record for Resident #D was reviewed on 09/29/16 at 4:50 A.M. Resident #D was admitted to the facility on 07/31/14, with diagnoses, including but not limited to dementia and depressive episodes.</p> <p>The MDS (Minimum Data Set) assessment, completed on 08/16/16, indicated Resident D required the extensive assistance of one staff for transfer, ambulation needs, dressing, and personal hygiene needs. Resident D required supervision and limited staff assistance for wheelchair locomotion. Resident D had experienced two or more falls since the previous MDS assessment.</p> <p>The fall events/investigation forms and nursing progress notes for Resident D indicated he fell on 09/07/16 at 9:40 A.M. Resident D was ambulating behind wheelchair to the bathroom when he lost his balance and fell. Bed alarm was sounding and staff attempted to help resident but he initially refused help and when falling his waistband was grabbed by staff and resident was lowered to the floor.</p> <p>On 09/07/16, a care plan intervention to use 2 to 3 person assistance with transfers</p>		<p>written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Resident D care plan has been reviewed and all interventions are in place and being followed. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents with care plans related to falls have the potential to be affected by this finding. · A facility audit will be completed by the Nurse Management Team to identify all residents with care plans related to falls. · All careplans will be reviewed to ensure that all interventions related to falls are present on the profile. Any errors and/or discrepancies noted will immediately be corrected and promptly reported to physicians and responsible parties. <p>What measures will be put into place or what systemic changes will be made to</p>		

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	<p>as resident would allow was immediately put into place.</p> <p>An observation of Resident D's room, conducted on 09/29/16 at 5:33 A.M. with the Director of Nursing (Director of Nursing) present. When Resident #D requested to be transferred back to his wheelchair on 09/29/16 at 5:35 A.M., CNA (Certified Nursing Assistant) #4 attempted 3 times to transfer the resident into bed by herself. She was unable to lift the resident and the resident was unable to assist with the transfer. CNA #4 then did go get CNA #5 to assist with the transfer. CNA #4 was unaware the resident was to have 2 to 3 staff members for transfers.</p> <p>This Federal tag relates to Complaint IN00210526.</p> <p>3.1-35(g)(2)</p>		<p>ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All fall interventions will be discussed and reviewed by the IDT team at the time of implementation. · The IDT/Nurse Management Team and/or Weekend Manager will review new falls on next business day to ensure appropriate interventions has been added. · The DNS/Nurse Management Team and/or Weekend Manager will be responsible for ensuring the residents profile is updated with the new intervention. The DNS/Nurse management team will ensure that all staff are aware of new interventions added. · A nursing in-service will be conducted on or before 10/24/16 by the DNS/designee. This in-service will include review of the policy related to fall management, and care plans. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing compliance with this corrective action will be monitored through the facility QAPI Program. 		

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F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure adequate supervision was provided and fall interventions consistently implemented on the secured dementia unit to prevent falls and accidents for 3 of 3 residents reviewed for falls. This resulted in Resident C sustaining a laceration to his head, a concussion and a fractured hip. (Residents B, C, and D)	F 0323	<ul style="list-style-type: none"> The DNS/designee will be responsible for completion of the QAPI Tool titled, "Fall management" daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <p>By what date the systemic changes will be completed:</p> <p>Compliance Date: 10/24/2016</p> <p>F323 – Free of Accident Hazards/Supervision/Devices</p> <p>It is the practice of this facility 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>What corrective action(s) will be accomplished for those</p>	10/24/2016

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	<p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 09/28/16 at 3:00 P.M. Resident #C was admitted to the facility on 06/16/16 with diagnoses, including but not limited to: dementia with behavioral disturbances, schizophreniform disorder and depressive episodes.</p> <p>The discharge instructions from the acute care facility, dated 06/16/16, indicated the following: "...up with assist, Fall Risk very unsteady...."</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 06/23/16, indicated Resident C scored 3 of 15 on a BIMS (Brief Interview for Mental Status) assessment and was severely cognitively impaired. Resident C exhibited verbally abusive behavior and rejected care, required extensive staff assistance of one staff for transfers, wheelchair locomotion, dressing and hygiene needs and was frequently incontinent of his bowels and bladder.</p> <p>The care plan related to the risk for falls was initiated on 06/16/16, with the following interventions: anti-rollbacks and anti-tippers on wheelchair, call light</p>		<p>residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> Residents B and D care plan has been reviewed and all current fall interventions are in place and being followed per MD order. Resident C no longer resides at the facility <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> All resident fall care plans will be reviewed by the Nurse Management Team. The prevention interventions on each resident's fall care plan will be compared to the physician's orders and Resident Profile to ensure all safety and fall interventions are in place and properly being utilized. The DNS and/or designee will be responsible for environmental inspections of all resident rooms and equipment. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> All nursing staff will be in-serviced on or before 10/24/16. This in-service will be 	

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	<p>in reach, non skid footwear, personal items in reach, and therapy screen, therapy as ordered.</p> <p>The fall event/investigation documentation and nursing progress note, dated 07/04/16 at 10:30 P.M., indicated Resident C was behind the nurse and medication cart, stood up from his wheelchair, lost his balance and fell. The IDT (Interdisciplinary Team) meeting notes regarding the fall, completed on 07/05/16 at 8:54 A.M., indicated the "root cause" of Resident C's fall was his wheel rolled back when he stood up. The intervention put into place was to put anti-rollback brakes on his wheelchair.</p> <p>During an interview on 09/29/16 at 8:30 A.M., the Director of Nursing indicated unless the nurse completing the progress note regarding the resident's falls, there was no place on the Fall event/investigation form to indicate if preventative interventions already care planned were in place and functioning properly. There were no updates added to the careplan after the 07/04/16, fall as the intervention was already care planned and should have been in place.</p> <p>The fall event/investigation documentation and nursing progress notes, dated 07/17/16 at 8:45 P.M.,</p>		<p>conducted by the DNS/designee and will include review of the facility policy related to the fall management program and the importance of following all fall prevention interventions per each resident's individual plan of care. The IDT team will be in service on or before 10/24/16. This in-service will be conducted by the DNSS and will include review of fall documentation to include review of previous fall interventions present.</p> <p>The DNS and/or designee, Charge Nurses and/or Weekend Nurse Manager will be responsible for environmental inspections of all resident rooms and equipment to ensure fall prevention interventions are in place and being utilized properly during daily rounds.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>Ongoing compliance with this corrective action will be monitored through the facility QAPI program.</p> <p>The DNS/designee will be responsible for completing the following QAPI Audit Tools: "Fall Management" weekly for 4 weeks and then monthly for 6 months.</p>	

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	<p>indicated the resident was found lying on the floor, fully dressed and wearing shoes.</p> <p>The fall event/investigation documentation and nursing progress notes, dated 07/18/16 at 2:00 A.M., indicated the resident was found lying face down on the floor in his room beside his bed. He suffered a hematoma to his right forehead.</p> <p>The IDT meeting notes for both falls, completed on 07/18/16 at 10:51 A.M., indicated the root cause of the resident's falls was thought to be decreased safety awareness and bed boundary issues. The interventions were to check a urinalysis and to add a mattress with bolstered sides. The care plan was updated with the mattress with bolsters intervention, labs as ordered and an intervention to toilet the resident between 1-2 (there was no indication if A.M. or P.M. was intended).</p> <p>The fall event/investigation documentation and nursing progress notes, dated 08/01/16 at 8:49 P.M., indicated the resident, who was seated in his wheelchair by the nurses station was observed to lean forward and fall out of his wheelchair. Staff were too far away to prevent the resident's fall. An IDT</p>		<ul style="list-style-type: none"> If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 10/24/2016</p>	

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	<p>note, on 08/02/16, indicated the resident was immediately assisted back into his wheelchair and placed in the activity lounge at a table and given an activity of choice. The resident was also screened by therapy for wheelchair safety. There were no safety updates added to the care plan.</p> <p>The fall event/investigation documentation and nursing progress notes, dated 09/03/16 at 1:40 P.M., indicated the resident was found fully dressed with his clothes and shoes on, lying on the floor in the dining room. The resident's fall was not witnessed by staff. An IDT team note, dated 08/06/16 at 11:16 A.M., indicated the root cause was unassisted ambulation attempted by the resident. The immediate intervention was to provide the resident with an activity. This was the same immediate intervention as the resident's previous fall. There was no documentation to indicate why the resident was in the dementia unit common area during the daytime hours was not being supervised and/or provided with an activity prior to his fall. The care plan was undated with an intervention to provide the resident with activities.</p> <p>The fall event/investigation documentation and nursing progress</p>			

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	<p>notes, dated 09/08/16 at 6:55 A.M., indicated the resident was found on the floor beside his wheelchair in the dining room. Direct supervision was immediately provided to ensure the resident did not fall again. The IDT team note, dated 09/02/16 at 11:52 A.M., indicated the root cause was once again the resident attempting to transfer himself and a therapy screen was again recommended. A therapy screen was added to the care plan interventions. There was no documentation to indicate why the resident was in the dining room at 6:55 A.M. without any staff supervision prior to his fall.</p> <p>The fall event/investigation documentation and nursing progress notes, dated 09/17/16 at 2:38 A.M., indicated the resident was found on the floor in his room beside his bed wearing pajamas and slipper socks. The resident suffered a 3.3 centimeter laceration to his right eyebrow and complained of left hip pain. A sensory pad alarm was added to the resident's bed. The resident was transferred to an acute care facility where he was diagnosed with a laceration to his head, a concussion and a fractured hip. He returned to the facility, on 09/17/16 at 10:00 A.M., and the sensory alarm, body pillows and visual observation were put into place as interventions. The care plan</p>			

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	<p>was updated with bed in lowest position, bed alarm and body pillow. There was no IDT team documentation attached to the fall event/investigation report.</p> <p>During an interview on 09/29/16 at 3:55 A.M., CNA (Certified Nursing Assistant) #4 indicated she was working the night that Resident C fell. She indicated she was on the dementia unit by herself and was in another resident's room when she heard a crash. She indicated Resident C was already on the floor in his room bleeding from the head and complaining of back pain when she got to him.</p> <p>During an interview on 09/29/16 at 9:00 A.M., the Director of Nursing indicated the IDT team meetings did not follow any facility policy. She indicated the IDT team, which consisted of the Director of Nursing, the Rehab Manager, and possible the Maintenance Supervisor, a Customer Care staff member assigned to the resident being reviewed, the Medical Records staff member and the SSD (Social Service Director) as needed would meet to discuss falls usually on the next day after a fall had occurred. The team would analyze the nursing progress notes and fall events report. In addition the team would look at the location and any equipment involved in the fall to try and determine the cause of the fall. An</p>			

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	<p>intervention was to be put into place immediately by the nursing staff and then sometimes the IDT team would add an intervention as necessary. The DON indicated previous interventions and their effectiveness or presence at the time of the fall was not always documented or analyzed when the IDT team looked at falls.</p> <p>2. The clinical record for Resident B was reviewed on 09/28/16 at 2:23 P.M. Resident #B was admitted to the facility on 10/14/15 with diagnosis, including but not limited to Alzheimer's disease, insomnia, restlessness and agitation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, completed on 07/16/16, indicated the resident required extensive staff assistance of two staff for transfer needs, required extensive staff assistance for wheelchair locomotion needs and ambulation needs, had exhibited both verbal abusive behaviors and wandering behavior and had not experienced any falls prior to admission and/or in the past 2 to 6 months.</p> <p>A care plan, initiated on 10/24/15, related to the resident risk for falls included interventions for therapy screens as needed, personal items in reach, staff assistance of one for transfers as needed,</p>			

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	<p>encourage non skid footwear and call light in reach. An intervention to redirect as accepted when wandering was added on 07/15/16, and interventions to obtain a urinalysis and review his medications was added on 09/21/16. An intervention added on 09/26/16 was to decrease the resident's Klonopin (an antianxiety medication) and administer an antibiotic medication.</p> <p>The event charting related to falls for Resident #B indicated he had fallen on 07/15/16 while ambulating in the hallway and the intervention to redirect him when wandering was added to his care plan. The resident did not fall again until September 2016. In September 2016, the resident was documented as having fallen on 09/19/16 at 3:58 P.M., 09/20/16 at 8:55 A.M., 09/21/16 at 3:45 P.M., 09/24/16 at 6:40 A.M. and at 1:15 P.M., and on 09/28/16 at 1:10 P.M. and 10:15 P.M.</p> <p>The nursing progress note, dated 09/20/16 at 8:56 A.M., indicated the resident was heard yelling in his room and was found lying on the floor. The intervention was to review his medications as he had experienced two falls in 24 hours. A urinalysis was ordered and his Klonopin medication was decreased.</p>			

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	<p>The nursing progress notes, dated 09/21/16 at 10:02 P.M., indicated the resident was found flying on the floor in his room wrapped in a blanket. The note indicated the resident was immediately given a snack and his urinalysis test was still pending.</p> <p>The nursing progress notes, dated 09/24/16 at 6:40 A.M., indicated a crashing noise was heard and Resident B was found lying on the floor in front of the refrigerator. The note indicated the resident had no injures but did need assistance to ambulate due to unsteadiness. The resident was visually observed as an immediate intervention.</p> <p>The nursing progress notes, dated 09/24/16 at 1:28 P.M., indicated the resident was found on the floor of his room at 1:16 P.M. His fall was not witnessed. The immediate intervention was to bring him to the lounge for direct supervision.</p> <p>Nursing progress notes, dated 09/28/16 at 1:15 P.M. indicated the resident attempted to get up from his chair, became unsteady and fell to the floor. The resident suffered abrasions to his back. The immediate intervention was to help him back into his chair and offer</p>			

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	<p>him the normally scheduled activities.</p> <p>Nursing progress notes, dated 09/28/16 at 10:15 P.M., indicated the nurse was called to Resident B's room by CNAs (Certified Nursing Assistants) who were doing shift change rounds. The resident was found on the floor by the closet and his roommate's dresser. The intervention of putting resident back to bed and visual observation was put into place.</p> <p>On 09/29/16 at 3:52 A.M., CNA #5 was noted to be sleeping in a recliner next to Resident B's bed. Resident B was awake but lying on his back in his bed. CNA #5 did not awaken until 3:55 A.M., when LPN #3 entered Resident B's room to take his vital signs and complete a post fall assessment.</p> <p>During an interview with the DON, on 09/29/16 at 8:30 A.M. she indicated Resident B had been suffering from a Urinary Tract Infection and had been really restless and was noted to be falling frequently. She indicated after he fell the previous evening, she instituted the "sitter" CNA #5 to watch him to prevent falls. She indicated the CNA was not to be sleeping while providing the supervision.</p> <p>The fall event/investigation forms and</p>			
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	<p>nursing progress notes did not indicate why immediate interventions of placing the resident in direct observation, put in place after his falls on 09/24/16 was not continued until he fell twice on 09/28/16.</p> <p>3. The clinical record for Resident #D was reviewed on 09/29/16 at 4:50 A.M. Resident #D was admitted to the facility on 07/31/14 with diagnoses including, but not limited to, dementia and depressive episodes.</p> <p>The most recent quarterly MDS assessment for Resident D, completed on 08/16/16, indicated the resident required the extensive assistance of one staff for transfer, ambulation needs, dressing and personal hygiene needs. Resident D required supervision and limited staff assistance for wheelchair locomotion. Resident D had experienced two or more falls since the previous MDS assessment.</p> <p>The care plan related to falls for Resident D, initiated on 08/01/14, had interventions to ensure personal items were within reach, non skid footwear was worn, the call light was in reach, and therapy screens were completed as ordered. Interventions were added as follows: *03/30/15: provide the resident with snacks in the afternoon.</p>			

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	<p>*10/28/15: utilize a large remote control.</p> <p>*06/16/16: utilize a toilet seat riser and non skid strips in the bathroom in front of the sink.</p> <p>*07/01/16: use a grab bar on the wall in the bathroom.</p> <p>*07/04/16: offer and assist with bedrest after the evening snack.</p> <p>*07/07/16: use non skid strips next to the bed for the entire length.</p> <p>*07/19/16: chair and bed alarm.</p> <p>*08/08/16: threshold alarm in the bathroom.</p> <p>*08/19/16: therapy screen.</p> <p>*09/06/16: remove shoes absent of nonskid bottoms.</p> <p>*09/07/16: occupational therapy evaluation and treatment.</p> <p>*09/26/16: readjust the non skid strips.</p> <p>The fall events/investigation forms and nursing progress notes for Resident D indicated he fell on the following dates and times:</p> <p>07/04/16 at 9:49 P.M. while attempted to transfer himself from his wheelchair into bed.</p> <p>07/05/16 at 9:46 A.M. resident fell while attempting to transfer himself from the wheelchair to a dining room chair.</p> <p>07/06/16 at 9:36 A.M. resident slid off the side of his bed.</p> <p>07/08/16 at 3:30 P.M. resident slid off of either wheelchair or bed in his room</p>			

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	<p>when trying to put his shoes on.</p> <p>07/18/16 at 1:55 P.M. resident tried to get himself out of bed and fell onto the floor.</p> <p>08/05/16 at 5:00 P.M. resident tried to transfer himself from his bed into his wheelchair to go to the bathroom.</p> <p>Resident complained of pain to his right hand. X-ray obtained did revealed a nondisplaced fracture of his 5th finger on the right hand.</p> <p>08/17/16 at 9:00 A.M. resident found in his room on hands and knees by his closet. Resident had gotten himself up out of bed. Bed alarm did not function and was subsequently replaced.</p> <p>08/19/16 at 2:15 P.M. resident noted attempted to ambulate from wheelchair in the dining room and lost balance and fell</p> <p>09/02/16 at 5:25 P.M. resident was attempting to stand and retrieve a snack basket off of a counter in the dining area kitchenette when he lost his balance and fell. He sustained a skin tear to his right forearm.</p> <p>09/07/16 at 9:40 A.M. resident ambulating behind wheelchair to the bathroom when he lost his balance and fell. Bed alarm was sounding and staff attempted to help resident but he initially refused help and when falling his waistband was grabbed by staff and resident was lowered to the floor.</p> <p>09/26/16 at 6:23 P.M. resident was found without his shoes on in the doorway to</p>			

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	<p>his bedroom on the floor. There was no documentation regarding any alarms or previous interventions. Resident complained of left shoulder pain.</p> <p>The IDT (Inter-Disciplinary Team) notes included in the nursing progress notes indicated the following interventions were to be put in place for each fall: 07/04/16 - resident to be offered and assisted into bed following the evening snacks and a psychiatric medication review 07/05/16 - unclear as all of the attached nursing notes and IDT team meeting notes are dated 07/06/16 and refer to the 07/06/16 fall. 07/06/16 the root cause was resident slipped out of his bed. The intervention was to place more gripper strips extending the whole length of his bed. 07/08/16 intervention for the resident to wear gripper socks at all times. 07/18/16 intervention to place a chair and bed alarm 08/05/16 - Tylenol was given for pain, a snack was given. In addition, a threshold alarm was placed in the bathroom and staff were instructed to assist the resident with all hygiene and toileting needs. 08/17/16 - Sensor alarm mat to be placed at the bedside when available. Bed alarm not functioning and was replaced. 08/19/16 - coffee and snacks were</p>			

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	<p>immediately offered and a therapy screen was ordered by the IDT team.</p> <p>09/02/16 - resident was given a snack, his skin tear was treated and IDT discovered his shoes did not have a non skid sole so his shoes were replaced. Resident already had an intervention to have nonskid footwear at all times in place.</p> <p>09/07/16 - an intervention to use 2 - 3 person assistance with transfers as resident would allow was immediately put into place</p> <p>09/25/16 - an immediate intervention to x-ray his left shoulder was implemented. IDT team reimplemented an intervention to adjust the nonskid strips next to his bed. Non skid strips were to have been put into place along his bed on 07/06//16.</p> <p>During an observation of Resident D's room, conducted on 09/29/16 at 5:33 A.M. with the Director of Nursing, the bathroom threshold alarm, noted on the wall above the toilet, was not functioning. The DON adjusted the alarm and put in a "code" and the alarm worked. The censored matt was not noted to be utilized. The DON indicated it was not being utilized currently. When Resident #D requested to be transferred back to his wheelchair on 09/29/16 at 5:35 A.M., CNA #4 attempted x 3 to transfer the resident into bed by herself. She was unable to lift the resident and the</p>			

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	<p>resident was unable to assist with the transfer. CNA #4 then did go get CNA #5 to assist with the transfer.</p> <p>4. During the initial tour of the facility, conducted on 09/28/16 between 9:00 A.M. to 10:08 A.M., there were two male residents observed wandering up and down the dementia unit hallways. One of the residents was noted to go into resident rooms and back into the hallway, muttering alphabetical letters repeatedly. There were several residents on the dementia unit noted seated around tables in the dining/activity lounge. The unit was L-shaped and the dining/activity lounge area did not provide visual access to the hallway. There was a round mirror which did show the hallway from the nurse's station area, which was located the end of the hallway.</p> <p>During an observation of the dementia unit, conducted on 09/29/16 from 3:50 A.M. to 6:00 A.M., the following was noted:</p> <p>At 3:45 A.M., upon entrance to the facility, LPN (Licensed Practical Nurse) #3 was noted at the nurses's station for the Moving Forward nursing unit. During an interview with LPN #3, on 09/29/16 at 3:45 A.M. she indicated she was responsible for both the Moving</p>			

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	<p>Forward rehabilitation unit and the Auguste's Cottage dementia unit. She indicated she split her time between the nursing units. LPN #3 indicated the staffing for he dementia unit was usually 1 CNA for third shift as well as herself going back and forth. She indicated because Resident B had been falling so much, there was a sitter, CNA #5 watching him tonight.</p> <p>At 3:50 A.M., upon entering the dementia unit, CNA #4 was observed coming out of a resident room with a back of soiled linens. During an interview with CNA #4, on 09/29/16 at 3:50 A.M., she indicated there was usually just one CNA and then the nurse, who was assigned to two units for the third shift. CNA #4 indicated the nurse usually spent most of the shift off of the dementia unit. CNA #4 indicated sometimes she could not provide the supervision needed for the unit because some residents would "stand up" and if she was in a different resident room providing care, she could not always get to the resident who had gotten up before they fell.</p> <p>At 3:52 A.M., CNA #5 was noted to be sleeping in a recliner next to Resident B's bed. Resident B was awake but lying on his back in his bed. CNA #5 did not</p>			

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	<p>awaken until 3:55 A.M., when LPN #3 entered Resident B's room to take his vital signs and complete a post fall assessment.</p> <p>At 4:00 A.M., LPN #3 left the dementia care unit. The call light was on for Resident room #128, CNA #4 was in a different resident room completing incontinence care and CNA #5 was in Resident B's room.</p> <p>At 4:06, CNA #4 exited Room #132 and answered the cal light for Room #128.</p> <p>At 4:10 A.M., a male resident in Room 124 was noted by CNA #4 up ambulating near the doorway to his room. CNA #4 entered room #124 and directed the resident back to his bed and covered him up with blankets.</p> <p>At 4:11 A.M., CNA #4 took over for CNA #5 who requested a break.</p> <p>At 4:12 A.M., LPN #3 entered the unit and was noted to be charting at the nurse's station.</p> <p>At 4:15 A.M., CNA #4 had assisted Resident B into his wheelchair. CNA #4 was noted to be providing incontinence care to Resident B's roommate.</p>			

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	<p>A 4:18 A.M., the DON entered the dementia unit, spoke briefly with LPN #3 and then left the unit.</p> <p>At 4:27 A.M., CNA #5 came back onto the unit from her break, got a cup of coffee from the nurse's station, and went back to Resident B's room.</p> <p>At 4:37 A.M., CNA #4 left the dementia unit, LPN #3 was still charting at the nurse's station, and CNA #5 was in Resident B's room.</p> <p>At 4:50 A.M., CNA #4 reentered the unit and proceeded to provide incontinence care for several different resident.</p> <p>At 5:07 A.M., the bed alarm for Resident D went off and LPN #3 went into his room to talk with him. CNA #4 was noted to exit Resident Room #127 with a male ambulatory resident.</p> <p>At 5:09 A.M., CNA #4 entered Room #124 and LPN #3 exited room #124.</p> <p>At 5:15 A.M. CNA #4 exited Room #124 with Resident D who was dressed and in his wheelchair. Resident D was noted to propel his wheelchair into the hallway around the corner towards the activity/dining lounge area.</p>			

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	<p>At 5:18 A.M., CNA #4 gave the ambulatory, male resident from room #127 and Resident D a cup of coffee. LPN #3 had entered Resident B's room to do vital signs and a post fall assessment.</p> <p>At 5:20 A.M. CNA #4 entered Resident room #127 and shut the room door.</p> <p>At 5:25 A.M., CNA #4 exited Resident room #127 with another male, ambulatory resident and soiled linens and trash. After washing her hands, CNA #4 gave the resident a bowl of cereal and some beverages and assisted him to sit at a table in the activity/dining lounge.</p> <p>At 5:30 A.M., DON entered the unit. She entered Room #124 and then left the unit at 5:33 A.M.</p> <p>At 5:34 A.M., CNA #4 was in Room #124 and three residents were unsupervised, all drinking coffee and one eating breakfast in the dining/activity lounge.</p> <p>From 5:35 A.M. - 5:42 A.M., CNA #4 was attempting to transfer Resident D, who had propelled himself back to his room because he was tired, back into bed. The resident was unable to hear instructions and/or unable to follow</p>			

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	<p>instructions and CNA #4 could not provide enough assistance to get the resident out of his wheelchair.</p> <p>At 5:42 A.M., CNA #4 went down to Resident B's room and got CNA #5 to assist her. CNA #5 then left Resident B's room and assisted CNA #4 to transfer Resident D back into his bed. While the CNAs were in Resident D's room, a Transportation Employee #6 entered the unit and directed the male resident who had been eating his breakfast out of the unit. Employee #6 indicated she was taking the resident to dialysis.</p> <p>At 5:43 A.M., the DON reentered the unit and then left again at 5:48 A.M.</p> <p>At 5:55 A.M., a housekeeper entered the unit, looked in the linen closet and left the unit.</p> <p>At 5:57 A.M., LPN #3 reentered the nursing unit.</p> <p>There were still brief periods of time where there was no visual supervision for residents in the hall and activity/dinting lounge area and there was no immediate assistance available for residents when CNA #4 was providing incontinence care to other residents in other resident rooms.</p>			

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	<p>Documentation provided by the Corporate RN (Registered Nurse), Employee #2 on 09/29/16 at 8:40 A.M., indicated the usual staffing for third shift included one CNA assigned to the secured dementia unit, and one licensed nurse assigned to both the secured dementia unit and the rehabilitation unit.</p> <p>Documentation provided by the DON (Director of Nursing), on 09/29/16 at 9:00 A.M., indicated there were 15 residents on the secured dementia unit. Of the 15 residents, 4 required the assistance of one staff for transfer needs and 2 residents required the assistance of two staff for transfer needs. Eight of the 15 residents exhibited behaviors and 2 were noted to have wandering behaviors. There had been 36 resident falls in the past 3 months.</p> <p>This Federal tag relates to Complaint IN00210526.</p> <p>3.1-45(a)(2)</p>			

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F 0353 SS=D Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a</p>			

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	<p>licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review and interview, the facility failed to ensure adequate staffing was provided on the secured dementia unit to prevent falls and accidents for one of 3 shifts. (Night Shift)</p> <p>This deficient practice potentially affected 15 of 15 residents on the unit. (Residents C, B and D)</p> <p>Findings include:</p> <p>During the tour of the facility, conducted on 09/28/16 from 9:00 A.M. - 10:08 A.M., the DON indicated there were 10 of 15 residents who required extensive staff assistance for dressing and grooming needs.</p> <p>Upon entrance to the facility on 09/29/16 at 3:45 A.M., LPN (Licensed Practical Nurse) #3 was noted at the nurses's station for the Moving Forward nursing unit. LPN #3 indicated she was responsible for both the Moving Forward rehabilitation unit and the Auguste's Cottage dementia unit and she split her time between the nursing units. LPN #3 indicated the staffing for he dementia unit was usually 1 CNA 9(Certified Nursing Assistant) for third shift as well as herself going back and forth. She indicated because Resident B had been falling so</p>	F 0353	<p>F 353 Sufficient 24 hour nursing staff per care plans</p> <p>It is the practice of the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · All residents have sufficient staff to provide for their needs. · The facility will schedule the first floor, with an extra "float" CNA in addition to the normally scheduled nursing staff on 3rd shift. This will bring the total nursing staff scheduled on the first floor on 3rd shift to one nurse and three C.N.A.'s. If less than 3 C.N.A.'s arrive for the shift, the on call nurse manager will be notified and make calls to replace staff. · The facility will ensure the Activity staff, will be certified as nursing assistants, to help supplement the C.N.A.'s when needed. 	10/24/2016

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	<p>much, there was a sitter, CNA #5 watching him tonight.</p> <p>During an observation of the dementia unit, conducted on 09/29/16 from 3:50 A.M. to 6:00 A.M., the following was noted:</p> <p>At 3:50 A.M., CNA (Certified Nursing Assistant) #4 was observed coming out of a resident room with a back of soiled linens. CNA #4 indicated there was usually just one CNA and then the nurse, who was assigned to two units for the third shift. CNA #4 indicated the nurse usually spent most of the shift off of the dementia unit. CNA #4 indicated sometimes she could not provide the supervision needed for the unit because some residents would "stand up" and if she was in a different resident room providing care, she could not always get to the resident who had gotten up before they fell.</p> <p>At 3:52 A.M., CNA #5 was noted to be sleeping in a recliner next to Resident B's bed. Resident B was awake but lying on his back in his bed. CNA #5 did not awaken until 3:55 A.M., when LPN #3 entered Resident B's room to take his vital signs and complete a post fall assessment.</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents residing on the cottage have the potential to be affected by the alleged deficient practice. · The facility will schedule the first floor, with an extra "float" CNA in addition to the normally scheduled nursing staff on 3rd shift. This will bring the total nursing staff scheduled on the first floor on 3rd shift to one nurse and three C.N.A.'s. If less than 3 C.N.A.'s arrive for the shift, the on call nurse manager will be notified and make calls to replace staff. · The facility will ensure the Activity staff, will be certified as nursing assistants, to help supplement the C.N.A.'s when needed. · The Executive Director/designee will review the staffing patterns and needs of the residents during night shift by October 24, 2016 to ensure the needs of the residents are met. · Staff will be in-serviced by the DNS/designee on including ensuring that there is adequate staffing to provide for the needs 				

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	<p>During an interview on 09/29/16 at 3:55 A.M., CNA (Certified Nursing Assistant) #4 indicated she was working the night that Resident C fell. She indicated she was on the dementia unit by herself and was in another resident's room when she heard a crash. She indicated Resident C was already on the floor in his room bleeding from the head and complaining of back pain when she got to him.</p> <p>At 4:00 A.M., LPN #3 left the dementia care unit. The call light was on for Resident room #128, CNA #4 was in a different resident room completing incontinence care and CNA #5 was in Resident B's room.</p> <p>At 4:06, CNA #4 exited Room #132 and answered the call light for Room #128.</p> <p>At 4:10 A.M., a male resident in Room 124 was noted by CNA #4 up ambulating near the doorway to his room. CNA #4 entered room #124 and directed the resident back to his bed and covered him up with blankets.</p> <p>At 4:11 A.M., CNA #4 took over for CNA #5 who requested a break.</p> <p>At 4:12 A.M., LPN #3 entered the unit and was noted to be charting at the nurse's station.</p>		<p>of the residents by October 24, 2016.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Staff will be in-serviced by the DNS/designee including ensuring that there is adequate staffing to provide for the needs of the residents by October 24, 2016. · The Executive Director/designee will review the staffing schedules daily to ensure that there is adequate staff to provide for the needs of the residents during nightshift. · Executive Director/designee will oversee compliance · Customer care representative/Manager on duty will interview residents daily to ensure that their needs have been met. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>	

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	<p>At 4:15 A.M., CNA #4 had assisted Resident B into his wheelchair. CNA #4 was noted to be providing incontinence care to Resident B's roommate.</p> <p>A 4:18 A.M., the DON (Director of Nursing) entered the dementia unit, spoke briefly with LPN #3 and then left the unit.</p> <p>At 4:27 A.M., CNA #5 came back onto the unit from her break, got a cup of coffee from the nurse's station and went back to Resident B's room.</p> <p>At 4:37 A.M., CNA #4 left the dementia unit, LPN #3 was still charting at the nurse's station, and CNA #5 was in Resident B's room.</p> <p>At 4:50 A.M., CNA #4 reentered the unit and proceeded to provide incontinence care for several different resident.</p> <p>At 5:07 A.M., the bed alarm for Resident D went off and LPN #3 went into his room to talk with him. CNA #4 was noted to exit Resident Room #127 with a male ambulatory resident.</p> <p>At 5:09 A.M., CNA #4 entered Room #124 and LPN #3 exited room #124.</p>		<p>i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Ongoing compliance with this corrective action will be monitored through the facility QAPI program. · The DNS/designee will be responsible for completing the following QAPI Audit Tools: "Accommodation of needs" weekly for 4 weeks and then monthly for 6 months. · If threshold of 90% is not met, an action plan will be developed. · Findings will be submitted to the QAPI Committee for review and follow up. <p>By what date the systemic changes will be completed:</p> <p>Compliance Date: 10/24/2016</p>	

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	<p>At 5:15 A.M., CNA #4 exited Room #124 with Resident D who was dressed and in his wheelchair. Resident D was noted to propel his wheelchair into the hallway around the corner towards the activity/dining lounge area.</p> <p>At 5:18 A.M., CNA #4 gave the ambulatory, male resident from room #127 and Resident D a cup of coffee. LPN #3 had entered Resident B's room to do vital signs and a post fall assessment.</p> <p>At 5:20 A.M., CNA #4 entered Resident room #127 and shut the room door.</p> <p>At 5:25 A.M., CNA #4 exited Resident room #127 with another male, ambulatory resident and soiled linens and trash. After washing her hands, CNA #4 gave the resident a bowl of cereal and some beverages and assisted him to sit at a table in the activity/dining lounge.</p> <p>At 5:30 A.M., DON entered the unit. She entered Room #124 and then left the unit at 5:33 A.M.</p> <p>At 5:34 A.M., CNA #4 was in Room #124 and three residents were unsupervised, all drinking coffee and one eating breakfast in the dining/activity lounge.</p>			

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	<p>From 5:35 A.M. to 5:42 A.M., CNA #4 was attempting to transfer Resident D, who had propelled himself back to his room because he was tired wanted back into bed. The resident was unable to hear instructions and/or unable to follow instructions and CNA #4 could not provide enough assistance to get the resident out of his wheelchair.</p> <p>At 5:42 A.M., CNA #4 went down to Resident B's room and got CNA #5 to assist her. CNA #5 then left Resident B's room and assisted CNA #4 to transfer Resident D back into his bed. While the CNAs were in Resident D's room, a Transportation Employee #6 entered the unit and directed the male resident who had been eating his breakfast out of the unit. Employee #6 indicated she was taking the resident to dialysis.</p> <p>At 5:43 A.M., the DON reentered the unit and then left again at 5:48 A.M.</p> <p>At 5:55 A.M., a housekeeper entered the unit, looked in the linen closet and left the unit.</p> <p>At 5:57 A.M., LPN #3 reentered the nursing unit.</p> <p>There were still brief periods of time</p>			

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	<p>where there was no visual supervision for residents in the hall and activity/dinting lounge area and there was no immediate assistance available for residents when CNA #4 was providing incontinence care to other residents in other resident rooms.</p> <p>Documentation provided by the Corporate RN (Registered Nurse), Employee #2, on 09/29/16 at 8:40 A.M., indicated the usual staffing for third shift included one CNA assigned to the secured dementia unit, and one licensed nurse assigned to both the secured dementia unit and the rehabilitation unit.</p> <p>Documentation provided by the DON, on 09/29/16 at 9:00 A.M., indicated there were 15 residents on the secured dementia unit. Of the 15 residents, 9 required assistance with incontinence care, 4 required the assistance of one staff for transfer needs and 2 residents required the assistance of two staff for transfer needs. Eight of the 15 residents exhibited behaviors and 2 were noted to have wandering behaviors. Five of the 15 required assistance with dressing and grooming and there had been 36 resident falls in the past 3 months.</p> <p>This Federal tag relates to Complaint IN00210526.</p>			

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F 0425 SS=D Bldg. 00	<p>3.1-17(b)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure medications were obtained timely to treat anxiety during care for 1 of 3 residents reviewed for Hospice recommendations. (Resident E)</p> <p>Finding includes: During a tour of the facility, conducted</p>	F 0425	<p>F425 Pharmaceutical Svc-</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident E has medication available as prescribed by physician.</p>	10/24/2016
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	<p>on 09/28/16 between 9:08 A.M. to 10:00 A.M., accompanied by the Director of Nursing (DON), Resident E was observed seated in a reclining wheelchair at a table in the activity/dining lounge. The DON indicated the resident required extensive staff assistance of two for transfers and received Hospice services. Resident E was calm and quiet when she was observed seated at the table.</p> <p>The clinical record for Resident #E was reviewed on 09/23/16 at 1:30 P.M. Resident #E was admitted to the facility on 05/04/16 with diagnoses, including but not limited to, end stage Alzheimer's dementia, anxiety and agitation.</p> <p>A Hospice nurse assessment, dated 09/20/16, indicated the resident had been combative and threw her breakfast tray and was refusing care. The Hospice nurse suggested Ativan gel (a medication to relieve anxiety) as a possible intervention. The facility nurse indicated she wanted to try a rectal insertion first. It was unclear what medication the facility nurse was going to insert rectally.</p> <p>A Hospice nurse assessment, dated 09/20/16, indicated the resident had continued to be combative with care, had a blistered area on the back of one of her legs but refused to let the nursing staff</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. An audit of all residents medication was performed to ensure all medication is available. The DNS/designee will ensure that MARs are audited daily to check for medication availability. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff will be in-serviced by the DNS/designee on pharmacy policy for medication delivery by October 24, 2016. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>	

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	<p>care for it. The Social Service Director (SSD) was notified and indicated she would like to try Ativan gel. An order was given by the Hospice physician for Ativan gel 1 mg routine in the AM. During the assessment on 09/23/16 Resident E was assessed to be anxious and angry. In addition, the nursing staff were instructed to call Hospice with any needs or changes for Resident E.</p> <p>A physicians order, dated 09/23/16 at 1:00 P.M., was written for "Ativan gel Give 1 mg topically q [every] AM [morning] for agitation with EOL [sic]."</p> <p>A subsequent physician's order, dated 09/26/16, was written for "Hold Ativan gel until available from pharmacy."</p> <p>During an interview on 09/29/16 at 8:30 A.M., RN (Registered Nurse) #1 indicated the Ativan gel had been delivered to the facility on 09/28/16, the same day the order had been filled by the facility's pharmacy. RN #1 indicated she was not working when the order was written on 09/23/16. She indicated the pharmacy required a "hard" script for the Ativan gel and Hospice had not left a "hard" script. RN #1 indicated she had notified Hospice of the need for the hard script when she became aware of the problem. RN #1 indicated Hospice staff</p>		<ul style="list-style-type: none"> · Ongoing compliance with this corrective action will be monitored through the facility QAPI program. · The DNS/designee will be responsible for completing the following QAPI Audit Tools: "Pharmacy services" weekly for 4 weeks and then monthly for 6 months. · If threshold of 90% is not met, an action plan will be developed. · Findings will be submitted to the QAPI Committee for review and follow up. <p>By what date the systemic changes will be completed:</p> <p>Compliance Date: 10/24/2016</p>	

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	<p>told her they were "working on it." RN #1 indicated Resident E had an oral Ativan ordered for anxiety but she would often refuse oral medications, even when crushed in applesauce, when she was anxious and upset. RN #1 indicated most of the resident's agitation occurred around care given in the mornings when getting her up and out of bed.</p> <p>During an interview on 09/29/16 at 8:40 A.M., RN #2, the Corporate nurse, indicated the facility had officially switched pharmacy providers effective 09/26/16. A former pharmacy policy, dated 02/2014, which would have been effective on 09/23/16, indicated the following: "1. The pharmacy will STAT medication orders when essential medications are required prior to the next scheduled delivery if the use of a local backup pharmacy or the EDK [Emergency Drug Kit]/Med-Select is not possible...." RN #2 indicated the previous pharmacy provider delivered medications once a day and she did not feel the Ativan gel was essential as the resident did have an oral antianxiety medication available. There was no policy given which indicated what the expected delivery time frame was for the Ativan gel if it was not considered "essential."</p>			

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	This Federal tag relates to Complaint IN00210526. 3.1-25(g)(2)				