

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155270	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2013
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NAME OF PROVIDER OR SUPPLIER  CORE OF HUNTINGBURG INC	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF DALE, IN 47523
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: August 22, 23, 26, 27, and 28, 2013.</p> <p>Facility number: 000170 Provider number: 155270 AIM number: 100287490</p> <p>Survey team: Terri Walters RN TC Martha Saull RN Dorothy Watts RN Sylvia Martin RN</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Genus payor type: Medicare: 5 Medicaid:41 Other: 1 Total: 47</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 4, 2013, by Jodi Meyer, RN</p>	F000000		

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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F-225	09/25/2013			

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	<p>review, the facility failed to report immediately an allegation of abuse to the state agency and/ or thoroughly investigate an allegation of abuse for 2 of 2 allegations of abuse reported to the state agency reviewed. Resident #41</p> <p>Findings include:</p> <p>1. A fax/incident report to the State Department of Health with an incident date of 8/23/13 had been received and reviewed on 8/27/13 at 12:46 P.M.</p> <p>The report indicated, "During interview with the state surveyor (Resident name) Resident #41 reported that CNA #8 was pulling , tugging and being rude (by laughing at her)..."</p> <p>The Administrator had been notified of the allegation on 8/23/13 at 9:00 A.M.</p> <p>During interview with the Administrator and Director of Nursing (DON) on 8/28/13 at 8:13 A.M., the DON indicated she had reported the allegation by fax on 8/24/13 at 12:21 A.M.</p> <p>The facility investigation report of the</p>		<p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUAL POLICY: It is the policy of CORE NURSING AND REHABILITATION to prohibit the mistreatment, neglect and abuse of residents including misappropriations of resident's funds/property, by anyone including staff, family, friends, vendors, volunteers etc. It is CORE policy to report all abuse/allegations, including significant injuries of unknown sources, to the DON or Administrator immediately and then Administrator/designated-staff will then notify other state officials in accordance to Federal/State guidelines through establish procedures (including to the state survey and certification agency). RESIDENTS AFFECTED: Resident #41 had reported an incident to this DON on my first day in the facility before my orientation had begun. Reported an incident that a cna was rough during brief change. During our conversation #41 explained that "this happened several weeks ago". Staff on duty stated that she reported this had happened at the facility she had just been transfered from. Resident was a new admit. I realize now that I should have investigated this thoroughly and reported promptly to Administrator and State Agency. RESIDENTS POTENTIALLY AFFECTED: All</p>				

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	<p>allegation was reviewed on 8/27/13 at 12:46 P.M. The investigation documentation indicated CNA # 8 was interviewed regarding allegation and then suspended pending investigation completion. Another CNA who had provided care at time of allegation, CNA #7, had also been interviewed regarding the allegation. Resident #41 had also been interviewed regarding the allegation during the investigation. Documentation was lacking of other residents or staff interviews in the investigation of the allegation.</p> <p>2. Another fax/incident report to the State Department of Health with an incident date of 8/23/13 had been received and reviewed on 8/27/13 at 12:46 P.M.</p> <p>The report indicated, "During (resident name) (Resident #41's) state survey interview she informed surveyor that a while back that CNA (CNA name) #10 had jerked her brief off during peri care and made her red &amp; caused injury..."</p> <p>The Administrator had been notified of the allegation on 8/23/13 at 9:00 A.M.</p>		<p>residents could have potentially been affected by this. A more thorough investigation at the time I recieved this deficiency in which I interviewed 8 residents that were interviewable and that were incontinent and housed in the same location as #41. 0 out of 8 residents reported that any staff member were ever rough with incontinence care. 0 out of 8 residents stated that staff were ever rude to them. I will be interviewing each resident at this facility by Plan of Correction completion date. SYSTEMIC CHANGES: · Abuse Policy revised to be more specific and instructional as to the steps taken with all allegations of Abuse/Mistreatment/Neglect, either with or without injury, to promote increased safety and security of our residents at CORE Nursing and Rehabilitation. · In-servicing of all staff with revised Abuse/Allegation Policy (emphasizing that all perceived mistreatment and rudeness of residents must also be reported immediately). In-service will include the specific protocol and responsibilities of each staff member so as to assure prompt and appropriate response that meet Federal/State guidelines. · Director of nursing to begin tracking all reported abuse/neglect allegations in a Record Binder. This Record will include specific aspects/intervention used for</p>				

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	<p>During interview with the Administrator and the DON on 8/28/13 at 8:13 A.M., the DON indicated she had reported the allegation by fax to the State Department of Health on 8/24/13 at 12:24 A.M.</p> <p>The facility investigation report of the allegation reported on 8/23/13 was reviewed on 8/27/13 at 12:46 P.M.</p> <p>The report investigation indicated, " Reportedly (sic) this was an event that had occurred in May, but was not able to be investigated due to she could "not remember the CNA name and she did not report incident to anyone, stating ' I didn't know who to tell. ' "</p> <p>A Resident Concern form dated 6/5/13 (included with the fax/incident report), indicated, "... she said that a night shift "aide" pulled her brief down rough and caused her ' private area ' to be sore and red..." Investigation documentation indicated charge nurse and CNAs were spoken to and not aware of the allegation.</p> <p>3. On 8/28/13 at 8:52 A.M., the Administrator and the DON were made aware an allegation of abuse needed to be reported immediately to</p>		<p>continuous review and assessment by interdisciplinary team members QUALITY ASSURANCE: · Abuse/allegations Record to be kept by Director of Nursing to include aspects for each incident and recorded procedures used to ensure compliance with State Guidelines. · Reporting of Abuse/Allegations Record at Quarterly Quality Assurance Meetings in a more aggressive approach of eliminating Abuse/Neglect/Mistreatment of our residents whether they be substantiated or unsubstantiated reports. · Quarterly Quality Assurance Meeting Policy revised to include reporting of data concerning abuse/allegations. This reporting will be on-going as data reviewed QA meetings so as to assess for patterns and track.</p>				

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	<p>the state agency. The Administrator indicated she thought she had 24 hours to report an allegation to the state agency. The DON and Administrator were also made aware at that time a thorough investigation of the allegation would include interviews of other residents and staff in the facility not only residents and staff named in the allegation to ensure a thorough investigation.</p> <p>3.1-28(c)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the facility abuse policy indicated the state agency was notified promptly of an allegation of abuse and included protocol for interviews of staff and residents during an abuse allegation investigation.</p> <p>Findings include:</p> <p>On 8/27/13 at 12:33 P.M., the facility abuse policy (dated) entitled , "Core Nursing and Rehab Procedure for Abuse Prohibition, Reporting and Investigating Policy (no policy date) had been received and reviewed.</p> <p>The policy included, but was not limited to, the following: 2. The Administrator or her designee will report it to the State Agency within 24 hours..."</p> <p>In regard to the investigation of the allegation the policy indicated, "...3. A thorough investigation is initiated of</p>	F000226	<p>F226: DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES: POLICY: It is the policy of CORE NURSING AND REHABILITATION to prohibit the mistreatment, neglect and abuse of residents including misappropriations of resident's funds/property, by anyone including staff, family, friends, vendors, volunteers etc. It is policy that CORE develops and implements written policy and procedures that prohibit the mistreatment, neglect, and abuse of residents and misappropriation of resident property. It is the Policy of CORE that all allegations/abuse be reported to Administrator and/or DON within 1 hour and that these then be reported to State Agency promptly per Federal/State Guide lines RESIDENT AFFECTED: #41 Reported that cna #8 this morning had been rough and rude with her incontinence care. Cna #8 called into Administrators office and suspended pending an investigation. Investigative interviews began and quickly learned that CNA #8 did not do any incontinence care this morning for #41. Another CNA</p>	09/25/2013			

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	<p>the allegations to gather pertinent information and verify the occurrence." "...5. If the suspected abusive individual is an employee, it is the responsibility of the staff member in charge of the facility, if other than the Administrator at the time of the incident, to suspend the alleged abusive employee until the incident can be fully investigated."</p> <p>On 8/28/13 at 8:52 A.M., the Administrator and the DON were interviewed regarding the facility's abuse policy. The Administrator and the DON were made aware the facility's abuse policy did not indicate the state agency needed to be notified immediately if an allegation of abuse had been reported to the Administrator. The Administrator and the DON were also made aware the facility's abuse policy lacked in regard to the investigation process the interviewing of other staff and residents not involved in allegation.</p> <p>On 8/28/13 at 8:52 A.M., the Administrator indicated she thought she had 24 hours to report an allegation to the Indiana State Department of Health (ISDH). The Administrator and DON at that time also indicated the policy was incomplete in regard to providing a</p>		<p>did and stated there was never mention from #41 of rough/rude treatment. Nurses and all CNA's interviewed. Social Service Director stated she had Care planned this as a recurrent behavior. Even though investigation interviews revealed this was an unsubstantiated allegation, DON failed to interview all other residents at CORE who were housed in this location. CORE's Abuse Policy was not complete to provide specific procedures of investigating and reporting of all allegations. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents could have potentially been affected by this. A more thorough investigation at the time I received this deficiency was done in which I interviewed 8 residents, that were interviewable, that were incontinent and housed in the same location as #41. 0 out of 8 residents reported that any staff member were ever rough with incontinence care. 0 out of 8 residents stated that staff were ever rude to them. I will be interviewing each resident at this facility by Plan of Correction completion SYSTEMIC CHANGES: · More complete education/orientation of DON to State Guidelines as defined by 483.13 so as to ensure that the state agency will be notified promptly of an allegation of abuse. · Update/Revised Abuse/Allegation Policy so as to</p>				

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	<p>complete procedure for a thorough investigation of an allegation. They indicated they were going to update their current abuse policy.</p> <p>3.1-28(a)</p>		<p>include protocol in regard to providing a complete procedure for a thorough investigation an allegation to include interviews of staff and residents (not only ones involved in this allegation). · Inservice for this revised policy with all staff in facility. QUALITY ASSURANCE: · Abuse/allegations Record to be kept by Director of Nursing to include aspects for each incident and recorded procedures used to ensure compliance with State Guidelines. · Quarterly Quality Assurance Meeting Policy revised to include reporting of data concerning abuse/allegations. · Reporting of Abuse/Allegations Record data at Quarterly Quality Assurance for all substantiated and unsubstantiated reports. This data reporting at QA meetings will be ongoing and included to assess for patterns and tracking incidents.</p>	

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure 1 of 1 residents reviewed for accidents was assessed for safety in regard to the operation of his electric wheelchair on a highway/street. The electric wheelchair lacked safety signs and/or flags to ensure the resident's wheel chair was highly visible to motorized vehicles. Resident #26</p> <p>Findings include:</p> <p>During an interview with QMA #5 on 08/27/13 at 8:15 A.M., QMA #5 indicated she did not know where Resident #26 was located that morning. QMA #5 indicated that the nurse at the end of the hall might know where Resident #26 had gone.</p> <p>During an interview with RN #2 on 08/27/13 at 8:18 A.M., RN #2 indicated that Resident #26 had signed out for LOA (leave of absence) this morning at 2:45 A.M., and that she did not know when he would</p>	F000323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES POLICY: It is the policy of CORE to ensure that the resident's environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Affected Resident: Resident # 26 had a reflector placed on his motorized wheelchair on 8/30/2013. The therapy department will monitor his reflector for it placement on the chair monthly for six months then quarterly thereafter. Other Residents potentially Affected: There are 2 other resident's with a motorized wheelchair and one enters the community and the other never leaves the building. The other resident that goes LOA had a reflector placed on his wheelchair on 8/30/2013. Due to the change in the policy the other resident that does not go LOA will also receive a reflector on 9/13/2013. Systemic Changes: The facility has revised the Rules pertaining to the Personal Powered Vehicles Policy and Procedure. All residents admitted to the facility having a motorized	09/25/2013			

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	<p>return to the facility. RN #2 indicated Resident #26 frequently left the facility in his electric wheelchair at all different times of the day and night. RN #2 indicated that Resident #26 did not obtain an automobile ride when departing the facility, but that Resident #26 just drove his wheel chair up the street by himself.</p> <p>The Resident Leave of Absence (LOA) Record for Resident #26 was reviewed on 8/26/13 at 8:30 A.M. Resident #26 had signed out of the facility at 2:45 A.M on 8/26/13. The LOA record recorded the resident had left the facility 49 times during the month of August.</p> <p>On 8/26/13 at 9:00 A.M., Resident #26 was observed sitting in his electric wheelchair at the nurses ' station. The wheelchair had a black backpack attached to the back of the seat of the wheelchair. No reflective tape, light or flag was observed on the back of the chair to alert cars of the wheelchair's presence on the highway/street.</p> <p>On 8/27/13 at 3:25P.M., Resident #26 was observed leaving the facility with an unidentified person. Resident #26 proceeded from the facility's parking lot onto the right side of Highway</p>		<p>wheelchair will have a reflector placed on their wheelchair. The Rehabilitation supervisor will monitor the reflectors monthly for six months and then quarterly. Quality Assurance: The Rehabilitation Supervisor will report the number of motorized wheelchairs in the building and the reflectors that have been placed and audits at quarterly QA meetings.</p>				

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	<p>62/Medcalf Street. While driving his wheelchair East on Highway 62/Medcalf Street, 4 vehicles traveling East on Highway 62/Medcalf Street veered over to the left side of the highway/street as they passed Resident #26 in his electric wheelchair. No sidewalks were available on the highway/street in front of facility.</p> <p>The clinical record for Resident #26 was reviewed on 8/27/13 at 12:32 P.M.</p> <p>The record indicated that diagnoses of Resident #26 included, but were not limited to, paraplegia, osteomyelitis, and insomnia.</p> <p>During an interview the Health Care Administrator (HCA) on 8/26/13 at 12:10 P.M., the HCA indicated that Resident #26 was responsible for himself. The HCA indicated that the street in front of the facility was not a highway. The HCA indicated that Highway 62/Medcalf Street was well lit at night. The HCA indicated that Resident #26 only drove his wheelchair to his friends' apartment just down the street.</p> <p>During an interview with the DON on 8/27/13 4:45 P.M., the DON indicated that Resident #26 said he had a</p>						

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	<p>reflective sign when he first came to the facility but he did not know what happened to it. The DON indicated she asked Resident # 26 if he would allow the facility to put reflective tape on his wheelchair. The DON indicated the tape had been ordered and would arrive at the facility 08/28/13.</p> <p>3.1-45(a)(2)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident did not experience an unplanned weight loss for 1 of 2 residents reviewed for weight loss. Resident #42</p> <p>Findings include:</p> <p>On 8/26/13 at 10 A.M., the clinical record of Resident #42 was reviewed. Diagnoses included, but were not limited to, the following: traumatic brain injury and major depressive disorder. The resident was admitted to the facility on 1/21/13. The minimum data set assessment (MDS) dated 1/28/13 indicated the following: moderately impaired cognition; independent in eating; height 61 inches and weight 164 lbs.</p> <p>On 8/26/13 at 4 P.M., the resident's weights for year to date were</p>	F000325	F 325: MAINTAIN NUTRITIONAL STATUS (unless unavoidable) POLICY: It is the policy of CORE to monitor the weight status of each resident upon admission and at regular intervals thereafter. Appropriate interventions will be initiated should weight decline/ incline be unplanned. AFFECTED RESIDENT: #42 incorrect weight entry lead to an error in transcription by Dietary Head. Due to this error there were no interventions placed or documentation to support #24 weight preference. Weight loss since June 2013, had been minimal and so appeared to stabilize weekly weights were discontinued, however weight was continuing at a gradual decline. On 8/27/2013 order obtained for health shakes bid and weekly weights restarted. During 08/29/2013 interview with Dietary dept. head resident #42 informed her that she had wanted to lose weight because she was	09/25/2013			

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	<p>reviewed. Following weights for 2013 were reviewed: January: 164.3 lb (pounds); February: 161.5 lb; March: 158.8 lb.; April 150.1 lbs.; May 145.8 lb.; June 140.7 lb.; July 138.3 lb.; August 134.3 lb.</p> <p>A Nutritional Screening and Assessment (NAS), dated 1/21/13 was reviewed. The resident's ideal body weight was documented to be 105 lbs. plus or minus 11 lbs. The resident was on a regular diet.</p> <p>A care plan for "Nutritional Risks Plan of Care" had an initial date of 1/22/13, and was most recently updated 7/25/13. Goal indicated "Weight will remain stable plus or minus 5 lbs." Interventions included, but not limited to, the following: monitor weights, MVI (multiple vitamin) dated 5/23/13.</p> <p>A Quarterly Dietary Progress note, dated 4/24/13 indicated the following: no significant weight change and "no" anticipated weight change.</p> <p>A NAS, dated 5/17/13, indicated the following: "Res (resident) reported with a s/c (significant change) in weight at 3 mos (months), (9.72% decline)...D/T (due to) a reduced intake, suggest a daily MVI with minerals. Res. not reported with</p>		<p>always a small girl. Resident agreed to continue with health shakes because she liked them. Educated resident on importance of 3 balanced meals per day to ensure good health. Guardian called to report and interview, and she also stated that resident's weight has always been around 110lbs. and she did not feel the weight loss to be detrimental.</p> <p>SYSTEMIC CHANGES: · Revised Nutritional Risk Program policy with inservice of Nursing Department · Licensed staff and Certified NA to be inserviced on Documentation and reporting of weight losses. · All residents on Nutritional Risk Program will be reviewed at weekly Interdisciplinary Clinical Meeting where interventions will be decided upon with documentation of progress.</p> <p>QUALITY ASSURANCE A weekly weight audit to be done x 8 weeks and then monthly x4 months to ensure new implemented processes with our Nutritional risk resident plan is effective tool as a safeguard and to promote all residents of CORE health and well-being.</p>				

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	<p>emesis, reduction in edema or use of a diuretic or other illness explaining declining intake (sic)...suggest a weekly weight for res."</p> <p>On 8/27/13 at 7 A.M., the resident was observed in her wheelchair in the dining room. The meal had not been served yet. At 7:05 A.M., the resident was observed to self propel herself out of the dining room, in her wheelchair. At 7:23 A.M., CNA #3 encouraged the resident to go back into the dining room. At 7:35 A.M., the resident was observed to have eaten 1/2 of her scrambled eggs but did not eat any biscuits and gravy. It appeared the resident may have eaten a few bites of cold ceral and milk.</p> <p>On 8/27/13 at 9:50 A.M., the FSM (Food Service Manager) was interviewed and also provided copies of the resident's weekly weights. Weekly weights began the week of 5/20/13, with a weight of 143.3 lb and ended the week of 6/24/13, with a weight of 141.5 lb. At that time, the FSM also provided a copy of Dietician notes, dated 6/21/13, which indicated the following: "Nursing reports a steady weight since admission in January with current weight at 141.6 (lb)...Res...noted with increased</p>						

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	<p>irritability...started on Buspar on 6/3/13...Meal intake varies 25-100%...Suggest continuing with weekly weights..." An amended note (no date) for 6/21/13 indicated the following "had a steady weight decrease since admission...Appears to be stabilizing at approximately 141 lb." The FSM indicated the weekly weights had not been continued after June 2013, and that was an oversight on her part.</p> <p>A Quarterly Dietary Progress note, dated 7/25/13, indicated the following: at 180 days percentage weight change was 15.8% and "no" anticipated weight change.</p> <p>A NAS noted, dated 8/23/13, indicated the following: "August weight 134.3 showing a continuous decline...Suggest a houseshake BID (twice a day)..."</p> <p>On 8/27/13 at 3 P.M., the DON was interviewed. The DON indicated the resident had told her she wanted to lose weight. She indicated for the last few months, her weights have been stable so they took her off weekly weights.</p> <p>On 8/27/13 at 3:13 P.M., the FSM provided a copy of a Dietician note,</p>				

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	<p>dated 8/26/13 and indicated the following: "Had unplanned weight loss. August weight is 134.3, showing a continuing decline...recommend house shakes bid (twice a day)."</p> <p>On 8/28/13 at 7:22 A.M., the FSM was interviewed. She indicated the resident had a steady weight decrease and appeared to have lost weight in the wrong way as the weight loss had not been planned. She indicated the resident was currently above her ideal body weight range. The FSM indicated the resident will be put back on weekly weights, which would be started today. The FSM indicated the resident had never told her she wanted to lose weight. The FSM indicated she would call the doctor to start health shakes today.</p> <p>On 8/28/13 at 2 P.M., the DON (Director of Nursing) was interviewed. She indicated the resident's weights in March of 158.8 lb. to April of 150.1lb. was a significant weight loss and should have been looked at. She also indicated the resident's weight loss from January of 164.3 lb. to June of 140.7 lb. was significant.</p> <p>At the time, the DON also provided a copy of the facility policy and procedure for "Nutritional Risk</p>			

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	<p>Program", undated. She indicated the policy was faxed to the facility from their sister facility. The policy included, but was not limited to, the following: "...policy ...to monitor the weight status of each resident to ensure weight remains stable..." Procedure included, but was not limited to, the following: "...If a resident experiences a weight loss of 5% or more in one month, 7.5 % in 3 months or a 10% weight loss in 6 months, which was not an anticipated loss, family and physician will be notified. Interventions will be put in place to prevent further weight loss/gain..."</p> <p>3.1-46(a)(1)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure antidepressant and/or antipsychotic medications were reviewed and/or had gradual dose reductions for 2 of 5 residents reviewed for unnecessary drugs. Resident #17, Resident #10</p> <p>Findings include:</p> <p>1. The clinical record of Resident #17 was reviewed on 8/27/13/ at 3:05</p>	F000329	F329 DRUG REGIME IS FREE FROM UNNECESSARY DRUGS POLICY: It is the policy of the facility that each resident's drug regimen be free from unnecessary drugs and to receive gradual dose reductions in effort to discontinue those drugs through the Consultant Licensed Pharmacist Recommendations. Affected Resident Resident #10 had his Depakote reduced on 8/27/2013 after a nursing medication transcription error was corrected. MD notified of error medication error form filled out	09/25/2013			

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	<p>P.M. Resident #17 had diagnoses which included, but were not limited to, depression, A-fib, hypertension and congestive heart failure. Resident #17 had been receiving anti-depressant medications Celexa (40 mg once daily) and Buspar (10 mg 1 tablet twice a day) since 10/24/11. Resident #17's monthly pharmacy reviews lacked recommendations from the consulting pharmacist for the physician to consider a gradual dosage reduction for the anti-depression medications Celexa and Buspar.</p> <p>The current August 2013 physician's orders for Resident #17 included, but were not limited to, Celexa 40 mg take 1 tablet daily and Buspar 10 mg take 1 tablet twice a day.</p> <p>According to guidelines provided by Centers for Medicare and Medicaid Services (CMS) ... Frequency of Gradual Dose Reduction: Within the first year of use, taper twice in 2 separate quarters with at least one month between attempts. After the first year, once annually..."</p> <p>Documentation was lacking in regards to the consulting pharmacist's recommendation to the physician to decrease Resident #17's Celexa.</p>		<p>and signed by MD, unable to educate the nurse making the error due to she is no longer an employee. Resident #17 had received antipsychotic/anti-depressant without a reduction since 10/24 2011. Pharmacy consultation request for a reduction was reportedly sent, but was not in the chart and no order obtained. It is reportedly the policy of consulting pharmacy to investigate if recommendation not returned. Psychologist notified and reduction was denied. Systemic Change All Pharmacist Recommendations will come to the facility and to go to the Director of Nursing. The recommendations will be taken to the Interdisciplinary Team meeting to review the recommendations. Each resident's behaviors will be reviewed (looking at the number of episodes, if behaviors have increased or decreased, and reviewing the patterns of behaviors and the effective interventions. The team will submit the review and recommendation to the Physician/ Mental Health Provider for denial or agree for the reduction of the psychotropic medication. The Director of Nursing will keep the Consultant Pharmacy Recommendation forms in a binder. The Director of Nursing will follow up and check the recommendation answers and</p>		

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	<p>Documentation was lacking in regards to the physician having addressed a recommendation to decrease the dosage of Resident #17's Celexa.</p> <p>The facility's policy and procedure for Psychotropic Medication Dose Reduction read as follows: "...3. The consulting Pharmacist will review all records of residents receiving psychotropic drugs on a quarterly basis and will recommend gradual dose reduction to the primary care physicians when appropriate."</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 8/27/13 at 2:44 P.M., the ADON indicated that Resident #17's Buspar medication had not been looked at for a reduction since 10/24/11. The ADON indicated she had called the pharmacy consultant and there had been a recommendation to decrease the Celexa 40 mg 1 tablet everyday to Celexa to 20 mg one tablet everyday on 10/3/12. The ADON indicated the form with that recommendation could not be found in the clinical record. The ADON indicated the pharmacy consultant said they never received the return notification copy from the physician indicating his decision concerning the reduction of the Celexa.</p>		orders were written in the physician orders. Quality Assurance Each Quarter the Director of Nursing and Social Services will review the recommendations made and the reductions approved and the effectiveness of those reductions the Quality Assurance Meeting.				

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	<p>2. On 8/27/13 at 2 P.M., the clinical record of Resident #10 was reviewed. Diagnoses included, but were not limited to, the following: explosive disorder, mood disorder with psychosis and Alzheimer ' s Dementia.</p> <p>A care plan dated 7/8/13 addressed the following problem: Potential for side effects related to psychotropic drug use: psychotropic drug use: Depakote.</p> <p>The August 2013 MAR (medication administration record) indicated a start date of 3/7/12 for Depakote, 125 mg, 4 capsules twice a day.</p> <p>The monthly drug regimen review, for 2013, indicated in June 2013, the pharmacy recommendation had been to "decrease Depakote."</p> <p>A "Consultant Pharmacist Recommendation" form, date 6/11/13, indicated the following: "May we decrease Depakote to 3 bid (twice a day)? On 7/5/13, the Nurse Practioner (NP) responded "agree."</p> <p>A physician order, dated 7/5/13</p>						

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	<p>indicated the following: "DC (discontinue) Depakote 125 mg, 4 (capsules) bid (twice a day). depakote 125 mg 3 caps TID (three times a day)."</p> <p>The August 2013 MAR (medication administration record) indicated the following: Depakote 125 mg, 3 caps (capsules) 3 times daily. The order was dated 7/5/13.</p> <p>On 8/27/13 at 10:32 A.M., the DON (Director of Nursing) was interviewed. She indicated the resident originally had an order, dated 3/7/12, for Depakote 125 mg, 4 times a day (8 caps). The DON indicated the pharmacy recommendation indicated a decrease of the Depakote was recommended to 125 mg, 3 caps twice a day (6 caps). She indicated when the order was written on the physician order, the Depakote order was written for 3 caps, 3 times a day (9 caps). The DON indicated at the time, the resident was actually receiving more medication per day. She indicated the pharmacy didn't catch the error either, when they completed their monthly review on 8/7/13.</p> <p>On 8/27/13 at 11 A.M., the DON was interviewed. She provided copies</p>				

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	<p>requested and indicated at the time, she would notify the physician of the discrepancy that the med was increased instead of decreased.</p> <p>3.1-48(a)(2)</p>				

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F000431 SS=D	<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 facility failed to ensure medications were returned to the pharmacy and/or disposed of in a</p>	F000431	F432 DRUG RECORDS,LABEL/STORE DRUGS & BIOLOGICALS POLICY: It is the policy of CORE to ensure that discontinued	09/25/2013			

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	<p>timely manner for 3 of 3 residents whose medications were observed in the medication storage room. Resident #56, Resident #18, Resident #27</p> <p>Findings include:</p> <p>On 8/28/13 at 3:11 P.M., an observation of the medication storage room was completed. Located in a locked cabinet above the counter was a basket with medications which had been discontinued by the physician. The medications had remained in the facility longer than 7 days.</p> <ol style="list-style-type: none"> <li>1. Resident #56 had five tablets of Namenda 5 mg</li> <li>2. Resident #56 had fifteen tablets of Zolof 50 mg</li> <li>3. Resident #27 had seven tablets of Estradiol 2 mg</li> <li>4. Resident #18 had nineteen tables of Zyprexa 10 mg</li> <li>5. Resident #18 had one Advir 250/50/ Diskus inhaler</li> </ol> <p>During an interview with RN #5 on 8/29/13 at 3:12 P.M., RN 5 indicated she was not sure when the facility had to return the medication to pharmacy or destroy them.</p> <p>The facility's policy and procedure for</p>		<p>medications are returned to Pharmacy pr disposed of in a timely manner per CORE/Pharmacy Policy manual. RESIDENTS AFFECTED: Resident #56, Resident#18, Resident#27. These residents had medication changes and/or discontinued and shift nurse Sunday night took out of locked medication cart and put into a bind marked as "medications to return to pharmacy" in a locked cabinet in the locked medications room. Medications should have been counted, labeled, recorded in discontinued medications record, placed into pharmacy return crate for pick up on the afternoon delivery. SYSTEMIC CHANGES: Policy concerning medication disposition to be placed where it is available for all nurses to review and new nurses to be made aware of procedure. Nurses to be in serviced on Pharmacy/Core policies. Quality Assurance: Medication room/cabinets/carts to be audited weekly for 4 weeks then every 2 weeks for 2 weeks then monthly for 4 months. Education given for each and every deficient practice found during audits for the staff on duty or responsible.</p>		

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	<p>Disposal of Medication and Medication-Related supplies was reviewed on 8/29/13 at 3:45 P.M. The Policy and Procedure lacked the time frames in which a medication needed to be returned to the pharmacy or destroyed.</p> <p>During an interview with the Assistant Director of Nursing (ADON), the ADON indicated the medications needed to be returned to the pharmacy.</p> <p>3.1-25(r)</p>				

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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to ensure a</p>	F000441	F441 INFECTION CONTROL, PREVENT SPREAD/LINENS	09/25/2013			

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	<p>contagious skin condition was monitored and tracked in the facility's infection control program for 5 of 5 residents reviewed who had complaint of a rash. Resident # 2, Resident #4, Resident #10, Resident #24, and Resident #8</p> <p>Findings include:</p> <p>On 8/28/13 at 9:38 A.M., the Director of Nursing (DON) was interviewed regarding the facility's Scabies policy. She indicated she had started as the DON at the facility the first week of June 2013. She indicated at that time Resident #2, #4, #10, #24, and #8 had skin rashes with symptoms of itching noted. She indicated the skin rashes had been treated as Scabies. The facility's Scabies policy entitled "Policy regarding Scabies (no policy date)" indicated, "Scabies is an itch mite that burrows under the skin and lays eggs. It causes a pimple like rash that has intense itching..." She also indicated at that time Residents #2, #4, # 10, #24, and #8 had been treated for Scabies (June 2013). She indicated the rest of the facility's residents and staff had also been treated for Scabies (prophylactically) on 6/6/13 and then a 2nd follow up treatment also .</p>		<p>POLICY: It is the policy of CORE to maintain an Infection Control Program that is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. RESIDENTS AFFECTED: Resident#2, Resident#4, Resident#10, Resident#24, and Resident #8. SYSTEMIC CHANGES: Infection Control Programs Logs/Audit sheets revised to include specific skin infections, such as parasitic skin infections. QUALITY ASSURANCE: Skin infections to be tracked specifically and separately, for example parasitic, impetigo, abscesses, allergic reactions, etc. These will be included in reports at Quality Assurance Meeting.</p>				

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	<p>On 8/28/13 at 8:38 A.M., during interview with the DON, she indicated the skin rashes treated as Scabies had not been included in her infection control monthly logs. She indicated she had not been tracking or monitoring the skin rashes/Scabies infections in the facility infection control program as she had been other infections such as urinary tract infections, eye infections, etc.</p> <p>On 8/28/13 at 10:25 A.M., the DON was made aware of the need to track and monitor Scabies's infections in the facility's infection control program. The DON indicated at that time she would start including Scabies in the monitoring and tracking of infections in the facility infection control program.</p> <p>3.1-18(b)(1)(A)</p>						

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F009999	<p>3.1-14(t)(1): "At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin test should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure two of ten employee files reviewed had documentation of a second step tuberculin test was given in a time period of 1 to 3 weeks after the first test. Employee #1, Employee #2</p> <p>On 8/28/13 at 2:00 P.M., ten employee files were reviewed for documentation of tuberculin testing.</p>	F009999	<p>F999: POLICY: It is the policy of CORE that all new hires will get physical from Medical Director before starting on the floor or in their departments. It is the policy of CORE that at the time of employment, or within one month prior to employment, that all staff get Tuberculosis screening test with a follow up second step screening in 14 days from date the initial injection given. And then will continue to be screened yearly thereafter. Affected Employees: Employee #1 and employee#2. SYSTEMIC CHANGES: Inservice nurses on immunization policy for new hires. All new employee info such as Medical, physical, immunization, CXR, Mantoux, CPR, Licensing/certification copies will be kept in folder in nursing office and will not go into Reception office in a permanent employee file until all completed. A checklist will be designed and implemented. New employees will be added to "immunization due" calendar and daily monitoring of dates to ensure our compliance with state guidelines. QUALITY ASSURANCE: All new hires Immunization/ physical audits will be done per nursing weekly x 4 weeks; then every other week for 2 weeks then monthly for 6 months. If no deficiencies noted for the 6 monthly audits then new hire</p>	09/25/2013			

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	<p>1. Employee #1, a CNA, had a hire date of 7/31/13. Documentation indicated she had the tuberculin 1st step given on 7/29/13. Documentation was lacking in the employee's file of a 2nd tuberculin step at the time of review, which was greater than 4 weeks after the first test.</p> <p>2. Employee #2, a CNA, had a hire date of 5/24/13. Documentation indicated she had a 1st step tuberculin test on 5/28/13. Documentation was lacking of a 2nd tuberculin test in the required 1 to 3 weeks after the first tuberculin test. Documentation indicated an additional 1st step was then given on 7/11/13 and a 2nd step on 8/12/13 (not in 1-3 week required time period).</p> <p>The facility policy entitled, "Policy and Procedure, Administering, Reading &amp; Documenting the PPD Skin Test" was received and reviewed on 8/28/13 at 3:10 P.M. The policy included but was not limited to: "...If a second step is to be done this should be set up or written down on a calendar so that it is not missed. Second steps should be done 14 days after the first step...."</p>		checklists given to DON to review and place in folder for one year for accountability of staff who check these tests off.				

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	On 8/28/13 at 3:20 P.M., she indicated she was aware that employee #1 and #2 did not have 2nd step as in time period required.				