

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/20/2012
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NAME OF PROVIDER OR SUPPLIER  ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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F0000	<p>This visit was for Investigation of Complaint IN00103699.</p> <p>Complaint: IN00103699 - Substantiated - deficiencies related to the allegations are cited at F157, F225, F226, F282, F328, F425.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: February 16, 17 &amp; 20, 2012</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: NF: 127 Total: 127</p> <p>Census payor type: Medicaid: 126 Other: 1 Total: 127</p> <p>Sample: 4 Supplemental sample: 5</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/23/12 Cathy Emswiller RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review, the facility failed to ensure an interested family member or responsible party was notified of a change in condition, in that when dependent residents had a change in condition, the</p>	F0157	F157 Requires the facility to ensure that an interested family member or responsible party is notified of a change in condition, in that when dependent residents have a change in condition, the	02/27/2012	

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	<p>nursing staff failed to ensure the family member or responsible party were notified.</p> <p>In addition, the facility failed to promptly notify a resident's physician, in that when a resident began to display signs and symptoms of a significant change in condition, the nursing staff failed to promptly notify the resident's physician.</p> <p>This deficient practice effected 3 of 4 sampled resident's. [Residents "A", "B" and "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 02-16-12 at 12:30 p.m. Diagnoses included but were not limited to premature birth, cerebral palsy, profound mental retardation, seizure disorder, scoliosis, and developmentally delayed. These diagnoses remained current at the time of the record review.</p> <p>The nurses notes indicated the following occasions which lacked family notification of a change in the resident's condition:</p> <p>"12-08-11 at 3:50 p.m. Res. [resident] had a 5 minutes sz. [seizure] while at school. Staff use &lt;sic&gt; the VNS [vagal nerve</p>		<p>nursing staff will ensure that the family member or responsible party is notified. In addition, the facility will promptly notify a resident's physician, in that when a resident begins to display signs and symptoms of a significant change in condition. The facility will ensure this requirement is met through the following:1. Resident A, B, and C were not harmed. 2. All residents have a potential to be affected. The Nurse's notes were reviewed for concerns of notification. See below for corrective measures.3. The Family and Physician Notification policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure.4. The nurse on duty will contact the family and physician immediately if the resident has a change in condition. The nurses were inserviced on the above policy to ensure they know when it is warranted to call the physician and the family. The DON or his designee will read nurse's notes to ensure that family and physicians are notified timely with a change of condition with the residents and document their findings on the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained.</p>				

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	<p>stimulator] times two with improvement. Diastat &lt;sic&gt;add. Returned to facility at 11:57 a.m.. Has remained asleep all shift."</p> <p>"12-19-11 4:40 a.m. Noted poss. [possible] sz. act. [activity]. Writer in room. Sl. [slight] twitch trunk and face. HR [heart rate] 80 - 90's, SATS [oxygen saturation level] 99% on RA [room air], resp. [respirations] 20 &lt;sic&gt; res. 20 lasting &gt; [greater than] 2 mins. VNS swiped - negative. sz. act. 2 mins. [minutes] et [and] swiped again - positive [result]."</p> <p>"12-22-11 0640 [6:40 a.m.] Res. had seizure at 0336 [3:36 a.m.] Diastat [a medication used in the treatment of seizures] given as ordered. Seizure activity decreased et stopped in 10 minutes after PRN [as needed] medications."</p> <p>"01-04-12 2:00 p.m. Pt. [patient] brought back to facility from school due to sz. act. received by report."</p> <p>"01-06-12 6 - 2:00 p.m. 20 sec. [sz.] report received from High School positive effect with VNS swipe."</p> <p>"01-07-12 Temp increased 100.9 at 11:00 p.m. slight decrease 100.4 again 101.3. Tylenol at 2:00 a.m. decreased 98 at 2:30</p>		(See attachment B) The nurse on duty will contact the family and physician immediately if the resident has any change in condition immediately The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. The above corrective measures will be completed on or before February 27, 2012.				

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	<p>a.m. Quiet - was not able to determine cause of fever."</p> <p>"01-14-12 9:23 p.m. Noted poss. [possible] sz. act. 40 secs. res jerked throughout. starring spell eyes. Cried out. HR [heart rate] 70, increase 112. SATS 99 and decreased 92%, HR 106."</p> <p>"01-18-12 0650 (6:50 a.m.) At 0205 (2:05 a.m.) Res. had 10 min. [minute] sz. Diastat administered after 5 mins per [name of licensed nurse] et was effective. At 0516 (5:16 a.m.) res. had 2 min. seizure."</p> <p>The resident's family member was not notified of the seizure activity and the need for medication until 01-18-12 at 2:00 p.m.</p> <p>"01-19-12 7:00 a.m. 30 second seizure observed. VNS swiped with positive effect."</p> <p>"01-19-12 9:12 p.m. Noted poss. sz. act. vocal. increase HR 142. SAT 97 % decreased 88% lasting approx. [approximately] 1 min. VNS swiped with positive. BP 147/107, HR decreased 83."</p> <p>"01-25-12 at 9:00 p.m., the resident had an "axillary temperature of 100.7."</p>			

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	<p>"01-26-12 0640 (6:40 a.m.) T 98.2 ax. s/s [signs and symptoms PL [percutaneous inserted central catheter] with dry yellow drng [drainage]</p> <p>"01-26-12 7:30 p.m. axillary temperature of 99.8, HR 112" with "abdomen distended and sluggish bowel sounds." The nurse also indicated the resident had a large amount of "BM [bowel movement] noted in rectal vault with supp. [suppository] admin. [administered]."</p> <p>The next nurses note entry dated 01-26-12 at 11:00 p.m. indicated the resident now had a temperature of 101.3 axillary and Tylenol was administered."</p> <p>2. The record for Resident "B" was reviewed on 02-16-12 at 11:40 a.m. Diagnoses included but were not limited to premature birth, history of norovirus, status post anoxic brain injury, ventilator dependent, and hepatomegaly. These diagnoses remained current at the time of the record review.</p> <p>Review of the "Initial Inquiry Call," dated 11-29-11 and 12-05-11 indicated "caseworker will have us notify both C/W [caseworker] and parents of anything."</p> <p>Further review of the record and the</p>			

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	<p>annual resident review, dated 08-05-11, indicated the resident was a ward of the [named county] DCS [Department of Children Services] and the name of the current Case Manager/guardian with contact information provided. The recommendations in this review instructed as follows:</p> <p>"5. [Name of resident] would benefit from continued monitoring by case manager or other designated persons with [named county] DCS to help with future decisions regarding care and placements."</p> <p>A review of the Resident's face sheet / contact information indicated the name of telephone number of the Guardian as the primary contact person. The information page also indicated the Guardian "says please notify her and [underscored] parents of anything. Parents prefer former foster parents [names documented] not check on [resident]. Code for receiving information : 2010."</p> <p>A review of the nurses notes indicated the following:</p> <p>"12-13-11 6:30 a.m. Res. quiet with multiple episodes of stiffening with fine tremors et vent high pressureing &lt;sic&gt; with eyes rolled into back of head, will cont. [continue] to monitor."</p>			

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	<p>"12-17-11 6:50 a.m. Increased spasticity noted at approx. 6:15 a.m. During spastic spell HR 90 - 100, RR [respiratory rate] irregular with nasal flaring. Called [name of physician] at 6:35 a.m. N.O. [new order] Ativan [an antianxiety medication] .5 IM [intramuscularly] times 1 now. Given in right leg. Spasticity cont. [continued] off and on. Family notified. Will continue to monitor."</p> <p>"12-19-11 2:10 p.m. N.O. received per [name of physician] 1. DC [discontinue] previous fdg. [feeding]. 2. Peptamen [feeding formula] Jr. per tube via pump at 25 ml. [milliliters] per hour continuous. 6:50 p.m. [Family member] in to visit et voiced concerns regarding increased spasticity et asked for Ativan order. Paged [name of physician] et received N.O. for Ativan 0.5 mg per tube every 6 hours PRN [as needed] ... ."</p> <p>"12-20-11 11:30 p.m. Noted spastics episodes times 7. HR increased 100 - 110 bpm [beats per minute] during episode. Legs are up and shaking, eyes rolled back and flickering to the side. Episode lasts 45 - 60 seconds. PRN Ativan given at 10:45 p.m. and effective. Called [family member] and updated on spasticity."</p> <p>"01-15-12 6:00 a.m. Loose stools cont. [continue] buttock excoriated."</p>			

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	<p>"01-16-12 1:50 p.m. Buttocks remains excoriated. Will continue to monitor. 6:00 p.m. Res. coccyx conts. to be excoriated with open areas [name of physician] aware and received orders for 1. Rileys butt cream to coccyx Q [every] shift et PRN. 2. C-diff [clostridium difficile] culture times 1 [family member] aware of n.o. et voiced no concerns."</p> <p>"01-16-12 6:00 p.m. Temp. 100.2 ax. at 4:30 p.m. Ibuprofen given at 5:15 p.m. Will cont. to monitor temp."</p> <p>The resident was diagnosed with Clostridium Difficile on 01-20-12 and placed in contact isolation. "[Family member notified]." The nurses notes, dated 01-20-12 at 3:00 p.m. indicated "New orders per [name of physician]. Flagyl [a medication used in the treatment of c-diff infection] 60 mg per tube QID [four times a day] times 14 days - contact isolation, [family member] notified."</p> <p>The record, dated 01-26-12, indicated the resident was "seen in pulmonary clinic by [name of physician]" with the following recommendations. "Recommended a different trach. [tracheostomy] to be reviewed by [name of primary physician]." A further notation indicated the family member called to "check" on</p>			

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	<p>the resident at 3:00 p.m.</p> <p>A notation dated 02-06-12 at 12:00 a.m. indicated the resident "noted with increased spasticity, increased HR [150]. PRN Ativan given at 9:00 p.m. [Family member] called to check on pt. aware of PRN Ativan given. Reported to [family member] pt's buttocks conts. [continues] to be excoriated, frequent diaper changes and PRN Riley butt cream applied."</p> <p>"02-13-12 at 12:00 p.m. T [temp] 98.1 ax. at beginning of shift. T 103.3 ax 10:30 a.m. PRN Ibuprofen given at 10:15 a.m. Res. HR increased 170 - 180 et unable to bring HR down. RT [respiratory therapist] at bedside et states res. lungs course bilaterally RR [respiratory rate] 22 - 42. Trach changed per RT, 2 Albuterol [a respiratory medication] tx. bagged per RT without relief. Oxygen saturation level 93 %. [Name of physician] paged et received N.O. send to ER for tx. et eval. Left message for [family member]. Res. left via ambulance at 11:00 a.m." The notation further indicated the resident was subsequently transported to a hospital in Indianapolis and diagnosed with bilateral pneumonia, and when the family member called the facility to check on the resident at 5:45 p.m., was informed of the resident's condition, and also transported to the hospital.</p>				

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	<p>The record lacked information the appointed guardian was updated in regard to the ongoing condition of the resident or subsequent transportation and admittance to a hospital.</p> <p>3. The record for Resident "C" was reviewed on 02-17-12 at 9:15 a.m. Diagnoses included but were not limited to cerebral palsy, pneumonia, and seizures due to infection. These diagnoses remained current at the time of the record review.</p> <p>A review of the nurses notes indicated the resident began to display a change in condition on 12-13-11 at 2:30 p.m. The notes indicated "T [temperature] 99.6 ax. [axillary] Tylenol given at 8:30 for increased temp of 103.4 eff. [effective] T 98.2 ax. N.O. for 1. Levaquin 500 mg [an antibiotic] [milligrams] every day per g-tube [gastrostomy feeding tube] until cultures come in. 2. CBC [complete blood count] blood cultures. 3. UA [urinalysis] C &amp; S [culture and sensitivity], resting quietly at this time. O/P [output] 100, 98/42 [Blood pressure], Will continue to monitor."</p> <p>"12-13-11 10:00 p.m. [temperature] 104 ax. at 3:00 p.m. PRN Motrin given. re-check T 101.2 at 7:00 p.m. ... loose</p>			

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	<p>stools noted. Will continue to monitor."</p> <p>"12-14-11 6:45 a.m. At 12:00 a.m. T 98.9 ax. no seizure noted. no urine in bag, @ [at] 1:00 a.m. T 100.5 ax. Tylenol given B/P [blood pressure] 94/58 - pulse 145 - watery BM yellowish in color. Bottom red and cream applied. At 3:30 a.m. T 101.2 ax. tol repositioning - is lethargic - reacts to touch. 5:00 a.m., T 102 ax. Tylenol ordered - called to room as CNA [certified nurses aide] and RT [respiratory therapist] couldn't get BP and feet were bluish - placed feet on pillow, color illegible word - cath'd [catherized] for urine specimen @ 1:30 a.m. 75 c.c. very concentrated urine obtained - no urine in bag thru noc. [night] [name of physician] notified of inability to get BP and lethargy and small response at this time - order to send out per 911 - left with 911 attendants at 5:25 a.m. [Family member] and Director of Nurses notified."</p> <p>During interview on 02-17-12 at 11:30 a.m. the Director of Nurses verified the physician was not called until 5:00 a.m. regarding the decline in condition of the resident and the lethargy noted at 3:30 a.m.</p> <p>Further review of the nurses notes indicated the facility received information from a local area hospital who determined</p>			

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	<p>the resident had a "perforated bowel and not doing well."</p> <p>The nurses notes indicated the resident expired on 12-14-11 at 5:00 p.m.</p> <p>4. Review of facility policy on 02-17-12 at 8:30 a.m., titled "PHYSICIAN AND FAMILY NOTIFICATION PROCEDURE [bold type and underscored]," and dated 01-06 indicated the following:</p> <p>"PURPOSE [bold type]: To keep the physician, resident and family appraised of all condition changes."</p> <p>'PROCEDURE [bold type]: Family Notification: Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plans [bold type and underscored]. Unless otherwise specified by the resident's responsible party, the facility will notify the resident's responsible party of non-critical changes between the hours of 8:00 a.m. and 10:00 p.m. If there is a significant change in the resident's condition which warrants emergency medical intervention, notification will be made immediately regardless of the hour of the day."</p> <p>This Federal tag relates to IN00103699.</p>			

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	3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(4)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, the facility failed to ensure physician orders were followed, in that when a resident who had recently been discharged from a local area hospital, the facility failed to ensure the resident received the medications as ordered by the physician for 1 of 4 resident's sampled for medications in regard to antibiotics. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 02-16-12 at 12:30 p.m. Diagnoses included but were not limited to premature birth, cerebral palsy, profound mental retardation, seizure disorder, scoliosis, and developmentally delayed. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had recently been discharged from a local area hospital on 02-03-12, with diagnoses which included "Left elbow MRSA [methicillin resistant staphylococcus aureus], status post right upper extremity PICC [percutaneous inserted central</p>	F0282	F282 Requires the facility to ensure physician orders are followed, in that when a resident who has recently been discharged from a local hospital, the facility will ensure the resident receives the medications as ordered by the physician. The facility will ensure this requirement is met through the following. 1. Resident A was not harmed. 2. All residents have the potential to be harmed. An audit was completed to ensure all medications that were ordered per the physician was present to be given. See corrective measures below. 3. The Medication Unavailable for Administration policy and procedure was reviewed with no changes made. The nursing staff was inserviced on this policy. 4. The nurses on duty will ensure all medications are present in their cart to be given per the physician order. If a medication is within five days of running out, the nurses will pull the refill label and ensure that the medication is reordered. The medication will continue to be monitored until the refill is obtained. If the medication is not present, the pharmacy will be contacted so the	02/27/2012

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	<p>catheter] line placement, seizure disorder with vagal nerve stimulator and c. difficile [clostridium difficile] colitis."</p> <p>The discharge instructions included Vancomycin 250 milligrams per g-tube [gastrostomy feeding tube] every 6 hours for 10 days, and intravenous Vancomycin 750 mg per PICC every 6 hours times 7 days.</p> <p>Review of the nurses notes, dated 02-03-12 indicated the resident returned to the facility at 6:30 p.m.</p> <p>The next nurses note dated 02-04-12 at 6:30 a.m., indicated "Started IV Vancomycin at 12:00 a.m., Other meds did not come."</p> <p>A nurses note dated 02-04-12 at 6:30 p.m. indicated "Called pharmacy on call regarding vanc. [Vancomycin] per g-tube order. She [in reference to the pharmacy staff member] pulled order and says they've missed it. Apologized and will send out tomorrow."</p> <p>Review of the February Medication Administration Record, for 2012 indicated the resident had not received the prescribed physician ordered antibiotic for 10 doses.</p>		<p>medication so the medication can be called into the back up pharmacy so it can be given per order. The DON or his designee will audit the MAR and TAR daily to ensure all medications are present to be distributed per the physician order. The nursing monitoring tool will be utilized to conduct this audit daily times four weeks, then weekly times four weeks, then every two weeks times two months then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted.Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. The above corrective measure will be conducted on or before February 27, 2012.</p>		

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	<p>The nurses notes, dated 02-05-12 at 3:45 p.m. indicated the physician was notified about the pharmacy not supplying the prescribed medications, over 24 hours after the resident returned to the facility.</p> <p>This Federal tag relates to IN00103699.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services to attain the highest physical well being of a resident, in that the nurse failed to ensure the resident's condition warranted the treatment or intervention by the physician for lacked of a bowel movement. This deficient practice effected 1 of 3 residents sampled for bowel movements in a total sample of 4. [Resident "C"].</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 02-17-12 at 9:15 a.m. Diagnoses included but were not limited to cerebral palsy, pneumonia, and seizures due to infection. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident "suffers from chronic constipation due to neurological impairment secondary to cerebral palsy and the use of Phenobarbital [a seizure medication]</p>	F0309	F309 Requires the facility to provide the necessary care and services to attain the highest physical well being of a resident, in that the nurses are to ensure the resident's condition warrant the treatment or intervention by the physician for the lack of bowel movement. The facility will ensure this requirement is met through the following. 1. Resident C was not harmed. 2. All residents have the potential to be harmed. An audit was conducted to review resident's bowel records. See corrective measures below. 3. The Bowel Elimination policy and procedure was reviewed with no changes made. The nursing staff was inserviced on this policy. 4. The third shift nurse daily will review all bowel records and any resident who has not had a bowel movement per their bowel protocol will receive a medication that is prescribed by their physician. If there is no results, the physician will be contacted. If the resident is having bowel movements the results will be documented on the bowel movement record. The DON or	02/27/2012	

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	<p>calcium and Benzodiazepines."</p> <p>The nurses notes dated 11-17-11 at 2209 [10:09 p.m.] indicated the following:</p> <p>"...noted abd. [abdomen] dist. [distended] and no BM [bowel movement] times 5 days. Contacted MD [medical doctor]. N.O. [new order] Ped. [pediatric] enema now, one time. enema given tol. [tolerated] well."</p> <p>Review of the CNA [certified nurses aide] Assignment sheet indicated the following:</p> <p>"November 12, 2011 LG. [large] bowel movement, November 13, 2011 LG bowel movement, November 14, 2012 SM. [small] bowel movement, November 16, 2011 MD [medium] bowel movement, and November 17, 2011 SM [small] bowel movement."</p> <p>During interview on 02-17-12 at 11:00 a.m., the Director of Nurses verified the resident had bowel movements prior to the day the licensed nurse contacted the physician and the resident received the enema. "He [in reference to licensed nurse employee #12] should have checked the CNA sheets before he did anything."</p> <p>3.1-37(a)</p>		<p>his designee will audit the bowel records daily times four weeks, then weekly times for weeks, then every two weeks times two months then quarterly thereafter until compliance is maintained to ensure that resident's bowel regimen is followed. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. the above corrective measure will be conducted on or before February 27, 2012.</p>		

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a resident's PICC [percutaneous inserted central catheter] Line was intact, in that when a dependent resident who had a PICC line was transported to a local area hospital for laboratory testing, the resident's catheter was found unclamped and lacking the required cap by the Emergency Room Nurse. The catheter was removed due to contamination for 1 of 1 residents with a PICC line in a sample of 4. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 02-16-12 at 12:30 p.m. Diagnoses included but were not limited to premature birth, cerebral palsy, profound mental retardation, seizure disorder, scoliosis, and developmentally delayed. These diagnoses remained</p>	F0328	F328 Requires the facility to ensure a resident's PICC line is intact, in that when a dependent resident who had a PICC line is transported to a hospital has their catheter clamped and with the required cap. The facility will ensure this requirement is met through the following.1. Resident A was not harmed. 2. All residents who has a PICC line has a potential to be affected. Currently there is no residents with a PICC line in the facility.3. The PICC policy and procedure was reviewed with no changes made. (See attachment H) The staff was inserviced on the above procedure.4. The nurses every shift will ensure that the catheter is clamped and capped. Another set of filters were placed by the bedside to ensure if it is found uncapped that one is applied immediately. The DON or his designee will conduct rounds to ensure the catheter is clamped and ensure the required cap is placed if a resident is to obtain a	02/27/2012			

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	<p>current at the time of the record review.</p> <p>The record indicated the resident had a PICC line.</p> <p>The nurses notes indicated the resident was transported to a local area hospital on 02-09-12 for laboratory testing.</p> <p>Review of the Emergency Room report, dated 02-09-12 indicated the resident arrived at the emergency room for an ED [emergency department] seizure medicine levels secondary to more frequent seizures while taking antibiotics. The physician included an "incidental note" of the right PICC line "with two ports, one of which was open to air with no cap. Unsure of duration of time that this was open. It was immediately clamped by nursing."</p> <p>Review of the RN [Register Nurse] documentation on 02-09-12 who worked in the Emergency department, indicated "called and spoke with [name of individual] at EKids. Informed her of [name of another RN] discovery that cap from one of PICC line ports was not in place and line was not clamped. This was discovered upon arrival to ED. Informed [name of facility staff member] that PICC line was pulled by [name of physician] per [name of primary physician]</p>		<p>PICC line and document their findings on the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. The above corrective measures will be completed on or before February 27, 2012.</p>				

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	<p>recommendation. [Nurse at facility] stated understanding."</p> <p>The hospital instruction sheet as sent to the facility indicated the PICC line had been "contaminated."</p> <p>During interview on 02-17-12 at 1:45 p.m., the Director of Nurses indicated he was alerted that the cap(s) to the PICC line were missing. He indicated he immediately retrieved new caps and instructed the nurse employee #3 to replace them. During a telephone interview on 02-17-12 at 1:50 p.m., licensed nurse employee #3 verified the Director of Nurses provided her with two caps for the PICC line. When further interviewed licensed nurse employee #3 indicated she had not placed the caps on the PICC line because the resident had already left with the ambulance crew. Licensed nurse employee #3 indicated she gave the caps to [name of licensed nurse employee #4] because licensed nurse employee #4 "relieved her."</p> <p>The Director of Nurses further indicated he spoke with the physician at the hospital emergency department and was informed the PICC line did not have a cap on one line and they had to pull the PICC line due to the possibility of contamination. "The risk was too great to leave the PICC</p>				

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	line in the resident."  This Federal tag relates to IN00103699.  3.1-47(a)				

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F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review, the facility failed to ensure a resident received medication as ordered by the physician, in that when a resident who had recently been discharge from a local area hospital, the facility failed to ensure the resident's received the medications as ordered by the physician for 1 of 4 resident's sampled for medications in regard to antibiotics. [Resident "A"].</p> <p>This deficient practice had the potential to effect 127 residents in the facility.</p> <p>Findings include:</p>	F0425	F425 Requires the facility to ensure a resident receives medication as ordered by the physician, in that when a resident is discharged from a hospital, the facility is to ensure the resident received the medications as ordered by the physician. The facility will ensure this requirement is met through the following. 1. Resident A was not harmed. 2. All residents have the potential to be harmed. An audit was completed to ensure all medications that were ordered per the physician was present to be given. See corrective measure below. 3. The Medications Unavailable for	02/27/2012	

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	<p>The record for Resident "A" was reviewed on 02-16-12 at 12:30 p.m. Diagnoses included but were not limited to premature birth, cerebral palsy, profound mental retardation, seizure disorder, scoliosis, and developmentally delayed. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had recently been discharged from a local area hospital on 02-03-12, with diagnoses which included Left elbow MRSA [methicillin resistant staphylococcus aureus], status post right upper extremity PICC [percutaneous inserted central catheter] line placement, seizure disorder with vagal nerve stimulator and c. difficile [clostridium difficile] colitis.</p> <p>The discharge instructions included Vancomycin 250 milligrams per g-tube [gastrostomy feeding tube] every 6 hours for 10 days, and intravenous vancomycin 750 mg per PICC every 6 hours times 7 days.</p> <p>Review of the nurses notes, dated 02-03-12 indicated the resident returned to the facility at 6:30 p.m.</p> <p>The next nurses note dated 02-04-12 at 6:30 a.m., indicated "Started IV</p>		<p>Administration policy and procedure was reviewed with no changes made. (See attachment F) The nursing staff was inserviced on this policy. 4. The nurses on duty will ensure all medications are present in their cart to be given per physician order. If a medication is within five days of running out, the nurses will pull the refill label and ensure that the medication is reordered. If the medication is not present to be given, the pharmacy will be contacted so the medication can be called into the back up pharmacy and given per order. The DON or his designee will audit the MAR and TAR daily to ensure all medications are present to be distributed per the physician order. The nursing monitoring tool will be utilized to conduct this audit daily times four weeks, then weekly times four weeks, then every two weeks times two months then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will</p>	

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	<p>Vancomycin at 12:00 a.m., Other meds did not come."</p> <p>A nurses note dated 02-04-12 at 6:30 p.m. indicated "Called pharmacy on call regarding vanc. [Vancomycin] per g-tube order. She [in reference to the pharmacy staff member] pulled order and says they've missed it. Apologized and will send out tomorrow."</p> <p>Review of the February Medication Administration Record, for 2012 indicated the resident had not received the prescribed physician ordered antibiotic for 10 doses.</p> <p>The nurses notes, dated 02-05-12 at 3:45 p.m. indicated the physician was notified about the pharmacy not supplying the prescribed medications, over 24 hours after the resident returned to the facility.</p> <p>A review of the Pharmacy Contract, "Services Agreement," "Provision of Services and Obligations of IPS [Innovative Pharmacy Solutions] [bold type] indicated the following:</p> <p>"In consideration for the compensation to be paid IPS as provided for in this Agreement, IPS agrees to provide directly the following specific pharmacy services to Facility the during term of this</p>		<p>be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. The above corrective measure will be conducted on or before February 27, 2012.</p>		

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	<p>Agreement. This Agreement is intended to meet the requirements of IPS provisions of the Privacy Standards and will govern the terms and conditions under which IPS may use, disclose or have disclosed to it, Protected Health Information on behalf of Covered Entity."</p> <p>"1.1 IPS shall comply with the Facility resident's plan of treatment."</p> <p>This Federal tag relates to IN00103699.</p> <p>3.1-45(a)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and safeguarded, in that when a resident had specific orders related to laboratory testing and when residents required the services of respiratory services, the facility failed to ensure the records were safeguarded and contained the physician ordered laboratory testing for 1 of 4 sampled resident's and residents who required the services of respiratory services. [Resident "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 02-17-12 at 11:50 a.m. Diagnoses included but were not limited to diabetes insipidus, cerebral palsy, with agitation, and a seizure disorder. These</p>	F0514	F514 Requires the facility to ensure resident records are complete and safeguarded, in that when a resident have specific orders to a laboratory test and when residents require the services of respiratory services, the facility will ensure records are safeguarded and contained the physician ordered laboratory testing. The facility will ensure this requirement is met through the following. 1. Resident D was not harmed. 2. All residents have the potential to be harmed. Labs were filed on the chart. Respiratory documentation were secured and will be computerized as of March 1, 2012. See corrective measures below. 3. The physician orders policy and procedure and the Storage/Maintenance of Nurse's Notes, Monthly Tracking Records and/or resident observation records were reviewed with no	02/27/2012			

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	<p>diagnoses remained current at the time of the record review.</p> <p>The current physician rewrite and medication administration record for February 2012 instructed the nursing staff "Sodium level every Monday and Thursday."</p> <p>The laboratory/testing section of the resident's record contained laboratory results dated January 2, 5, 9 and 12, 2012.</p> <p>When interviewed on 02-17-12 at 2:00 p.m., the Director of Nurses was not aware the results after the January 12, 2012 laboratory report were not in the resident record.</p> <p>On 02-20-12 at 8:30 a.m., the Director of Nurses provided the documentation and indicated the results were faxed to the facility from the local area hospital. "The doctor can get into the hospital computer and review the labs when he is over there. We just didn't have them in the chart."</p> <p>In addition, multiple physician telephone/verbal orders taken by the nursing staff lacked the "time" the physician order was received. The order dates included 01-16-12, 02-13-14, 02-12-12 and two orders dated 02-15-12.</p>		<p>changes made.(See attachment I and J) The nursing staff was inserviced on this policy. 4. Once labs are received and the physicaian is contacted, the nurse on duty will immediately file the lab in the chart. The respiratory documentation is secured in the computer system at all times and is only assessible to staff. The DON or his designee will audit to ensure labs are placed on the charts immediately after the physican is contacted, ensure that physician orders are times and dated and that respiratory records are secured daily times four weeks, then weekly times four weeks, then every two weeks times two months then quarterly thereafter until compliance is maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly if warranted. Aforementioned auditing/monitoring will continue quarterly ongoing and results presented to the Quality Assurance Committee. Should evidence of consecutive continued 100% compliance be evident for three meetings , it will be at the discretion of the Quality Assurance Committee to continue quarterly monitoring as a preventative measure or to cease said monitoring. 5. The above corrective measure will be conducted on or before February</p>				

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	<p>2. During observation on 02-16-12 at 12:45 p.m., the record for Resident "A" was requested. An unidentified staff nurse staff indicated they were unable to find the record for Resident "A". At 1:00 p.m., numerous chart racks were observed in the hallways for the vent unit as well as south front units #1 and #2. During this observation the Assistant Director of Nurses approached and indicated the records contained within the chart racks were the respiratory therapist resident records. The records/chart racks had been left unattended and the records were not safeguarded.</p> <p>3. Review of facility policy on 02-20-12 at 9:00 a.m. indicated "Procedures [bold type] 1. Document each drug order in the resident's clinical records with the date, time and signature of the person receiving the order."</p> <p>3.1-50(a) 3.1-50(d)</p>		27, 2012.		