

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: April 29 , 30, May 1, 2, and 3, 2013</p> <p>Facility number: 000326 Provider number: 155430 AIM number : 100290770</p> <p>Survey team: Debora Kammeyer, RN-TL April 29, 30, May 1, 2, and 3, 2013 Lora Swanson, RN April 29, 30, May 1, 2, and 3, 2013 Julie Wagner, RN April 29, 30, May 1, and 2, 2013</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census Payor Type: Medicare: 2 Medicaid: 23 Private: 6 Other: 2 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly.</p> <p>This Plan of Correction is submitted to meet the requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective June 2, 2013.</p>	
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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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	Quality Review completed in May 9, 1013, by Brenda Meredith, R.N.			

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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 record review and</p>	F000225	F 225 This plan of	06/02/2013			

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	<p>interview, the facility failed to ensure an allegation of abuse was reported timely to the Administrator and thoroughly investigated for 1 of 1 allegation of abuse reviewed. (Resident #5)</p> <p>Finding includes:</p> <p>On 5/1/13 at 10:30 A.M., an allegation of abuse for Resident #5 was reviewed. The allegation was provided by the Administrator.</p> <p>Review of the incident report dated 3/29/13 at 1:30 P.M., indicated "Both residents were sitting in the foyer area of the facility. Employee #2 observed Resident #20 touching Resident #5's right breast through her clothing. "</p> <p>Review of the investigation of the allegation, indicated Employee # 2 reported to the Director of Nursing (DON), on 3/29/13 at 1:30 P.M., that both residents were out of Employee #2's direct line of site for a short period of time (approximately one minute). When Employee #2 returned, she found Resident #20 moving his hand over Resident #5's right breast over her clothing. During the course of the investigation it was discovered that a similar incident may have occurred on 3/28/13.</p>		<p>correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 6/2/13. <u>What corrective action will be done by the facility?</u> Resident #5 was immediately separated from Resident #20 and placed in a separate supervised area. Resident #5 was examined by nursing staff on 3/30/13 for any signs of injury. Since that time, the resident has been monitored for any signs or symptoms of injury or distress due to this incident – at no time have any been observed or identified. Resident #20 was seen by the facility's psych services provider, as well. Care plans for both #5 and #20 have been reviewed and updated to include new interventions. The CNA assignment sheets have been updated to include any new interventions. The Director of Nursing received a written disciplinary action for her lack of immediate response to the CNA's reports of alleged abuse. The Administrator has reviewed the</p>				

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	<p>Review of the written statement made by Employee #4 on 3/30/13, indicated "I Employee # 4 saw on the day of March 28th at 1:00, Resident #20 a resident touching Resident #5's breast. I went to help clean therapy room up after lunch, the cook Employee #6 said to me...look he's playing with her. I looked over to see Resident #20 touching Resident #5's breast. She was in front entryway looking out the glass doors, Resident #20 was sitting in red chair leaning up next to her touching her breast. I told him to stop he jerked his hand away, I took Resident #5 up front to nurse station, and found the D.O.N. and told her what happened. She replied to me...ok, so I left it at that thinking she would report the situation, later to find out she did not."</p> <p>Review of the written statement made by Employee #2 on 3/30/13, indicated "On 3/29/13 I witnessed Resident #20 fondling Resident #5's right chest. I said Resident #20 what are you doing? Resident stated 'Playing with her titty.' I told Resident to stop and it was inappropriate and asked him to go to his room. I took Resident #5 to her room. I reported the incident to Employee #7 who instructed me to report it to the DON, which I did</p>		<p>facility's policy and procedure with the DON regarding abuse, neglect, and misappropriation of property, including the need for immediately reporting such allegations to the Administrator and the need for making sure that the safety of the residents involved is addressed as soon as the incident is discovered and reported. All staff will be re-trained by 6/2/13 on the facility's policy and procedure for abuse, neglect, and misappropriation of property and the requirement that the Administrator is notified immediately of any such allegations. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice; however, there have been no other reports or allegations of abuse, neglect, or misappropriation of property since the survey. In the future, if any allegation of abuse is received by a supervisor or department manager, he/she will notify the Administrator immediately and will make sure that the residents involved are safe. Once that is done, the Administrator will initiate an investigation. If any concerns are identified regarding staff practice in regards to the allegations or reporting of them, the Administrator and/or</p>		

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	<p>immediately. The DON said 'ok we will keep an eye on him.'"</p> <p>Review of the written statement made by Employee # 7 on 3/30/13, indicated "Employee #2 informed writer of an incident between Resident #5 and Resident #20. Writer asked Employee #2 to speak with DON immediately. After Employee #2 left my office I went to speak with Resident #20. I found Resident in his room with the door closed. Writer asked to enter the room he stated yes writer asked resident if he was touching a woman he stated yes. Writer asked resident if he had permission he stated 'yes'. Writer asked him how he got permission resident stated she told me I could. Writer explained that was impossible she can not talk. Resident stated yes she can. Writer again reaffirmed resident could not give permission and he does not have permission. Writer was very firm in explaining how inappropriate his actions were and that even the police could be called. Resident stated writer was mean. Writer had resident repeat what he was told about his actions being inappropriate and he was able too. Conversation reported to DON. Resident to be observed."</p>		<p>Department Manager will re-train the staff involved regarding the facility policy and procedure for allegations of abuse, neglect, and misappropriation of property. Progressive disciplinary action will be rendered, as well, for instances of noncompliance. <u>What measures will be put into place to ensure that this practice does not recur?</u> Any allegations of abuse, neglect, or misappropriation of property will be brought to the Administrator immediately as outlined previously. In addition, the DON will review the focus charting, 24 hour report, and incident reports at the beginning of her tour of duty. The results of these reviews, as well as any allegations of abuse, neglect, or misappropriation of property that have been reported to the team members and the Administrator will be brought to the next scheduled morning interdisciplinary management meeting that meets at least 5 days a week for review and discussion by the interdisciplinary team. Any changes or additions to interventions for the involved residents will be followed up by the DON, Social Worker, or other designated department manager. The DON will make sure that these recommendations are put on the 24 hour report for communication to the other shifts of nursing - she will also make sure that the C.N.A. assignment</p>		

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	<p>On 5/1/13 at 12:20 P.M., an interview with the Director of Nursing indicated "On 3/29/13 Resident #20 had his hand on Resident # 5's breast while both were sitting in the front lobby. Employee #2 reported this incident to me on 3/29/13. When the investigation was started on 3/30/13, I found out a similar incident might have occurred on 3/28/13. No incident report was completed on 3/28/13. Employee # 4 stated that she informed me of the incident occurring on 3/28/13 but I do not remember that conversation occurring. The Administrator called me at home on 3/30/13 to ask me if an incident occurred on 3/28/13, this was the first time I remember hearing about this."</p> <p>On 5/1/13 at 12:40 P.M., an interview with the administrator indicated, "The Director of Nursing interpreted this incident as a report of a behavior and not as an allegation of abuse so therefore did not report it to me. I found out about the incident, on 3/30/12 around 12:00 P.M., and immediately started an investigation. During the course of my investigation Employee #4 indicated she had observed a similar incident on 3/28/13, and reported it to the DON, but the DON again felt it was a report</p>		<p>sheets are updated accordingly. If any concerns are identified as part of the investigation regarding staff involvement or response to the incident itself, these will be addressed as outlined in question #2. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the investigations done for allegations of abuse, neglect, or misappropriation of property to the monthly QA Committee. The DON will also bring the results monthly of her reviews that have been brought to the morning meetings for further review and process improvement by the QA Committee. The DON or other designated department manager will be responsible for following up any recommendations made by the QA Committee and for reporting the results of those recommendations to the next scheduled QA Committee meeting. This process will continue on an ongoing basis. Date of Compliance: 6/2/13</p>				

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	<p>of a behavior and not an allegation of abuse so a report was not made."</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 record review and interview, the facility failed to ensure their abuse prevention protocol was implemented related to reporting and investigating allegations of abuse to the Administrator and other state agencies for 1 of 1 allegation of abuse reviewed. (Resident #5)</p> <p>Finding includes:</p> <p>On 5/1/13 at 10:30 A.M., an allegation of abuse for Resident #5 was reviewed. The allegation was provided by the Administrator.</p> <p>Review of the incident report dated 3/29/13 at 1:30 P.M., indicated "Both residents were sitting in the foyer area of the facility. Employee #2 observed Resident #20 touching Resident #5's right breast through her clothing. "</p> <p>Review of the investigation of the allegation, indicated Employee # 2 reported to the Director of Nursing (DON), on 3/29/13 at 1:30 P.M., that both residents were out of Employee</p>	F000226	<p>F 226 This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 6/2/13. <u>What corrective action will be done by the facility?</u> Resident #5 was immediately separated from Resident #20 and placed in a separate supervised area. Resident #5 was examined by nursing staff on 3/30/13 for any signs of injury. Since that time, the resident has been monitored for any signs or symptoms of injury or distress due to this incident – at no time have any been observed or identified. Resident #20 was seen by the facility's psych services provider, as well. Care plans for both #5 and #20 have been reviewed and updated to include new interventions. The CNA</p>	06/02/2013			

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	<p>#2's direct line of site for a short period of time (approximately one minute). When Employee #2 returned, she found Resident #20 moving his hand over Resident #5's right breast over her clothing. During the course of the investigation it was discovered that a similar incident may have occurred on 3/28/13.</p> <p>Review of the written statement made by Employee #4 on 3/30/13, indicated "I Employee # 4 saw on the day of March 28th at 1:00, Resident #20 a resident touching Resident #5's breast. I went to help clean therapy room up after lunch, the cook Employee #6 said to me...look he's playing with her. I looked over to see Resident #20 touching Resident #5's breast. She was in front entryway looking out the glass doors, Resident #20 was sitting in red chair leaning up next to her touching her breast. I told him to stop he jerked his hand away, I took Resident #5 up front to nurse station, and found the D.O.N. and told her what happened. She replied to me...ok, so I left it at that thinking she would report the situation, later to find out she did not."</p> <p>Review of the written statement made by Employee #2 on 3/30/13, indicated, "On 3/29/13 I witnessed</p>		<p>assignment sheets have been updated to include any new interventions. The Director of Nursing received a written disciplinary action for her lack of immediate response to the CNA's reports of alleged abuse. The Administrator has reviewed the facility's policy and procedure with the DON regarding abuse, neglect, and misappropriation of property, including the need for immediately reporting such allegations to the Administrator and the need for making sure that the safety of the residents involved is addressed as soon as the incident is discovered and reported. All staff will be re-trained by 6/2/13 on the facility's policy and procedure for abuse, neglect, and misappropriation of property and the requirement that the Administrator is notified immediately of any such allegations. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice; however, there have been no other reports or allegations of abuse, neglect, or misappropriation of property since the survey. In the future, if any allegation of abuse is received by a supervisor or department manager, he/she will notify the Administrator immediately and</p>				

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	<p>Resident #20 fondling Resident #5's right chest. I said Resident #20 what are you doing? Resident stated 'Playing with her titty.' I told Resident to stop and it was inappropriate and asked him to go to his room. I took Resident #5 to her room. I reported the incident to Employee #7 who instructed me to report it to the DON, which I did immediately. The DON said 'ok we will keep an eye on him.'"</p> <p>Review of the written statement made by Employee # 7 on 3/30/13, indicated "Employee #2 informed writer of an incident between Resident #5 and Resident #20. Writer asked Employee #2 to speak with DON immediately. After Employee #2 left my office I went to speak with Resident #20. I found Resident in his room with the door closed. Writer asked to enter the room he stated yes writer asked resident if he was touching a woman he stated yes. Writer asked resident if he had permission he stated 'yes.' Writer asked him how he got permission resident stated she told me I could. Writer explained that was impossible she can not talk. Resident stated yes she can. Writer again reaffirmed resident could not give permission and he does not have permission. Writer was very firm in explaining how</p>		<p>will make sure that the residents involved are safe. Once that is done, the Administrator will initiate an investigation. If any concerns are identified regarding staff practice in regards to the allegations or reporting of them, the Administrator and/or Department Manager will re-train the staff involved regarding the facility policy and procedure for allegations of abuse, neglect, and misappropriation of property. Progressive disciplinary action will be rendered, as well, for instances of noncompliance. <u>What measures will be put into place to ensure that this practice does not recur?</u> Any allegations of abuse, neglect, or misappropriation of property will be brought to the Administrator immediately as outlined previously. In addition, the DON will review the focus charting, 24 hour report, and incident reports at the beginning of her tour of duty. The results of these reviews, as well as any allegations of abuse, neglect, or misappropriation of property that have been reported to the team members and the Administrator will be brought to the next scheduled morning interdisciplinary management meeting that meets at least 5 days a week for review and discussion by the interdisciplinary team. Any changes or additions to interventions for the involved residents will be followed up by</p>		

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	<p>inappropriate his actions were and that even the police could be called. Resident stated writer was mean. Writer had resident repeat what he was told about his actions being inappropriate and he was able too. Conversation reported to DON. Resident to be observed."</p> <p>Review of the current policy revised on 9/2010, titled "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property" received from the Administrator indicated, "...All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately...The facility has a designated employee/supervisor of each shift/tour of duty responsible for the initial reporting and investigation of allegations of mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion, injuries of unknown or unwitnessed etiology or significant injuries. The designated employee will communicate all investigation information to the administrator, who</p>		<p>the DON, Social Worker, or other designated department manager. The DON will make sure that these recommendations are put on the 24 hour report for communication to the other shifts of nursing – she will also make sure that the CNA assignment sheets are updated accordingly. If any concerns are identified as part of the investigation regarding staff involvement or response to the incident itself, these will be addressed as outlined in question #2. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the results of the investigations done for allegations of abuse, neglect, or misappropriation of property to the monthly QA Committee. The DON will also bring the results monthly of her reviews that have been brought to the morning meetings for further review and process improvement by the QA Committee. The DON or other designated department manager will be responsible for following up any recommendations made by the QA Committee and for reporting the results of those recommendations to the next scheduled QA Committee meeting. This process will continue on an ongoing basis. Date of Compliance: 6/2/13</p>		

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	<p>will determine further action...."</p> <p>On 5/1/13 at 12:20 P.M., an interview with the Director of Nursing indicated "On 3/29/13 Resident #20 had his hand on Resident # 5's breast while both were sitting in the front lobby. Employee #2 reported this incident to me on 3/29/13.</p> <p>When the investigation was started on 3/30/13, I found out a similar incident might have occurred on 3/28/13. No incident report was completed on 3/28/13. Employee # 4 stated that she informed me of the incident occurring on 3/28/13 but I do not remember that conversation occurring. The Administrator called me at home on 3/30/13 to ask me if an incident occurred on 3/28/13, this was the first time I remember hearing about this."</p> <p>On 5/1/13 at 12:40 P.M., an interview with the administrator indicated, "The Director of Nursing interpreted this incident as a report of a behavior and not as an allegation of abuse so therefore did not report it to me. I found out about the incident, on 3/30/12 around 12:00 P.M., and immediately started an investigation. During the course of my investigation Employee #4 indicated she had observed a similar incident on 3/28/13</p>			

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	and reported it to the DON, but the DON again felt it was a report of a behavior and not an allegation of abuse so a report was not made." 3.1-28(a)			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to ensure a care plan was initiated regarding insomnia for 1 of 10 residents (Residents #11) reviewed for unnecessary medications. In addition, the facility failed to ensure a care plan regarding anxiety was developed for 1 of 10 residents reviewed for unnecessary medications. (Resident #11)</p> <p>Finding includes: The clinical record for Resident #11</p>	F000279	<p><u>F 279</u> It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, including anxiety issues and possible adverse side effects that the resident might experience when taking psychotropic medication. <u>What corrective action will be done by the facility?</u> In reviewing the medical record for Resident #11, a care plan dated 6/17/12 was</p>	06/02/2013			

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	<p>was reviewed on 05/02/13 at 1:00 P.M. Resident #11 was admitted to the facility, on 07/30/10, with diagnoses, including but not limited to, paranoid schizophrenia, bipolar disorder, anxiety, insomnia, osteoporosis, hypertension, malaise and fatigue, hyperlipidemia, COPD,(chronic obstructive pulmonary disease) urine retention, CHF (congestive heart failure), and hypopotassium</p> <p>The physician orders for medication for May 2013 included orders for the medications,Zyprexa (an antipsychotic), Trazadone (an antidepressant), and Ativan (an antianxiety medication).</p> <p>A physician's note, dated 03/11/13 , indicated the following: "It is clinically contraindicated to reduce the current doses of Ativan .5 mg [milligrams] q [every] hs [hour of sleep], Zyprexa 10 mg qd [daily] and Trazodone 50 mg q hs since these are the lowest, most effect doses to treat this resident's schizophrenia, insomnia, anxiety and bipolar disorder. Gradual dose reductions should not be attempted due to her behaviors. At this time, any attempt at drug reduction would not be in the resident's best interest and will not be attempted."</p>		<p>located for monitoring for adverse effects of the Ativan use. A clarification order was received from the primary care doctor for Resident #11. The physician discontinued the insomnia diagnosis since it is not an issue at this time. Resident #11's care plans have been reviewed by the interdisciplinary team and have been updated with interventions to address the resident's anxiety issues as well as the monitoring for any adverse side effects of the psychotropic drugs that the resident is taking. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents receiving psychotropic medications or who have psychiatric diagnoses have the potential to be affected by this practice. The Director of Nursing audited all residents' medical records to ensure that residents with psychiatric diagnoses had care plans in place to address any issues that correlate to the use of psychotropic medications ordered for each resident. Care plans were also checked to make sure that they address any adverse side effects that the resident might experience due to taking psychotropic drugs. No other problems were identified. If, however, the DON or other interdisciplinary team member finds that a resident's care plans are not inclusive of the reasons</p>				

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	<p>Review of the current health care plans for Resident #11, reviewed on 02/27/13, indicated there was no specific plan to address the resident's anxiety issues or the resident's insomnia. There were care plans to address any adverse side effects the resident might experience due to taking the ativan and the desyrl.</p> <p>Interview with CNA #5 and 6, on 05/02/13 at 1:45 P.M., indicated Resident #11 did not exhibit any real behaviors recently but they knew to watch the resident for agitation issues and constipation issues.</p> <p>There was no plan to address the resident's anxiety issues or insomnia issues.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>		<p>for a resident receiving psychotropic drugs or monitoring activities for adverse side effects of taking prescribed psychotropic drugs, he/she will notify the interdisciplinary team. The resident's care plan will be brought to the next scheduled morning clinical interdisciplinary team meeting which occurs at least 5 days a week for review by the team members and development of appropriate care plans and interventions to address the identified issues. The DON will make sure that the new interventions are put on the 24 hour report so that oncoming shifts are aware of any changes, and she will update the C.N.A. assignment sheets to reflect the change in interventions. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or designee will review the focus charting, 24 hour nursing report, and all new physician orders during her tour of duty which occurs at least five times a week to identify any new psychiatric diagnoses and/or psychotropic medication changes. She will bring any identified changes to the next scheduled morning clinical interdisciplinary meeting. Care plans and interventions will be reviewed and developed as indicated in question #2. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put</u></p>		

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			<p><u>into place?</u> The DON will bring the results of her reviews to the monthly QA&A Committee meeting for further review and recommendation. Any recommendations made by the committee will be followed up by the DON and the results of implementing those recommendations will be brought back to the next scheduled QA Committee meeting for discussion and further process improvement if needed. This will continue on an ongoing basis. Date of Compliance: 6/2/13</p>	

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F000323 SS=E	<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, and interviews the facility failed to ensure the mattresses fit the bedframes and were free of gaps for 3 residents who met the criteria. (Residents #39, #5, #1)</p> <p>Findings include:</p> <p>1. Observation of the bed for Resident #39, on 04/29/13 at 1:30 P.M., indicated the bed mattress was noted to be too short for the bed frame. There was a gap, greater than 4 3/4 inches noted between the top of the mattress and the head of the bed frame. On 04/30/13 at 2:15 P.M., the gap remained between the mattress and the bed frame for Resident #39. There were some loosely rolled up lap robes placed between the bottom of the bed and the bottom of the mattress, however, the rolled up lab robes had fallen down against the bed frame holding the mattress and were no substantial enough to have prevented the mattress from sliding down to the end of the foot board.</p>	F000323	<p>F323 It is the policy of this facility that the resident environment remains free of accident hazards as is possible and that mattresses fit the bed frames and are free of gaps. <u>What corrective action will be done by the facility?</u> An environmental tour was conducted. All mattresses that were found not to fit appropriately were replaced. 25 new mattresses were totally replaced on 05/01/2013. 4 Bolsters were ordered to fit the beds where residents preferred to keep their mattresses. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> After an environmental tour of the facility, it was found that 23 resident mattresses did not fit the bed frames, and were not free from gaps. Immediately upon this finding, the Administrator called the mattress supplier and placed an order for 25 mattresses to replace the 21 resident mattresses as well as the 4 unoccupied facility beds. Because the mattresses could not be shipped for next day delivery, staff was inserviced and</p>	05/14/2013

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	<p>The clinical record for Resident #39 was reviewed on 05/01/13. Review of the most recent quarterly MDS (minimum data set) assessment for Resident #39, completed on 03/01/13, indicated the resident limited staff assistance of 1 for bed mobility and transferring needs. Resident #39 was observed, on 05/01/13 at 10:00 A.M., to be independent for ambulation but very confused and required extensive staff cues.</p> <p>Review of a nursing notes, for February through April 2013, indicated there was no documented falls from bed.</p> <p>2. During observation of the room for Resident #5, conducted on 04/29/13 at 08:55 A.M., the mattress was noted to be too short for the bed frame. There was a gap, greater than 4 3/4 inches noted between the bottom of the mattress and the foot board of the bed.</p> <p>The clinical record of Resident #5 was reviewed on 05/01/13 at 9:45 A.M. The most recent Minimum Data Set (MDS) Quarterly Assessment, competed on 03/12/13 , indicated the resident was severely cognitively</p>		<p>instructed to roll blankets at the foot of each of the 25 resident mattresses to create a bolster effect and eliminate the gap. An audit tool was created and implemented to audit and ensure placement of bolsters, every shift until the arrival of the appropriate size mattresses. Mattresses were received by May 9, 2013 and replaced all previous ill-fitting mattresses. <u>What measures will be put into place to ensure that this practice does not recur?</u> Correct size mattresses were received on May 9, 2013 and immediately put in place for those 24 beds that were affected. The Maintenance Director, while completing his quarterly preventive maintenance checklist, will assess the mattresses for correct fitting for each of the 36 bed frames in the facility and will document those checks. In addition, the Maintenance Director will assess the mattress fit whenever a mattress or a bed is changed, or if an overlay or other type of device has been added to the bed or mattress for preventive or treatment purposes. If there are any findings, he will report this to the Administrator and/ or designee immediately. The maintenance bed audit is completed on 05/14/2013. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> TheMaintenance Director will</p>				

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	<p>impaired and required extensive staff assistance for 2 for bed mobility and transferring needs.</p> <p>Nursing notes, for February through April 2013, did not indicate any injuries from the resident having fallen from bed.</p> <p>3. During the observation of the room for Resident #1, on 04/29/13 at 1:45 P.M., the mattress was noted to be shorter than the bedframe.</p> <p>Observation, on 04/30/12 between 2:15 P.M. - 2:30 P.M., indicated there was a gap, larger than 4 3/4 inches noted at between the top of the resident's mattress and the bedframe. There were no blanket "bolsters" noted on Resident #1's bed.</p> <p>The clinical record for Resident #1 was reviewed on 05/02/13 at 10:00 A.M. The most recent quarterly MDS review, on 2-11-13, indicated the resident was independent with bed mobility. Resident #1 also had a diagnosis of legal blindness.</p> <p>4. During the survey process, on 04/29/13, during Stage 1 observations, it was noted the mattresses on most of the resident beds were significantly shorter than</p>		<p>report his quarterly findings to the QA&A meeting the month during which they are completed. There after the QA reporting will occur quarterly unless a bed structure change occurs or unless the QA Committeemembers direct otherwise. Date of Compliance: May 14, 2013</p>		

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	<p>the bed frames, leaving a large gap at either the top, bottom, or both ends of the beds.</p> <p>On 04/30/13 at 2:30 P.M., the Administrator was notified of the concern and a brief environmental tour was conducted. During the tour of the facility, conducted on 04/30/13 between 2:15 P.M. - 2:30 P.M., there were 20 resident beds noted to have ill fitting mattress. Interview with the Administrator, on 04/30/13 at 2:30 P.M., indicated he had instructed staff to place rolled up blankets to act as "bolsters" temporarily until new mattresses could be ordered. He indicated the facility had evidently ran out of big blankets and had utilized any type of blanket, such as aphgan throws, and lap robes in an attempt to "bolster" the beds.</p> <p>The mattresses and bedframes were measured, on 05/01/2013, by the facility Maintenance Supervisor, employee #13. The bed mattress for Resident #39, who resided in room 4 was noted to have a gap of 4 1/8 inches as the mattress measured 75 inches and the bed frame was documented as measuring 79 1/8 inches. The mattress for Resident #5, who resided in room #7 had a gap of 5 1/8 inches as the mattress</p>						

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	<p>measured 74 inches and the bed frame measured 79 1/8 inches. The mattress for Resident #1 had a gap of 5 1/8 inches as the mattress measured 74 inches and the bed frame measured 79 1/4 inches.</p> <p>Interview with the Administrator, on 05/02/2013, indicated the mattresses in the building were not too old and the bed frames were also newer. He indicated he thought the items had been "mismeasured" by previous Administration. The Administrator indicated he had received corporate consent to order new mattresses for all of the beds with ill-fitting mattresses except the two residents who had specialty mattresses. He indicated they would order a more permanent "bolster" for those beds.</p> <p>On 05/02/13 at 11:30 A.M., rolled blanket bolsters were observed in place in all of the affected beds. The bolsters were placed between the bottom of the mattress and the foot of the bed to allow the head of the bed to be raised without dislodging the bolsters.</p> <p>Interview with the Administrator, on 05/02/13 at 3:00 P.M., indicated he had confirmed the mattresses were to be delivered in the next week. In the</p>						

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	<p>meantime he had a daily audit form to ensure bolsters were in place, had borrowed enough substantial blankets to create the appropriate sized bolsters for the beds, and had inserviced staff regarding the continued need for bolsters and the size and placement of the bolsters.</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=E	<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 observation, record review and interviews, the facility failed to ensure there was adequate behavior monitoring for psychoactive medications for 3 of 10 residents reviewed for unnecessary medication use. (Residents # 11, 28, and 32) In addition, the facility failed to ensure a gradual dose reduction was attempted for 1 of 7 residents receiving an antipsychotic medication in 10 residents reviewed for unnecessary medications. (Resident</p>	F000329	<p>F329 It is the policy of this facility to ensure individual care plans are in place for all residents receiving psychotropic medications including the intervention of gradual dose reduction and adequate behavior monitoring. <u>What corrective action will be done by the facility?</u> The medical records of residents #11, #32, #28 and #6 were reviewed. For resident #11, the physician has discontinued the diagnosis of "insomnia" since it is not a current issue, and the resident does not take any</p>	06/02/2013			

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	<p>#6)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #11 was reviewed on 05/02/13 at 2:40 P.M. Resident #11 was admitted to the facility on 07/30/10 with diagnoses, including but not limited to, paranoid schizophrenia, bipolar disorder, anxiety, insomnia, osteoporosis, hypertension, malaise and fatigue, hyperlipidemia, chronic obstructive pulmonary disease, urine retention, congestive heart failure, and hypopotassium.</p> <p>The resident's current physician's orders for medications included the following psychoactive medications: Ativan (an antianxiety medication) .5 mg (milligrams) at bedtime, Zyprexa (an antipsychotic medication) 10 mg once a day, and Trazadone (an antidepressant medication) 50 mg at bedtime.</p> <p>A note from Resident #11's physician, dated 03/11/13, indicated the following: "It is clinically contraindicated to reduce the current doses of Ativan .5 mg q hs (bedtime), Zyprexa 10 mg qd (once a day) and Trazadone 50 mg q hs since these are the lowest, most effect doses to</p>		<p>medication for insomnia at this time. The care plan of #11 has been updated to address the resident's anxiety issues and depression. For resident #32, a care plan has been updated to monitor and address the resident's insomnia and a behavior tracking sheet has been formulated for staff to indicate when the resident has behaviors associated with her insomnia. For resident #28, a care plan has been developed to address the resident's depression, and the behavior tracking plan and form has been modified to monitor the resident for signs/symptoms of depression, as well as interventions that can be used if the resident displays depression. For resident #6, the physician was contacted and an order was received 5/20/13 to decrease his Seroquel to 12.5mg daily at bedtime. The interdisciplinary team will be inserviced by the Nurse Consultant by 6/2/13 regarding the need for developing care plans and interventions for residents who take psychoactive medications, including those who have insomnia and depression. The Nurse Consultant will also re-train the interdisciplinary team on the requirements for Gradual Dose Reductions for all types of psychoactive drugs and the documentation needed to demonstrate the attempts at dose reduction. <u>How will the facility identify other residents having the</u></p>		

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	<p>treat this resident's schizophrenia, insomnia, anxiety and bipolar disorder. Gradual dose reductions should not be attempted due to her behaviors. At this time, any attempt at drug reduction would not be in the resident's best interest and will not be attempted."</p> <p>Review of the current health care plans, reviewed on 02/27/13, included plans to monitor the resident for any adverse side effects of the Ativan, Trazadone, and Zyprexa medications, and plans to monitor the residents long history of paranoia, distrust of people, and refusing care from unfamiliar staff. In addition, there were behavior plans to address the resident's hallucinations, refusing care/ADL (activities of daily living)/meals, verbal aggression, and purposely ignoring conversation. There were no plans to address the resident's anxiety issues and insomnia issues.</p> <p>The most recent MDS (minimum data set) Assessment for Resident #11, completed on 02/21/13, indicated the resident scored an "11" on the mood indicator section of the assessment. The resident indicated she had experienced "feeling down, hopeless, a poor appetite, trouble concentrating,</p>		<p><u>potential to be affected by the same practice and what corrective action will be taken?</u> A review of all residents' medical records was completed by the interdisciplinary team to ensure that care plans and appropriate behavior tracking forms are in place for all residents receiving psychotropic medications. The interdisciplinary team has also audited all records for residents receiving psychotropic medications to ensure gradual dose reductions were completed, as required. No other residents were found to be affected by this practice. But if an issue is identified in the future, the interdisciplinary team will work together to have the issue addressed as quickly as possible - whether the need is for care plan or behavior tracking development or revision, or for gradual dose reduction attempts. Their efforts will be documented in the individual resident's medical records as part of the Social Service progress notes. Changes to the care plan or behavior interventions will be documented on the 24 hour report sheet by the DON for communication to all shifts. In addition, the DON will update the C.N.A. assignment sheets as needed to reflect any changes that were made. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or</p>				

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	<p>feeling tired or having little energy, and feeling bad about herself.</p> <p>There was also no plan to address the resident's depression.</p> <p>Interview with CNA's #6 and #7, staff who routinely took care of Resident #11, on 05/02/13 at 2:20 P.M. indicated they had not noticed any behaviors recently from Resident #11 but they would monitor the resident for agitation and constipation issues.</p> <p>2. The clinical record for Resident #32 was reviewed on 05/02/13 at 10:00 A.M. Resident #32 was admitted to the facility on 01/06/2012, with diagnoses, including but not limited to: Hx (history of) intraochanteric fx (fracture) - closed reduction, mental disorder, esophageal reflux, depressive disorder, insomnia, Vitamin D deficiency, eating disorder, PVD (peripheral vascular disease), hypothyroidism, arthropathy, chronic pain, HTN (hypertension), and dementia.</p> <p>The physician's orders, for May 2013, included orders for the following medications: Cymbalta (an antidepressant) 60 mg every day, and Melatonin (a natural supplement to</p>		<p>designee will review the focus charting, 24 hour nursing report, and all new physician orders during her tour of duty which occurs at least five times a week to identify any new psychiatric diagnoses and/or psychotropic medications changes. She will bring any identified changes to the next scheduled morning clinical interdisciplinary meeting. Care plans, interventions, behavior tracking, and/or the need for gradual dose reduction will be reviewed and developed as indicated in question#2. In addition, all residents receiving psychotropic medications are reviewed monthly during behavior meeting by the interdisciplinary team. Residents are reviewed to determine if a gradual dose reduction should be requested from the primary physician. In addition, the results of behavior tracking and interventions for those behaviors are discussed.</p> <p>The outcome of the team's discussions are documented on the Behavior/Psychotropic Medication review form and maintained by Social Services. Care plan interventions and behavior tracking forms are updated at this time as well.</p> <p><u>How will correction action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of her reviews and the Social Services Designee will bring the results of</p>		

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	<p>induce sleep) 3 mg at bedtime.</p> <p>The current health careplans for Resident #32, review date of 03/27/13, included plans to monitor the resident's mood and monitor the resident for adverse side effects of her mood medications, cognitive medications and hypnotic medications. However, there was no plan to monitor and address the resident's actual insomnia.</p> <p>Interview with LPN #8, on 05/02/13 at 10:45 A.M., indicated for routine hypnotic medication they (the facility) did not do behavior tracking just monitored the resident for adverse side effects.</p> <p>3. The clinical record for Resident #28 was reviewed on 05/02/13 at 10:20 A.M. Resident #82 was admitted to the facility on 08/13/10, with diagnoses, including but not limited to, Alzheimer's Disease, adjustment disorder, diabetes, hypertension, hyperlipidemia, cardiac dysrhythmias, cardiac pacemaker, chronic pain, and headache.</p> <p>The current physician's order for Resident #28, for May 2013, included orders for the antidepressant medication, Cymbalta 30 mg to be</p>		<p>the Behavior/Psychotropic Drug Review to the monthly QA&A Committee meeting for further review and recommendation. Any recommendations made by the committee will be followed up by the DON or other pertinent interdisciplinary team members. The results of implementing those recommendations will be brought back to the next scheduled QA Committee meeting for discussion and further process improvement if needed. This will continue on an ongoing basis. Date of Compliance: 6/2/13</p>		

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	<p>given once a day.</p> <p>The current health care plans for Resident #28, updated on 02/27/13, included plans to monitor the resident for "grouchy" behavior regarding bathing, a plan to monitor the resident for being "bossy" to other resident, and plans to monitor the resident for any adverse side effects of the antidepressant medication. However, there was no plan to address the resident's depression.</p> <p>The Behavior tracking plan for Resident #28 for April and March 2013, indicated the resident was being monitored for "refusing care." There was no plan to monitor the resident for any signs and/or symptoms of depression and no plan to address what to do if the resident displayed depression.</p> <p>Interview, on 05/02/13 at 2:00 P.M., with CNA # 6 and #7, indicated they had only observed the resident get verbally frustrated or irritated with other residents while playing cards and refusing to take showers. They indicated there was a behavior plan to follow if the resident refused her showers or care.</p> <p>3. The clinical record for Resident #6</p>				

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	<p>was reviewed on 5-1-13 at 9:06 a.m. The resident's diagnoses included, but were not limited to: organic brain syndromes, anxiety state, unspecified disorder of kidney & ureter, Type II diabetes, paralysis reflux, hyperlipidemia, acute myocardial infarction of other inferior wall, malignant neoplasm of prostate and dementia with behaviors.</p> <p>A review of the Careplan indicated the resident received an antipsychotic medication called Seroquel. The interventions included, but were not limited to: monitor for signs and symptoms of adverse side effects such as dizziness, nausea etc., routine psychiatrist visits, review psychotropic medications/behaviors at behavior committee meeting, notify doctor of adverse reactions and if resident refused 3 times, and gradual dose reductions (GDR).</p> <p>Nursing notes, dated 11-23-12, indicated the psychiatric provider assessed the resident, and that "...previous requests for GDR declined by PCP [primary care physician] (11/15). Clarify diagnosis for Seroquel to depression instead of Behaviors If that is why PCP had ordered med [medication]...."</p>			

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	<p>On 5-1-13 at 9:16 a.m., a review of the Medication Administration Record (MAR) indicated the resident was taking Seroquel for depression.</p> <p>On 5-1-13 at 9:36 a.m., a review of a fax to Physician #5 the facility had made a request to the physician to continue Ativan but decrease Seroquel to 12.5 mg at bedtime. The physician's response was "...continue all at current doses. He is stable...."</p> <p>On 5-1-13 at 9:53 a.m., a review of a form titled "Consultant Pharmacist's Medication Regimen Review," dated 12-11-13, and directed to the physician, indicated the pharmacist had a concern "...if he is not having behaviors and if he is not depressed why are we keeping this therapy on board. We could always try to decrease to just 12.5 mg QHS [every bedtime]...." Physician #5's response was "...He is doing quite [sic] well on the current regimen...."</p> <p>On 5-1-13 at 10:30 a.m., a review of the "Monthly Psychotropic Medication Summary," for January, February, March and April 013, indicated no incidents of behaviors was documented.</p> <p>On 5-1-13 at 10:45 a.m., a review of</p>			

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	<p>notes form from consulting services titled "Session Report," dated 1-23-13, indicated the "... "identified problem(s):: Exit Seeking Behaviors.</p> <p>On 5-1-13 at 10:50 a.m., a review of the Behavioral Medicine Evaluation & Management Note, dated 4-4-13, from a psychiatric group indicated "...Patient's deterioration physical health is a principal source of his/her mental health disease...." The form also indicated the resident was depressed but had no delusions, hallucinations or behavior changes.</p> <p>An interview with Director of Nursing, on 5-1-13 at 12:30 p.m., indicated the medical director was aware of Physician #5's refusal to reduce the dose of Seroquel and give an appropriate diagnosis for its use. She further explained that the Medical Director didn't intervene because of the low dose the resident was receiving and that a psychologist hadn't made a recommendation.</p> <p>An interview on 5-1-13 at 2:15 p.m., with the granddaughter who worked at the facility indicated, the behavior of exit seeking had been resolved almost 2 years ago. She further indicated the resident gets anxious when his wife is ill and he has</p>			

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	<p>difficulty with sleeping and picking at self.</p> <p>On 5-3-13 at 11:10 a.m., a review of a policy titled "Medication - Unnecessary," dated June 2004 with a revision date of 6/2011, indicated, on page 8 first paragraph "...The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms...." On page 8 paragraph 5 indicated, "...For residents who are receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and the physician has documented the clinical rationale for why an additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior...."</p>						

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	3.1-48(a)(6)			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, and interview the facility failed to provide actual hours worked for registered nurses (RN) and licensed practical nurses (LPN) for 3 of the 5 days during the survey process.</p>	F000356	<p><u>F356</u> It is the policy of this facility to post the required nursing staffing information including actual hours worked for RNs and LPNs 7 days a week. <u>What corrective action will be done by the facility?</u> It has been</p>	05/03/2013

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	<p>Finding includes:</p> <p>On 4-30-13 at 2:30 p.m., an observation was made of a form titled "Daily Nursing Staffing Form" in the hallway by the nurses station. The actual hours an RN and LPN worked that day for each shift was not posted with information to differentiate if a RN or LPN was working the day, evening, or night shift as required by the regulations.</p> <p>On 5-1-13 at 9:30 a.m., an observation was made of the "Daily Nursing Staff Form" and indicated the actual hours worked by an RN and LPN was not posted with information that notified the public if an RN or LPN was working the day, evening or night shift.</p> <p>On 5-2-13 at 11:00 a.m. an observation was made of the "Daily Nursing Staff Form" and indicated the actual hours worked by an RN and LPN was not posted with information that notified the public if a RN or LPN was working the day, evening or night shift.</p> <p>An interview with the the Business Office Manager, on 5-2-13 at 11:05 a.m., indicated she wasn't aware that</p>		<p>an oversight that the wrong from was posted which did not break out the separate amounts of the RN and LPN hours per shift. Once this issue was identified on 05/01/2013, the Business Office Manager immediately reconstructed our notification form to separate the RN hours from the LPN hours. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Even though the incorrect form was used, there were no resident affected by this practice. <u>What measures will be put into place to ensure that this practice does not recur?</u> The corrected interdisciplinary form will be used daily by the Business Office Manager as a method to notify residents and concerned parties of daily RN and LPN work/ assignment hours effective 05/01/2013. This report form will be posted daily by the Office Manager. The Administrator or designee will check the posted form as part of frequent daily rounds at least 5 days a week to make sure that the correct form is in place and being used appropriately. The Manager of the Day will check to see that the correct form is in place and being used on weekends. Staffing forms from previous days will be retained by the Administrator/Business Office Manager for 18 months as per</p>				

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	the form she was using needed to differentiate the actual hours worked by the RN and LPN. 3.1-13(a)		facility policy. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will bring the copies of this report to the monthly QA&A Committee meeting for review. This will be confirmed at the Quality Assurance monthly meeting for the next two months. The QA&A Committee may decide that monthly review of the staffing forms is no longer necessary at the end of the 2 month review period when 100% compliance is reached. Date of Compliance: May 3, 2013		

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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, interview and record review, the facility failed to ensure there was an accurate system for liquid narcotic reconciliation. This</p>	F000431	F431 It is the policy of this facility to establish a system in conjunction with a licensed pharmacist to record the receipt and disposition of all controlled	06/02/2013			

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	<p>deficient practice affected 1 of 1 medication carts in the facility.</p> <p>Finding includes:</p> <p>Observation of liquid narcotics, stored in the double locked compartment on the medication cart, on 05/02/13 at 10:45 A.M., with QMA 9 and LPN #8, indicated the liquid narcotics were often hard to measure due to the large bottles delivered for residents who required small doses at one time to be given. The liquid Phenobarbital (an antiseizure medication) for Resident #5 was noted to have been dispensed in a large bottle. The narcotic documentation record indicated the pharmacy had delivered a bottle containing 473 cubic centimeters (cc). However, observation of the bottle indicated the highest graduated measuring mark on the bottle was for 400 cc's of medication. The resident received 10 ml (10 cc) doses routinely, however, the graduated measurement, which started at 400 cc were in 50 cc measurements.</p> <p>The liquid Hydrocodone/Apap (a narcotic pain medication) medication for Resident #2 appeared to have between 300 - 350 cc's of medication left in the large brown bottle. QMA #9</p>		<p>drugs to enable an accurate reconciliation, including for liquid narcotics. The facility has asked its current pharmacy to explain the use of the size and type of bottles for the liquid narcotics that are currently in the facility.</p> <p><u>Per2567</u>: "The liquid phenobarbital for resident #5 was noted to have been dispensed in a large bottle. The narcotic documentation record indicated the pharmacy had delivered a bottle containing 473mL, however, observation of the bottle indicated the highest graduated measuring mark on the bottle was for 400mL. The resident received 10mL doses routinely, however, the graduated measurement, which started at 400mL were in 50mL measurements."</p> <p><u>Response</u>: The manufacturer of phenobarbital supplies the medication in a single volume for purchase: 473mL. See Figure 1. To decrease the risk of dispensing errors the pharmacy dispenses phenobarbital in a plastic medication bottle adequate in size to contain the entire supply of medication. Phenobarbital is typically dosed 10mL twice to three times daily.</p> <ul style="list-style-type: none"> o Residents will consume 473mL of phenobarbital every 15 to 23 days o Pharmacies are allowed to dispense 30 day supplies of generic medications <p>The statement by surveyor about available graduations is simply false, as seen in the picture</p>		

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	indicated it looked like around 350 cc's of medication left in the bottle, but LPN #8 indicated it looked more like around 330 cc's of medication left in the bottle. The narcotic record form indicated there was supposed to be 330 cc's of medication left in the bottle. A bottle of liquid Morphine (a narcotic pain medication) medication for Resident #37 was noted to have around 17 ml of medication left in the bottle. LPN #8 indicated it looked like 17 ml (cc's) and QMA #9 indicated it looked like just under 19 ml's. The resident was ordered to receive .25 ml doses of the medication. The graduated measurements on the side of the bottle were in 2 ml increments. The paper record for the liquid Morphine indicated there was supposed to be 17.75 ml of the liquid left but there was no way to determine the exact amount. - Both LPN #8 and QMA #9 indicated the bottles of liquid medications were overfilled routinely into the neck of the bottles where there was no measuring scale and the pharmacy documented the cc's of medication they had delivered and documented the amount on top of the narcotic sheets. The facility nursing staff then "went from there" because they were unable to tell the exact amount of medication to begin with due to the overfilling and		attached, the 473mL marking is available. See Figure 2. To the knowledge of this pharmacist, and after several hours of research, no other pharmacy approved polyethylene terephthalate (PET) plastic bottles exist for purchase with greater degree of graduations. This is not new to pharmacy practice, due to lack of alternatives, and in the previous 10 years of nursing home experience the pharmacist has never had this concern in a nursing facility. <u>Per 2567:</u> "The liquid hydrocodone/APAP for resident #2 appeared to have between 300-350mL of medication left in the large brown bottle. QMA #9 indicated it looked like around 350mL of medication left in the bottle, but LPN #8 indicated it looked more like around 330mL of medication left in the bottle. The narcotic record form indicated there was supposed to be 330mL of medication left in the bottle." <u>Response:</u> Please see explanation above, and also of note: o As noted above the graduations of this bottle are in 50mL increments o The difference between 350mL and 330mL should have been easily identified o See Figure 3 attached. <u>Per 2567:</u> "A bottle of liquid Morphine for resident #37 was noted to have around 17mL of medication left in bottle. LPN #8 indicated it looked like 17mL and QMA#9 indicated it looked		

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	<p>large bottles</p> <p>Interview with DON, on 05/02/13 at 3:00 P.M., indicated she had asked a previous pharmacy for smaller bottles to help with accuracy but did not get cooperation from that particular pharmacy.</p> <p>3.1-25(e)(2)</p>		<p>like just under 19mL. The resident was ordered to receive 0.25mL doses of the medication. The graduated measurements on the side of the bottle were in 2mL increments. The paper record for the liquid morphine indicated there was supposed to be 17.75mL of the liquid left but there was no way to determine the exact amount." <u>Response:</u> Morphineconcentrate (100mg/5mL or 20mg/mL) is supplied in 30mL bottles from the manufacturer</p> <p>Morphine concentrate, due to the risk of overdose, is to be supplied in the original packaging per the manufacturer,manufacturer instructions have been copied below (package insert):</p> <p>Instructions for Use Mororphine Sulfate Oral Solution 100 mg per 5 mL (20 mg/mL) Important information about measuring morphine sulfate oral solution · Always use the oral syringe provided with your morphine sulfate oral solution to make sure you measure the right amount.</p> <p>When dispensed with oral syringe: 1. Insert bottle plug into neck of the bottle, ribbed end first. 2. Insert syringe tip into hole on the top of the plug until secure. 3. Turn bottle upside down. Pull down white syringe plunger to prescribed dose. 4. Turn bottle right sideup. Remove syringe by</p>		

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			<p>twisting. 5. Take your medicine by slowly pushing the plunger until the oral syringe is empty.</p> <p>6. Leaving the plug in the bottle, recap the bottle tightly with the supplied cap. See Figure 4 for additional information. Per 2567: "Both LPN #8 and QMA #9 indicated the bottles of liquid medications were overfilled routinely into the neck of the bottles where there was no measuring scale and the pharmacy documented the mL of medication they have delivered and documented the amount on the top of the narcotic sheets. The facility nursing staff then went from there because they were unable to tell the exact amount of medication to begin with due to the overfilling and large bottles." <u>Response:</u> Please see above explanations. Please also see attached letter from the manufacturer of morphine concentrate (attachment F431-1) explaining the overfill of pharmaceutical supplies of medications, specifically in this case their medication but explanation is accurate for all liquid medications. Per 2567: "Interview with DON, indicated she had asked pharmacy for smaller bottles to help with accuracy but did not get cooperation from that particular pharmacy." <u>Response:</u> The facility's current pharmacy is not the one referred to by the DON</p>	

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			<p>when she indicated that she had not gotten cooperation from them for this issue. The facility's current pharmacy has responded and explanations have already been given previously, but to summarize: Unavailable pharmacy approved plastic bottles with more specific graduations Morphine concentrate specifically not appropriate to remove from original packaging The facility believes that there is no specific issue regarding reconciliation of liquid narcotics from the pharmacy standpoint; however, we are providing a plan of correction for this issue since it is required by federal law. <u>What corrective action will be done by the facility?</u> On On 5/2/13 and 5/13/13 the DON spoke with the pharmacy to confirm the method of dispensing the liquid narcotics as well as the availability of containers for them. She received the same information as presented previously in this plan of correction. All nurses and QMAs will be inserviced by the DON by 6/2/13 on the information presented here regarding the dispensing of liquid narcotics, as well as the preferred method to obtain the amount ordered from each bottle and the documentation of the administration of the narcotic and the reconciliation of the amount of narcotic left in the bottle. <u>How will the facility identify other</u></p>	

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			<p><u>residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No residents have been affected by this practice. If any question arises about whether or not the amount of the drug has been accurately counted, the nurse will contact the Director of Nursing immediately who will follow up on the concern until it has been resolved. Once the resolution has been reached, the DON will also follow up with staff involved to re-train them in the process if this has been identified as a root cause of the issue and to administer progressive discipline if it is warranted. <u>What measures will be put into place to ensure this practice does not recur?</u> Effective May 27, 2013, when liquid medications are delivered to the facility a permanent mark will be made on the bottle to indicate the exact amount received. All nurses responsible for receiving medications into the facility from the pharmacy have been inserviced on this new practice of marking the liquid narcotic content when delivered. A nurse who fails to mark the content of a newly delivered liquid narcotic bottle will receive further training on this procedure and receive disciplinary action following established policy. A narcotic count is completed between nurses at each shift change to verify the remaining doses. The</p>	

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			nurses sign on the narcotic count sheet when administering a narcotic to indicate the amount remaining following each dose administered. The Director of Nursing or designee will check the liquid medication bottles 3 days a week for 30 days and then weekly for 60 days to ensure the bottle has been marked when delivered and that the content matches the amount recorded as remaining on the narcotic count sheet. The DON will report her findings and action taken to the Administrator and interdisciplinary team at the next morning management meeting which is scheduled at least 5 days a week for further review. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The results of the Director of Nursing/designee audits will be reviewed by the QA&A committee for 90 days for further process improvement. Once 100% compliance is obtained the committee may decide to end the DON's audits;however, the DON will continue to check the liquid narcotic reconciliation on a periodic basis as part of her routine duties. Any issues will be brought back to the QA Committee for further review and recommendations. Date of Compliance: 6/2/13	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents 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 observation, interview and record review, the facility failed to</p>	F000441	<u>F441</u> The facility has an infection control program which	06/02/2013			

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	<p>ensure that staff wash their hands after direct resident contact during a meal service. This had the potential to affect 1 of 27 residents that eat in the main dining room. (Employee # 1)</p> <p>Findings include:</p> <p>On 4/29/13 at 12:36 P.M., Employee #1 was observed seated next to Resident # 33 assisting resident with her lunch. Resident # 1 got up from her chair and needed assistance to exit the dining room. Employee #1 got up from her chair and assisted Resident # 1 from the dining room holding onto Resident #1's arm. Employee #1 returned to her seat next to Resident # 33 and proceeded to feed the resident without washing her hands or using hand sanitizer.</p> <p>On 5/1/13 at 3:00 P.M., an interview with the Director of Nursing indicated that staff should wash their hands or use hand sanitizer in the dining room after each direct resident contact.</p> <p>On 5/1/13 at 3:15 P.M., record review of the current policy titled "Handwashing/Alcohol-Based Hand Rub" received from the Director of Nursing indicated, "...The absolute indications for and the ideal frequency of handwashing are not known.</p>		<p>includes a handwashing policy designed to prevent the development and spread of infection, including during meal service. <u>What corrective action will be done by the facility?</u> All staff will be in-serviced by 5/24/13 by the Director of Nursing regarding proper hand hygiene during dining services, including the appropriate use of hand sanitizer or handwashing after direct resident contact. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this deficient practice. The DON reviewed the infection control logs for the past six months. No trends were identified to indicate infection transmission that could be traced to improper hand hygiene in the dining room. <u>What measures will be put into place to ensure that this practice does not recur?</u> Department managers or charge nurses are scheduled for each meal service to ensure that proper hand hygiene is occurring. The manager or charge nurse will complete a "Dining Room Hand Hygiene Audit" which will be brought to the next scheduled morning management meeting which meets 5 days a week for review and discussion. If a concern in hand hygiene is observed at any time by a manager or charge</p>				

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	<p>However, in the absence of a true emergency, personnel should always wash their hands...Before and after each resident contact...After touching a resident or handling his/her belongings...."</p> <p>3.1-18(l)</p>		<p>nurse, he/she will stop the staff member at that time and re-educate him/her on the proper technique and use of hand sanitizer or hand washing. The manager of the department that the employee works under will then follow up with progressive disciplinary action as indicated by continued noncompliance. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or DON will bring the results of the dining room audits to the QA&A Committee at their monthly meeting for further review and suggestions for process improvement. After 90 days has elapsed and the audits demonstrate 100% compliance, the QA&A Committee may consider ending the written audits. However, the managers' observations during meal service will continue on an ongoing basis and any identified issues will be brought to the nexts cheduled QA&A Committee meeting for consideration and review. Date ofCompliance: 6/2/13</p>		