

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit resulted in a partially extended survey- Immediate Jeopardy.</p> <p>This visit included investigation of Complaint IN00133654.</p> <p>Complaint IN00133654-Substantiated. No Federal/ State deficiencies were cited related to the allegations.</p> <p>Survey dates: August 12, 13, 14, 15, 16, 19, 20 and 21, 2013.</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Survey team: Angela Strass RN TC Sue Brooker RD Julie Call, RN Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 46</p>	F000000	This Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. Date of Compliance 9/20/13	

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>Total: 46</p> <p>Census payor type:</p> <p>Medicare: 5</p> <p>Medicaid: 37</p> <p>Other: 4</p> <p>Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 27, 2013 by Randy Fry RN.</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F 225 Reporting unusual	09/20/2013			

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	<p>review, the facility failed to notify the Indiana State Department of Health (ISDH) of a reportable unusual occurrence for a significant medication error for 1 Resident. (Resident #34)</p> <p>Findings include:</p> <p>During an interview on 8/12/13 at 11:07 a.m. with Resident #34, he indicated he was given his roommates medications on Saturday (8/10/13) morning when he was in the dining room. Resident #34 indicated he needed to have IV(intravenous) fluids to flush out the medication. The Resident indicated he took 9 pills that were not his medications. The Resident indicated he began to feel very weak and could not transfer to a wheelchair by himself and needed assistance of 2 staff. He indicated the nurse called the Physician and reported he was given the wrong medications and the Doctor ordered an IV to be started.</p> <p>A Review of Resident #34's clinical records indicated his diagnoses included but were not limited to coronary artery diseases (CAD), diabetes mellitus Type II, hypertension (high blood pressure), bipolar disorder, hyperlipidemia,</p>		<p>occurrence for significant medication error 1.On 8/10/13 resident #1 (BIMS 14) notified of receipt of wrong medications. MD notified, sister notified Vital sign assessment conducted through 8/11/13 2.All in-house residents MARs/TARs were audited to validate picture were in place. 3.ED/DCS will review ISDH reportable quidelines, and will discuss with RVP to and RVDCS to ensure that all sigificant medication areas are submitted.All licensed nurses to be educatted on Medication Administration and the five rights of Medication administration. Education includes Preventing Medication errors At-A-Glance (attachment #1) and identificationnof resident through picture on MAR/TAR. The Admission Coordinator or designee will be educated to take photograph of all new admissions and readmissions at the time of admission/readmission. The director of Clinical Services (DCS) and/or Assistant Director of Clinical Services (ADCS) will conduct Competency 6 (attachment #2) of the Clinical Nurse Skills Checklist with all current licensed nurses. Competency will be evaluated through return demonstration. All new hires (licensed nurses) will demonstrate competency in medication administration through Competency 6 of the Clinical Nurse Skills Checklist prior to</p>				

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	<p>hypothyroidism, dementia, syncope, obesity, history of falls and history of pulmonary embolus. Resident #34's BIMS (Brief Interview for Mental Status) was 14/15 indicated he was alert and oriented.</p> <p>A review of the facility's Medication Administration Investigation, dated August 10, 2013, provided by the Interim DCS (Director of Clinical Services) indicated, "...LPN #2 reported to ED (Executive Director) LPN #1 had given the wrong medication to Resident #34. ED directed nurse to notify MD of the medication administration and the name of the medications...Record review indicated the resident received the following medications which were not ordered for him: Baclofen 10 mg (muscle relaxant, anti spasm), Carveil 6.25 mg (cardiac medication, Tab-A-Vit (vitamin supplement); Tradjenta (anti-diabetic to lower BS), Cymbalta 60 mg (antidepressant), Gabapentin 600 mg (anticonvulsant and for nerve pain), Levetiracetan 500 mg (anticonvulsant), Loratidine 10 mg (allergy medication), Miralax (for constipation), Ranitidine 150 mg (GI, reduction of acid production).... LPN #2 indicated she identified the resident to LPN #1....LPN #1 indicated she had called the resident</p>		<p>administering medications without direct supervision. 4. Medical Records will audit all new admissions/readmissions within 72 hours to validate that all MARs/TARs have a current photograph. The DCS will review and sign all new hires (licensed nurses) Competency 6 of the Clinical Nurse Skills Checklist to validate the new hire demonstrated competency prior to administering medications without direct supervision. All audits and Competency 6 of the Clinical Nurse Skills Checklist will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated. An ad hoc QAC meeting was held on 8/13/13 to review and approve the Action Plan. The Medical Director was notified of Action Plan on 8/13/13.</p>				

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	<p>by (first name of Resident # 63) and Resident # 34 stuck his hand out and took the medication cup....On 8/10/13, it was determined the MARS (Medication Administration Record's) for Resident #63 did not have a photograph for identification...."</p> <p>Review of Resident #34's Physician Orders on 8/13/13 at 3:45 p.m., included the following:</p> <p>Order dated 8/10/13: "...Normal Saline IV 100 cc/hr. until BP increases to 120/60 or greater then D/C (discontinue) IV. Hold next dose of BP medication...."</p> <p>Order dated 8/12/13: "...CBC (Complete Blood Count) and Chem 6 (Blood Chemistry Screen) on 8/13/13, D/C IV...."</p> <p>On 8/16/13 at 11:09 a.m., the Interim DCS provided Vital Signs and Weight Record and Blood Sugar Record for Resident # 34. The clinical records indicated his V/S(vital signs) included blood pressure and pulse, were monitored every hour for 8 hours, then every 4 hours and prn from 4:00 p.m. until 6:00 a.m. on 8/11/13. Resident # 34's blood sugar was monitored before meals and bedtime.</p>			

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	<p>Review of Resident #34's Nurse's Notes on 8/14/13 at 3:45 p.m., indicated the following:</p> <p>On 8/10/13 at 8:15 a.m., "...Dr. notified. Vital Signs being monitored. B/P (Blood Pressure) 90/35, P (Pulse) -81." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 9:45 a.m., "...B/P 85/45, P 82...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 10 a.m., "...Dr. returned call to facility. N.O. (Nursing Order) obtained for IV NS (Normal Saline Solution) at 100 cc/hr until B/P comes up and hold B/P medications until B/P comes up...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, "...B/P baseline 120/60 for resident, new orders. IV to be D/C (discontinued) when B/P reaches baseline or greater...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 11:30 a.m., "...IV nurse here for peripheral line placement. Site noted to resident's L (left) hand. IV fluids were initiated. B/P continues to be monitored q (every) hour. Last B/P 99/54, P 77. Resident in bed at this time. HOB (head of bed) up 30 degrees...." Nurse's Note signed by</p>			
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	<p>LPN #1.</p> <p>On 8/10/13, 2 p.m., "...B/P obtained again, Resident up in recliner chair in room. Resident alert and oriented x 3. Resident continues to answer questions appropriately. No apparent S/S (sign and symptoms) of injury. Resident also has been socializing with other residents and visitors in his room. IV patent to L hand and infusing at 100 cc/hr. No S/S phlebitis. Res assisted x 2 staff to bathroom. Res. voided quantity sufficient...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 5:35 p.m., "...Resident alert and talkative no C/O (complaints of) pain or discomfort continuing to monitor B/P...." Nurse's Note signed by LPN #2.</p> <p>The next nurses notes for Resident #34 available were dated 8/12/13 and included the following:</p> <p>On 8/12/13, 10:30 a.m., "...N.O. (new order) CBC (Complete Blood Count) and Chem 6 (Blood Chemistry Screen) on 8/13/13, D/C IV...."</p> <p>On 8/12/13, 11:00 a.m., "...Residents Victoza (diabetes medication) (18 mg/3 ml pen) Give 1.8 mg(0.3 ml)</p>			

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	<p>daily clarification with pharmacy via nurse...."</p> <p>On 8/13/13, 2:30 p.m., :...D/C W/C (wheelchair), Bed alarm and check alertness d/t (due to) Resident up ad lib...."</p> <p>Interview with the Interim DCS on 8/15/13 at 11:28 a.m. indicated the significant medication error on 8/10/13 was not reported the ISDH.</p> <p>Interview with Interim DCS on 8/20/13 at 10:30 a.m., indicated Resident #34 continued to have IV fluids until Physician's Order to discontinue IV on 9/12/13.</p> <p>On 8/15/13 at 11:28 a.m., the DCS provided the ISDH Division of Long Term Care Reportable Incident Policy with a revision date of 01/15/2013, which indicated, "...I. Reportable Incidents...6. Significant Injuries...B) Medication errors that caused resident harm or required extensive monitoring for 24-48 hours...."</p> <p>3.1-28(e)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review the facility failed to follow their policy and procedure for reporting a significant medication error to the Indiana State Department of Health (ISDH) of a reportable unusual occurrence for a significant medication error for 1 Resident. (Resident #34)</p> <p>Findings include:</p> <p>1. During an interview on 8/12/13 at 11:07 a.m. with Resident #34, he indicated he was given his roommates medications on Saturday (8/10/13) morning when he was in the dining room. The Resident indicated the nurse that gave him the medications was in training, and the other staff nurse stood in the doorway of dining room and pointed to table where he was seated. The Resident indicated the nurse did not verify who he was and he just glanced at the pills and swallowed them. After he swallowed the pills, he then realized the medications were not his usual</p>	F000226	<p>F 226 Reporting unusual occurrence to the ISDH</p> <p>1. Reportable sent to the ISDH on 8/22/13, reporting medication error 2. No other residents were effected 3..ED/DCS will review ISDH reportable quidelines, and will discuss with RVP to eand RVDCS to ensure that all sigificant medication areas are submitted. All licensed nurses to be educatted on Medication Administration and the five rights of Medication administration. Education includes Preventing Medication errors At-A-Glance (attachment #1) and identificationnof resident through picture on MAR/TAR. The Admission Coordinator or designee will be educated to take photograph of all new admissions and readmissions at the time of admission/readmission. The director of Clinical Services (DCS) and/or Assistant Director of Clinical Services (ADCS) will conduct Competency 6 (attachment #2) of the Clinical Nurse Skills Checklist with all current licensed nurses. Competency will be evaluated through return demonstration. All new hires (licensed nurses) will</p>	09/20/2013			

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	<p>medications because there was a purple capsule in the medication cup. He then reported to his usual nurse he was given the wrong medications.</p> <p>An interview on 8/15/13 at 12:15 p.m. with LPN #2 indicated she had worked at the facility for a while and she knew the residents. She indicated she assisted new staff by pointing out the residents for them during administration of medications. She indicated they have put pictures in the MAR to identify the residents, but not all of the residents had photos on the MAR yet.</p> <p>A Review of Resident #34's clinical records indicated his diagnoses included but were not limited to coronary artery diseases (CAD), diabetes mellitus Type II, hypertension (high blood pressure), bipolar disorder, hyperlipidemia, hypothyroidism, dementia, syncope, obesity, history of falls and history of pulmonary embolus. Resident #34's BIMS (Brief Interview for Mental Status) was 14/15 indicated he was alert and oriented.</p> <p>Review of Resident #34's nurses notes included the following: On 8/10/13 at 8:15 a.m., "...Writer approached resident asking if he was</p>		<p>demonstrate competency in medication administration through Competency 6 of the Clinical Nurse Skills Checklist prior to administering medications without direct supervision. 4. Medical Records will audit all new admissions/readmissions within 72 hours to validate that all MARs/TARs have a current photograph. The DCS will review and sign all new hires (licensed nurses) Competency 6 of the Clinical Nurse Skills Checklist to validate the new hire demonstrated competency prior to administering medications without direct supervision. All audits and Competency 6 of the Clinical Nurse Skills Checklist will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated. An ad hoc QAC meeting was held on 8/13/13 to review and approve the Action Plan. The Medical Director was notified of Action Plan on 8/13/13.</p>		

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	<p>the (resident's roommate's name). Resident #34 smiled and accepted medications from writer. Resident took medications. Resident then after 15 minutes stated to another nurse that he knew he took his am meds from her at breakfast and thinks he took his roommate's pills from writer. Writer verified that this resident acknowledged himself as (roommates' name) and took medications handed to him. Resident asked why did he take medications if name was incorrect and he had already taken them. Resident stated he didn't know." Nurse's Note signed by LPN #1.</p> <p>A review of the facility's Medication Administration Investigation, dated August 10, 2013, provided by the Interim DCS (Director of Clinical Services) indicated, "...LPN #2 reported to ED (Executive Director) LPN #1 had given the wrong medication to Resident #34. ED directed nurse to notify MD of the medication administration and the name of the medications...Record review indicated the resident received the following medications which were not ordered for him: Baclofen 10 mg (muscle relaxant, anti spasm), Carveil 6.25 mg (cardiac medication, Tab-A-Vit (vitamin supplement);</p>				

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	<p>Tradjenta (anti-diabetic to lower BS), Cymbalta 60 mg (antidepressant), Gabapentin 600 mg (anticonvulsant and for nerve pain), Levetiracetan 500 mg (anticonvulsant), Loratidine 10 mg (allergy medication), Miralax (for constipation), Ranitidine 150 mg (GI, reduction of acid production).... LPN #2 indicated she identified the resident to LPN #1....LPN #1 indicated she had called the resident by (first name of Resident # 63) and Resident # 34 stuck his hand out and took the medication cup....On 8/10/13, it was determined the MARS (Medication Administration Record's) for Resident #63 did not have a photograph for identification...."</p> <p>Interview with the Interim DCS on 8/15/13 at 11:28 a.m. indicated the significant medication error on 8/10/13 was not reported to the ISDH.</p> <p>Interview with Interim DCS on 8/20/13 at 10:30 a.m., indicated Resident #34 continued to have IV fluids until a Physician's Order to discontinue IV on 9/12/13.</p> <p>On 8/15/13 at 11:28 a.m., the Interim DCS provided the ISDH Division of Long Term Care Reportable Incident Policy with a revision date of 01/15/2013, which indicated, "...I.</p>			

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	Reportable Incidents...6. Significant Injuries...B) Medication errors that caused resident harm or required extensive monitoring for 24-48 hours...."  3.1-28(a)			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility failed to ensure the dignity of 3 residents (Resident #71, Resident #4, and Resident #9) who required assistance from staff during mealtime.</p> <p>Findings include:</p> <p>1. During an observation of the breakfast meal on 8/13/13 at 8:15 a.m. in the South Hall lounge, Resident #71 was observed seated in his wheelchair. Certified Nursing Assistance (CNA) #3 was observed standing next to Resident #71 while feeding him breakfast.</p> <p>2. During an observation of the breakfast meal on 8/14/13 at 8:21 a.m. in the main Dining Room, CNA #8 was heard to ask the Certified Dietary Manager (CDM) in the presence of the residents in the dining room for a bib for Resident #9 whom she was feeding. LPN #9 was heard to also ask the CDM in the</p>	F000241	<p>F 241 Resident Dignity and Respect 1. Facility has reviewed concerns with residents #71, #4 and #9 and corrected all issues. 2. All Direct Care Staff were in-serviced on Dignity and Respect regarding dining room services. 3. Audits will be completed by Management or designee to ensure residents will have dignity during dining service (breakfast, lunch, and dinner). Audits will be completed daily times 1 month then weekly times 1 month. Then audits will be done monthly times 4 months. Until 100% compliance is achieved. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	09/20/2013			

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	<p>presence of the residents in the dining room for a bib for Resident #4 whom she was feeding.</p> <p>3. During an observation of the breakfast meal on 8/14/13 at 8:15 a.m. in the South Hall lounge, Resident #71 was observed seated in his wheelchair. CNA #3 was observed standing next to Resident #71 while feeding him breakfast.</p> <p>4. During an observation of the breakfast meal on 8/15/13 at 8:23 a.m., Resident #71 was observed in an upright position in his bed in his room. His breakfast meal tray was on his bed table which had been placed in front of him. CNA #3 was observed standing next to Resident #71 while feeding him breakfast.</p> <p>5. During an observation of the breakfast meal on 8/19/13 at 8:25 a.m., Resident #71 was observed seated in his wheelchair in his room. His breakfast meal tray was on his bed table which had been placed in front of him. CNA #3 was observed standing next to Resident #71 while feeding him breakfast.</p> <p>Social Services staff was interviewed on 8/19/13 at 8:30 a.m. During the interview she indicated staff were to</p>			

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	<p>be seated when feeding a resident. She also indicated the facility used garment covers to protect the clothing of the residents at mealtime and staff should not be referring to the covers as bibs.</p> <p>A current undated facility policy "Your Rights As A Nursing Home Resident", available in the pre-survey book, indicated "...You have the right to be treated with respect and dignity...."</p> <p>3.1-3(t)</p>				

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to honor Resident choices for 3 Residents (Residents #63, #6 and #56) of 4 Residents who met the criteria for choices. This had the potential to affect 46 of 46 Resident's in the facility.</p> <p>Findings include:</p> <p>1. An interview with Resident #63 on 8/12/13 at 9:33 a.m., indicated he did not get to choose when to get up in the morning. He indicated he could stay in bed if he was sick. He also indicated he would rather wait to get up in the morning.</p> <p>During the interview with Resident #63 on 8/12/13 at 9:34 a.m., he indicated he had to go to bed when the CNAs had time to assist him into bed. He indicated he wanted to go to bed earlier but the CNAs are outside</p>	F000242	F 242 Resident Choices 1. Resident #63, #6, #56 were interviewed per staff to update care plan for choices of shower time, frequency and when they would like to get up and go to bed. 2. Staff was inserviced on resident choices. 3. All residents will be interviewed to determine shower preference and a schedule will be created to reflect resident preference. Showers will be provided in accordance with resident preference and schedule. All residents will be interviewed to determine preference on times to wake in morning and times to go to bed at night. Social Service or designee will complete audits. Residents preference of wake times and times to go to bed at night will be accommodated. Alist of preference will be placec in Communication Book at the Nurses's station. Staff are responsible to review the Communication Book at the beginning of the shift to review resident preference. 4. Audits will be reviewed in the	09/20/2013			

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	<p>with the smokers and he has to wait until the CNAs were available.</p> <p>During the interview with Resident #63 on 8/12/13 at 9:36 a.m., he indicated he cannot choose when he gets a shower. He indicated he got whatever shower the staff gave him; maybe 1 or 2 times a week. He indicated he would like showers more often, he did not know who to inform of his wishes.</p> <p>Review of the clinical record for Resident #63 on 8/14/13 at 2:00 p.m. indicated he was admitted on 12/5/12 and his diagnoses included but were not limited to S/P (status post) right side CVA (cerebrovascular accident/stroke) with left hemiplegia (one sided paralysis), seizure disorder, dementia, HTN (hypertension/high blood pressure), cardiovascular disease, DM II (adult onset of diabetes), depression, degenerative arthritis and disc disease. Resident #63's BIMS (Brief Interview for Mental Status) was 14/15 which indicated he was alert and oriented.</p> <p>On 8/14/13 at 11:30 a.m. the facility provided a list of interviewable Residents; the list indicated Resident #63 was interviewable.</p>		<p>monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>		

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	<p>An interview with Resident # 63 on 8/16/13 at 10:00 a.m. indicated the facility did not make him aware he could have a shower more often than 1 time per week. He also indicated there was not enough staff available to give him a shower. He indicated the CNAs give him a bed bath daily, but he preferred to have a shower more often.</p> <p>An interview with Resident #63 on 8/19/13 at 9:30 a.m., he indicated he did not receive a shower over the weekend or this morning.</p> <p>A review of Resident #63's clinical record, the bathing record provided by the Interim DCS on 8/14/13 at 4:20 p.m., indicated the Resident only received 7 showers from 6/1/13 through 8/14/13.</p> <p>An interview on 8/16/13 at 11:45 a.m. with CNA #10 indicated Resident #63 mostly received a bed bath. The CNA #10 indicated the Resident could have a shower on other days if she has time; she indicated they are usually short on staff to add in extra showers.</p> <p>An interview on 8/19/13 at 9:30 a.m. with the Interim DCS (Director of</p>			

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	<p>Clinical Services) indicated the Residents' choices are reviewed on admission and then quarterly with the care plan meetings. The Interim DCS indicated the Resident's choices should be documented on the care plan when the reviewed quarterly if it was done. The Interim DCS indicated a Resident could request an increase in the number of showers per week to any of the facility's staff and it should be done. The Interim DCS also indicated Residents could make their preferences known about time to rise in the morning and to go to bed at night to any of the facility's staff and their preferences should be honored.</p> <p>An interview on 8/19/13 at 11:00 a.m. with the Interim DCS indicated the facility did not have a policy addressing the Resident's choice of rising in the morning or going to bed at night.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>				

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	<p>2. Review of the clinical record for resident #6 on 8/15/13 at 10:00 a.m. indicated she was admitted to the facility on 10/8/12 . Review of a list of interviewable residents, provided by the facility on 8/14/13 at 11:30 a.m., indicated resident #6 was interviewable.</p> <p>Interview with resident #6 during stage 1 of the survey indicated she did not get to chose when to get up in the morning. Resident #6 stated, "they wake me up between 6:45 a.m and 7:00 a.m. to go to breakfast." Resident indicated she did not have a</p>			
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	<p>choice when to get up in the morning.</p> <p>3. Review of the clinical record for resident #56 on 8/14/13 at 11:00 a.m. indicated she was admitted to the facility on 10/8/12 . Review of a list of interviewable residents, provided by the facility on 8/14/13 at 11:30 a.m., indicated resident #56 was interviewable.</p> <p>Interview with resident #56 during stage 1 of the survey indicated she did not get to chose when to get up in the morning.</p> <p>Interview with the interim DNS (director of Nursing Services) on 8/19/13 at 11:00 a.m. indicated the facility did not have a policy addressing the resident's choice of when to get up in the morning.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>				

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F000245 SS=D	<p>483.15(d) PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY</p> <p>A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>Based on interview and record review, the facility failed to inform residents upon admission of the facility's policy requiring Resident supervision when going outside of the facility for 1 of 38 Residents reviewed for outside activities. (Resident #45)</p> <p>Findings include:</p> <p>An interview with Resident #45 on 8/15/13 at 12:15 p.m. indicated her Rights were being violated and she was upset. Resident #45 indicated she felt she was being held captive and she could not go outside.</p> <p>An interview with Resident #45 on 8/19/13 at 4:50 p.m. indicated the staff told her she could not go outside when "State" is here. The Resident also indicated she felt very anxious and feels trapped when she is not able to go outside. She indicated she can only go outside at the facility when her Mother is there.</p> <p>A review of Resident #45's clinical record indicated she was admitted to</p>	F000245	F 245 Resident Supervision 1. Resident # 45 no longer resides at the facility. 2.All residents will be notified on admission regarding staff supervision when going outside. 3. Supervision outdoors is provided due to the proximity of the facility to the parking lot and the highway. Audits will be completed on new admissions regarding notification of supervision outdoors. Audits will be completed weekly on all new admissions times one month then monthly times 6 months. Social Service or designee will monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>the facility on 7/5/13 and her diagnoses included but were not limited to severe debility, DM (diabetes mellitus), hypertension (high blood pressure), paroxysmal atrial fibrillation, cardiac pacemaker, morbid obesity, history of DVT (deep vein thrombosis/blood clots). Resident #45's BIMS (Brief Interview for Mental Status) was 15/15 which indicated she was alert and oriented.</p> <p>An interview with Social Service on 8/20/12 at 9:25 a.m. indicated the facility's policy is to provide all residents supervision when going outside of the facility for safety. Social Service indicated Resident #45 could not go outside with the residents who smoke because the staff were to supervise the Residents who are smoking for safety and the staff's attention should not be on anything else. Social Services indicated Resident #45 could go outside with her Mother, who visits almost every day. Social Service indicated the policy is for the safety of the resident. The facility's entry doors are coded for exit and entry and staff is not available to be at the door to let residents into the facility. Social Services indicated the Residents are not informed on admission of the facility's policy to go outside. Social</p>			

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	<p>Services indicated Resident # 45 was recently informed of this facility policy.</p> <p>On 8/20/13 the Executive Director provided the facility's policy titled, Resident Supervision (Outside), not dated. The policy indicated, "...It is the practice of this facility to provide supervision to all residents for their safety and well being when they visit outside facility areas. Due to the proximity of the parking lot and a major highway to the facility this facility provides supervision to our residents as a safety measure. It (supervision) is not intended to supersede, or, infringe on our resident's desires to go outside and utilized the outside resources but a measure to oversee their safety and well being and be available in the event of a resident's need for assistance...."</p> <p>3.1-3(m)</p>			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review the facility failed to provide activities for 1 of 3 residents reviewed who met the criteria for activities. (resident #25)</p> <p><b>Finding includes:</b></p> <p>1. On 8/14/13 at 9:30 a.m. review of the clinical record for resident #25 indicated she was admitted to the facility on 7/9/10 with diagnoses including but not limited to Cerebral Cortical Atrophy, Alzheimer's Disease, Dementia, and Carotid Stenosis.</p> <p>Review of the Quarterly MDS (Minimum Data Set) Assessment dated 7/18/13 indicated resident #25 had short term and long term memory problems.</p> <p>Review of the residents written plan of care for activities indicated the following:</p>	F000248	F 248 Activities 1. Resident #25 Care Plan and Activity Assessment has been reviewed and updated. 2. Audits were completed all residents activities and participation. All residents will be provided with individual and/or group activities based on resident preference. Residents will be encouraged to participate in individual and/or group activities. Residents will be assisted to participate in individual and/or group activities. 3. Audits will be completed weekly times one month and then monthly times 6 months. Activity Director will monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>Resident needs encouragement and reminders to attend activities and also needs directed to their location. Will sometimes wander out of activity because she does not remember why she is there.</p> <p>Resident will participate in 3 to 5 group activities per week through next review 10/23/13.</p> <p>Resident will be open to receiving in room activities such as pet visits and music. 10/23/13</p> <p>Resident will remain open to occasional visits with activity staff. 10/23/13</p> <p>Engage resident in group activities.</p> <p>Provide an activity calendar to resident</p> <p>Provide materials needed for self initiated activities such as music and coloring pages.</p> <p>Remind her why she is in the activity frequently, and about what the group is doing.</p> <p>Praise for participation in activity.</p> <p>Transport resident to activities as</p>			

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	<p>needed</p> <p>Give resident verbal reminders of activity before commencement of activity.</p> <p>Resident #25 was observed throughout the survey with the following observations noted:</p> <p>8/14/13 at 9:15 a.m. resident awake, laying flat on back in bed. 8/14/13 at 10:50 a.m. resident awake, laying flat on back in bed. 8/14/13 at 11:55 a.m. resident awake, laying flat on back in bed. 8/14/13 at 2:10 p.m., resident awake, laying flat on back in bed. 8/14/13 at 3:35 p.m., resident awake, laying flat on back in bed.</p> <p>8/15/13 at 9:00 a.m. resident awake, laying in bed. Pulling at blankets. 8/15/13 at 10:35 a.m. resident awake, laying in bed, playing with her pillow, by placing it on top of her head. 8/15/13 at 2:30 p.m. resident, awake, laying flat on her back in bed, playing with her hair. 8/15/13 at 3:45 p.m. resident observed laying in bed on her back, slapping herself on stomach with both hands.</p>			

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	<p>8/16/13 at 9:35 a.m. resident observed laying in bed awake, rubbing her head and stomach.</p> <p>8/16/13 at 11:30 a.m. resident awake , laying flat on her back in bed.</p> <p>On 8/19/13 at 9:15 a.m. interview with the activity director indicated she stops in the resident's room and asks her to come to activities but the resident tells her "no". The activity director was queried related to activities for lower functioning residents and she indicated she had "simply senses" which were activities like hand massages.</p> <p>Review of the residents "Individual Resident Daily Participation Record" for the month of August, 2013 indicated from August 1st through August 16th, 2013 the resident had been asked to current events three times and refused. The resident had been invited to Social/Party Activities three times and had refused. The only activity listed was "walking" which was listed 13 times.</p> <p>Interview with the Administrator on 8/19/13 at 9:30 a.m. indicated the activity "walking" was for the resident to walk to her meal and back.</p>			

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	3.1-33(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 observation, interview and record review, the facility failed to initiate a care plan for non-compliance with positioning and for use of a specialty bed for 1 of 4 residents who met the criteria for positioning. (Resident #51)</p> <p>Findings include:</p> <p>1. The following observations of Resident #51 in her bed on a low air loss specialty mattress included:</p> <p>-An observation on 8-12-2013 at</p>	F000279	F 279 Turning and Positioning 1. Resident # 51 care plan was reviewed and update for specialty mattress. 2.Facility completed audit of all residents on specialty mattresses and updated care plans as necessary, to include if necessary turning and positioning. 3. DCS or designee will audit residents weekly times one month and then monthly times 6 months.4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>10:54 a.m., indicated the resident was leaning to the right side while in bed and hanging onto the enabler.</p> <p>-An observation on 8-14-2013 at 2:00 p.m., indicated the resident was in bed, leaning toward her right and with her right arm wrapped around the enabler.</p> <p>-An observation on 8-14-2013 at 3:45 p.m., indicated the resident was in bed, leaning toward her right and her right arm was wrapped around the enabler.</p> <p>-An observation on 8-15-2013 at 2:41 p.m., indicated the resident was in bed with the head of the bed elevated 30 degrees and the resident was leaning to her right side toward the enabler.</p> <p>An interview with LPN (Licensed Practical Nurse) #3 on 8-14-2013 at 10:15 a.m., indicated Resident #51 leans to her right side and staff repositions her. LPN #3 indicated the resident did not want to lay on her side and refused a pillow to support her right side.</p> <p>An interview with Resident #51 on 8-14-2013 at 11:47 a.m., indicated the use of a pillow to support her right</p>			

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	<p>side might work to keep her upright, but the resident indicated she did not want to use a pillow.</p> <p>An interview with CNA (Certified Nursing Assistant) #15 on 8-15-2013 at 2:50 p.m., indicated during the 2nd shift, the resident did not want to be bothered until after supper. CNA #15 indicated the resident did not want to be turned on her side, preferred only to lay on her back toward her right side and would not allow the CNA to place a pillow under her right arm for support.</p> <p>The clinical record of Resident #51 was reviewed on 8-14-2013 at 9:16 a.m., indicated diagnoses included but were not limited to, muscle spasms, degenerative joint disease, chronic pain, diabetes, chronic low back pain, depressive disorder, lupus erythroblasts, peripheral neuropathy, anxiety and chronic pain.</p> <p>The Physician recapitulation for July 2013 was signed on 7-14-2013 and indicated in the treatment orders "turn and/or reposition every 2 hours"</p> <p>A review of the quarterly MDS (Minimum Data Set) assessment for Resident #51 dated 6-19-2013, indicated a BIMS (Brief Interview</p>			

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	<p>Mental Status) of 15/15, the resident required an extensive assist of 1 person for bed mobility and the upper extremity was not impaired.</p> <p>A review of OT (Occupational Therapy) discharge notes dated 2-1-2013, indicated resident had instruction from OT to maintain right hand on pillow with inconsistent return demonstration.</p> <p>A review of the current care plans last reviewed on 6-26-2013 for Resident #51 lacked care plans for non-compliance with positioning and for the use of a specialty bed.</p> <p>A policy "Care Plan" dated 9-1-2011 and provided by the Interim Director of Clinical Services on 8-19-2013 at 10:30 a.m., indicated "the facility must develop a comprehensive Care Plan for each resident that includes measurable objectives and timetable to meet the resident medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment...there may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan...."</p> <p>3.1-35(a) 3.1-35(b)(2)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to update care plans for 1 of 4 residents who met the criteria for positioning. (Resident #51)</p> <p>Finding includes:</p> <p>1. The following observations of Resident #51 in her bed on a low air loss specialty mattress included:</p> <p>-An observation on 8-12-2013 at 10:54 a.m., indicated the resident was leaning to the right side while in bed and hanging onto the enabler.</p>	F000280	<p>F 280 Care Plans 1. Resident # 51 care plan was reviewed and update for specialty mattress. 2.Facility completed audit of all residents on specialty mattresses and updated care plans as necessary, to include if necessary turning and positioning. 3. DCS or designee will audit residents weekly times one month and then monthly times 6 months.4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	09/20/2013	

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	<p>-An observation on 8-14-2013 at 2:00 p.m., indicated the resident was in bed, leaning toward her right and with her right arm wrapped around the enabler.</p> <p>-An observation on 8-14-2013 at 3:45 p.m., indicated the resident was in bed, leaning toward her right and her right arm was wrapped around the enabler.</p> <p>-An observation on 8-15-2013 at 2:41 p.m., indicated the resident was in bed with the head of the bed elevated 30 degrees and the resident was leaning to her right side toward the enabler.</p> <p>An interview with the Administrator on 8-15-2013 at 12:18 p.m., indicated "the resident had a specialty bed that turned her from side to side and the aides did not turn her routinely."</p> <p>An interview with the Interim Director of Clinical Services (DCS) on 8-16-2013 at 11:15 a.m., indicated the resident's alternating low loss air mattress did the pressure relieving for the resident and the "turn and reposition every 2 hours" should have been removed from the interventions in the care plan.</p>			

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	<p>The clinical record of Resident #51 was reviewed on 8-14-2013 at 9:16 a.m., indicated diagnoses included but were not limited to, muscle spasms, degenerative joint disease, chronic pain, diabetes, chronic low back pain, depressive disorder, lupus erythromatosis, peripheral neuropathy, anxiety and chronic pain.</p> <p>The Physician recapitulation for July 2013 was signed on 7-14-2013 and indicated in the treatment orders "turn and/or reposition every 2 hours"</p> <p>A review of care plans for risk for impaired skin integrity dated 5-1-2012 and pressure ulcer dated 5-24-2013 indicated interventions of "turn and reposition every 2 hours."</p> <p>A policy "Care Plan" dated 9-1-2011 and provided by the Interim DCS on 8-19-2013 at 10:30 a.m., indicated "the Care Planning Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's status to the existing Care Plans on a daily basis...."</p> <p>3.1-35(d)(2)(b)</p>				

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F000282 SS=E	<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 observation, interview and record review, the facility failed to obtain laboratory tests per the physician's orders for (residents #84 and #43), pressure ulcer wound care for (resident #71), fluid restriction for (resident #66) and medications for (resident #45) for 5 of 38 residents reviewed for physician orders, and failed to ensure the plan of care was followed for 1 of 3 residents reviewed who met the criteria for dental. ( Resident # 63)</p> <p>Findings include:</p> <p>1. Review of the clinical record for resident #43 on 8/15/13 at 9:30 a.m. indicated he was admitted to the facility on 4/3/09 with diagnoses including but not limited to hypertension, urinary retention alzheimers dementia, and delusions.</p> <p>Review of the clinical record indicated resident #43 had physician laboratory orders for a BMP (basic metabolic profile), Lipid Profile (cholesterol test) and ALT (liver function test) to be</p>	F000282	<p>F 282 Lab test, physicians order, wound care, fluid restriction and medication 1. Lab orders were reviewed per physicians orders and updated on residents #84, and #43 care plan update on both residents.. Wound care order updated per physicians order on resident #71, care plan updated. Resident #66 fluid restriction was reviewed by RD and updated per physician order for 1200 cc/day, care plan also updated. Resident #45 medication list and orders were reviewed and update, care plan was also updated. Residents #63 and #10 oral care orders were reviewed and updated per physicians order. Care plans were also updated. 2. All nursing staff were inserviced on MD orders, labs, fluid restrictions, med orders and follow through and documentation. 3. DCS or designee will complete audits on the above issues weekly times one month then monthly time six months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	09/20/2013			

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	<p>done every May and November, and a Hemoglobin A1C (blood sugar test) to be done every 3 months.</p> <p>Review of the clinical record did not indicate the laboratory work had been done as ordered.</p> <p>"Interview with the Interim DCS (Director of Clinical Services) on 8/15/13 at 10:40 a.m. indicated there were no labs drawn in May for the Basic metabolic Profile, Lipid Profile, ALT or Hemoglobin A1C.</p> <p>2. Review of the clinical record for Resident #66 on 8/15/13 at 8:57 a.m., indicated the following: diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, depression and dementia.</p> <p>A Nutrition Data Collection Tool for Resident #66, dated 12/31/12, indicated he received a Mechanical Soft LCS (low concentrated sweets), NAS (no added salt) diet, no foods high in K+ (potassium) or phosphorus. The note also indicated he received 1 can Nepro (nutritional supplement for dialysis) daily.</p> <p>A Nutrition Data Collection Tool for Resident #66, dated 2/18/13, indicated he was hospitalized from</p>						

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	<p>1/24/13 - 2/12/13 related to an infection. The note also indicated his diet on return to the facility was a Mechanical Soft NAS diet, limit foods high in K+, and 1200 cc (cubic centimeters) fluid restriction. The note further indicated he received 1 can Nepro daily.</p> <p>A Nutrition Data Collection Tool for Resident #66, dated 6/24/13, indicated he remained on a Mechanical Soft NAS diet with a 1200 cc fluid restriction. The note also indicated he received 1 can Nepro daily, or 240 cc's.</p> <p>A meal tray card for Resident #66 indicated he received 600 cc at breakfast, 240 cc's at lunch, and 480 cc's at dinner, or a total of 1320 cc's for all 3 meals.</p> <p>The Certified Dietary Manager was interviewed on 8/15/13 at 9:31 a.m. During the interview he indicated he was not aware of any fluid distribution plan for Resident #66. He also indicated nursing provided the balance of fluids for Resident #66 dietary did not provide. Based on information provided by dietary, Resident #66 was receiving more fluids at mealtime than ordered for the entire day.</p>						

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	<p>LPN #9 was interviewed on 8/15/13 at 9:40 a.m. During the interview she indicated Resident #66 had been receiving 240 cc's of water with each med pass or a total of 480 cc's per day. With the addition of 1 can of Nepro daily, the total amount of fluid provided by nursing daily was 720 cc's. The total amount provided by dietary and nursing for Resident #66 in a 24 hour period was 2040 cc's.</p> <p>Review of the Medication Administration Records (MAR) for Resident #66, dated February, 2013 and March, 2013, indicated he was on a 1200 ml fluid restriction every 24 hours. No fluid amounts given to Resident #66 were recorded for each shift only the initials of the staff. The MAR indicated he received 1 can of Nepro daily as ordered.</p> <p>Review of the MAR for Resident #66, dated May, 2013, June, 2013, and August, 2013, indicated he received between 480 cc's to 960 cc's per day from nursing. The MAR indicated he received 1 can of Nepro daily as ordered.</p> <p>The facility could not locate any additional MAR's for Resident #66.</p>				

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	<p>Based on calculations, Resident #66 was being provided a total of 2040 cc's of fluid to 2520 cc's of fluid daily.</p> <p>A facility care plan for Resident #66, dated 7/19/12, indicated the problem area of at risk for alteration in nutrition/hydration related to end stage renal disease and dementia, has NAS low K+ diet, gets dialysis 3 days a week, has 1200 ml fluid restriction, and is aware of importance of keeping to fluid restriction due to dialysis but will still ask for extra fluids and will drink pop. Approaches to the problem included, but were not limited to, diet per order, monitor intake, monitor daily fluid intake, and encourage to follow diet restriction and educate on consequences.</p> <p>The Corporate Dietitian was interviewed on 8/15/13 at 9:45 a.m. During the interview she indicated Resident #66 did not have a fluid distribution plan. She also indicated he had been receiving more fluid than ordered. She further indicated his orders did not indicate the Nepro was not to be included in the fluid restriction, so her assumption was the Nepro was part of the total fluid he was to receive in 24 hours.</p>			

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	<p>A current facility policy "Fluid Restriction", with a review date of 1/1/10 and provided by the Director of Clinical Services on 8/15/13 at 11:45 a.m., indicated "...This facility is responsible for insuring that all residents receive adequate intake within the limitations determined by the attending physician...The resident will have fluid restrictions calculated so that he/she can have intake on each shift based on resident preferences...The dietitian documents the allowed fluids in the medical record and provides a written breakdown of fluids to the nursing staff...At the end of each shift the CNA will report the intake to the Clinical Nurse who will document it on the Medication Record...."</p> <p>3. An interview with Resident #63 on 8/12/13 at 10:05 a.m., during stage 1 Resident interview, indicated his right lower tooth hurts sometimes and the area is aggravated by heat and cold or when he bit down. He indicated he had gone to the dentist on 2 occasions. He indicated the dentist told him he needed a good cleaning of his teeth.</p> <p>During the stage 1 interview with Resident #63 on 8/12/13 at 10:07 a.m., he indicated the CNA assists</p>			

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	<p>him once in a while with oral care if he asked for assistance. He also indicated the CNA assists him about 1 time a month.</p> <p>An interview with Resident #63 on 8/14/13 at 10:03 a.m. indicated he had seen the Dentist 2 times and required deep cleaning by the Dentist. He indicated he was not aware of instructions from the Dentist for his oral care. The Resident indicated he was able to do his own oral care but he needed assistance with set up or assistance to go into the bathroom. The Resident indicated he was only assisted with oral care set up if the staff has enough time. He also indicated the staff does not offer to assist him with oral care.</p> <p>Review of the clinical records for Resident #63 on 8/14/13 at 2:00 p.m. indicated he was admitted to the facility on 12/5/12 and his diagnoses included but were not limited to S/P (status post) right side CVA (cerebrovascular accident/stroke) with left hemiplegia (one sided paralysis), seizure disorder, dementia, HTN (hypertension/high blood pressure), cardiovascular disease, DM II (Adult onset of diabetes), depression, degenerative arthritis and disc disease. Resident #63's BIMS (Brief</p>			
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	<p>Interview for Mental Status) was 14/15 which indicated he was alert and oriented.</p> <p>An interview with LPN #2 on 8/16/13 at 10:37 a.m. indicated the Residents oral care is part of their personal hygiene and is documented in the Care Tracker (electronic clinical record). She indicated she was not aware what the Nursing Care Plan indicated for Resident #63 and she hoped he received oral care at least daily.</p> <p>An interview with CNA #10 on 6/16/13 at 11:45 a.m. indicated she assisted the resident with his oral care when he requested assistance to brush his teeth. CNA #10 also indicated he needed assistance to get into and out of his bathroom.</p> <p>An interview with DCS on 8/19/13 at 9:30 a.m. indicated there was not specific documentation for completion of oral care. She indicated nursing staff is responsible to make sure oral care was done.</p> <p>An interview with Resident #63 on 8/19/13 at 9:40 a.m. indicated he had not had assistance to brush his teeth.</p> <p>An interview with LPN #11 on 6/19/13</p>			

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	<p>at 2:45 p.m. indicated if a Resident has specific care needs, such as oral care, then nursing staff was to check if it was completed and the documentation would be on the Resident's TARs (Treatment Administration Record).</p> <p>A review of Resident #63's TARs on 6/19/13 at 3:30 p.m., indicated there was no documentation for completion of oral care on the TARs per Nursing Care Plan.</p> <p>A review of Resident #63's Physician Progress Note dated 5/8/13 at 12:00 p.m., indicated, "...Home care recommendations: brushing of the teeth twice a day and flossing once a day to remove plaque and prevent further progression of periodontal disease...."</p> <p>On 8/14/13 at 9:20 a.m., a review of Resident #63's Nursing Care Plans indicated, "...Resident's inability to complete self care task independently r/t (related to) left hemiplegia. Ext (extensive) assist of 1-2 staff...Approaches...Supervise and assist with ADL (activity of daily living) hygiene, AM/PM and providing unaided assist to achieve increased independence or maintain current function...Orient to task at hand and</p>			

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	<p>allow sufficient time for completion of task...Assist with oral care BID (2 time a day)...Role(s)...N (nursing)...."</p> <p>Interview with Social Services on 8/14/13 at 3:05 p.m. indicated the letter "N" on the Nursing Care Plans stood for Nursing and indicated Nursing was responsible to make sure Resident's teeth were brushed 2 times a day.</p> <p>4. An interview with Resident #45 on 8/13/13 at 8:45 a.m. indicated she was upset because she did not receive her green pill 2 nights in a row, on Sunday night (8/11//13) and Monday night (8/12/13). She indicated the green pill helped her leg pain the most. The Resident indicated she did not know the name of the medication, knew it was a small green pill she took at night. The Resident indicated the nurse brought the pill to her but took it away when she told her she needed fresh water to take it. She indicated the nurse did not bring the pill back to her or fresh water.</p> <p>An interview with RN #12 on 8/13/13 at 3:00 p.m. indicated Resident #45 green pill at night was Ropinirole (for restless leg syndrome) 1 mg (milligram). The nurse indicated the</p>			

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	<p>Resident received 1 tablet at HS (bedtime). RN #12 provided Resident #45's Medication Blister Card for Ropinirole, a small green pill. The Rx (prescription) on the card indicated, Resident # 45's name, Medication: Ropinirole 1 mg, give 1 tablet at HS.</p> <p>A clinical record review on 8/13/13 at 3:00 p.m., of Resident #45's MARs (Medication Administration Records) indicated Mirapex 0.5 mg (for restless leg syndrome) 1 tablet p.o. (by mouth) was discontinued and Ropinirole 1 mg, give 1 tablet p.o. (by mouth) at HS was given.</p> <p>On 8/13/13 at 3:00 p.m., a review of Resident #45's Physician Orders indicated there was not an order for Ropinirole 1 mg p.o. daily at HS.</p> <p>A record review of Resident #45's MARs indicated Ropinirole 1 mg, give 1 tablet p.o. (by mouth) at HS was given. Documentation indicated Resident refused medication and the Nurse's Medication Notes, dated 8/12/13 indicated, "...I don't want it, there is no cold water. Ropinirole..."</p> <p>The documentation on the MARs dated 8/13/13 appeared to indicate the Resident refused Ropinirole, there was no additional documentation on the Nurse's Medication Notes for the</p>			

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	<p>date of 8/13/13. A review of the MARs also indicated Resident #45 did not receive Buspar 5 mg 1 tablet at 8 p.m. on 8/12/13 and the Nurse's Medication Notes dated 8/12/13 indicated, "...refused Buspar...No cold water...."</p> <p>An interview with DCS on 8/20/13 at 8:55 a.m. indicated the Pharmacy sent an interchange order. She indicated the interchange order was not on Resident #45's clinical record. The DCS indicated the Pharmacy faxed the missing interchange order to the facility. The DCS provide the interchange order, dated 7/29/13; the interchange order indicated, "...DC order: Mirapex 0.5 mg orally at bedtime...New order: Ropinirole HCL 1 mg p.o. at bedtime..." The DCS indicated a Physician's order should have been written and signed by the physician.</p> <p>5. Review of Resident #71's clinical record on 8/13/13 at 2:20 p.m. indicated he was admitted to the facility on 5/18/13 and his diagnoses included but were not limited to DM II (adult onset diabetes), HTN (hypertension), CAD (Coronary Artery Disease), advanced dementia, BPH (benign prostatic hyperplasia), chronic kidney disease, UTI (urinary tract</p>			

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	<p>infection).</p> <p>On 8/13/13 at 11:10 a.m. a review of Resident #71's Physician's Orders dated 7/24/13 indicated, "...Cleanse Right heel with soap and H2O (water), pat dry, apply Santyl (an enzymatic debriding agent for skin ulcers) and cover with Dermaform (a dressing) daily...."</p> <p>On 8/13/13 at 11:30 a.m. a review of Resident #71's Physician Progress Note, dated 7/24/13 at 10:00 a.m., indicated, "...Required visit: patient is doing well. Appetite is good, Afebrile. Area to Left heel dry and hard...open area to Left heel...Plan: Change Santyl daily...."</p> <p>On 8/13/13 at 2:20 p.m. an observation assessment with the Corporate Nurse Consultant of Resident #71's left heel, indicated the following: His heels were floated on a pillow and the wound was without a dressing. Wound had a thin pale callous with dry edges, skin surrounding wound was pink, no drainage noted. There was not a dressing or Santyl on the wound.</p> <p>Review of Resident #71's TARs (Treatment Administration Records) on 8/13/13 indicated there was no</p>						

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	<p>documentation the Resident's wound care to heel was done daily from 7/24/13 to 8/13/13.</p> <p>An interview with DCS on 8/19/13 at 11:15 a.m. indicated there was no documentation in Resident #71's clinical record to determine if the Physician's Order for daily wound care treatment to the Resident's left heel was done. The DCS also indicated the nurse who wrote the verbal order for wound care indicated the treatment to the right heel and it should have been for the left heel.</p> <p>The facility's policy, titled Wound Care Prevention &amp; Treatment Objectives with a revision date of 09-01-2011, provided by the DCS on 8/20/13, indicated, "...Every treatment will be individualized to each resident's need and specific physician's order...."</p> <p>6. The record review for Resident #84 began on 8-19-2013 at 2:57 p.m.</p> <p>Resident #84 was admitted to the facility on 6-14-2013.</p> <p>Diagnoses included but were not limited to, pancreatitis, diabetes, anemia, coumadin therapy, gastritis, duodenitis and esophagitis.</p>			

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	<p>A review of the physician's orders on 6-14-2013 indicated a PT/INR (Prothrombin Time and International Normalized Ratio, a blood test to measure blood clotting time and to ensure accurate dosing of Coumadin) to be done daily and creatinine blood test (measures kidney function) to be done three times per week.</p> <p>A review of the laboratory results provided by the Interim Director of Clinical Services (DCS) indicated no results of a PT/INR for 6-15-2013, 6-16-2013 and 6-17-2013.</p> <p>A review of the creatinine laboratory results provided by the Interim DCS indicated a lack of results for the 1 creatinine test for the week of July 28th and 2 tests were not done during the week of August 4th.</p> <p>An interview with the Interim (DCS) on 8-19-2013 at 4:30 p.m., indicated the creatinine labs were ordered three times per week and were not completed three times a week.</p> <p>Further interview with the Interim (DCS) on 8-20-2013 at 8:57 a.m., indicated there were not lab tests and results for the daily ordered PT/INR lab test for June 15, 16 and 17, 2013.</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 interview and record review, the facility failed to assess the dialysis shunt every shift for 1 of 1 resident (Resident #66) who met the criteria for dialysis.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #66 on 8/15/13 at 8:57 a.m., indicated the following: diagnoses included, but were not limited to, end stage renal disease, hypertension, diabetes mellitus, depression and dementia.</p> <p>Physician orders for Resident #66, dated for the month of August, 2013, indicated he received dialysis on Monday, Wednesday, and Friday.</p> <p>A facility care plan for Resident #66, dated 7/19/12, indicated the problem area of renal dialysis and a 1200 ml (milliliter) fluid restriction. Approaches to the problem included, but were not limited to, monitor fluid intake, monitor</p>	F000309	F 309 Dialysis Shunt 1. Resident # 66 Care Plan, Physician orders have been reviewed and updated regarding AV Shunt. 2. All A/V Fistula and Shunts were reviewed and updated per physicians orders. Access point will be monitor for bruit and thrill and documented on the MAR. All charge nurses were inserviced documentation and care. 3. Audits of A/V Shunts and Fistulas we be completed weekly times 4 weeks then monthly times 6 months for proper documentation. DCS or designee will monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>shunt for patency, check access site for thrill and bruit every shift, and assess access site for signs of infection.</p> <p>Review of the Skilled Nursing Progress Notes for Resident #66, dated 5/28/13 through 8/19/13, indicated his access site was checked for bruit and thrill only on 5/31/13 and 8/2/13.</p> <p>Review of the available Medication Administration Records (February 2013, April 2013, June 2013, July 2013, and August 2013) for Resident #66, did not indicate staff were monitoring the shunt for patency, checking access site for thrill and bruit every shift, and assessing access site for signs of infection.</p> <p>Nurse #14 was interviewed on 8/15/13 at 2:20 p.m. During the interview she indicated there were no documents in the clinical record for Resident #66 where nursing staff were monitoring his shunt for patency, assessing access the site for signs of infection, and checking access site for thrill and bruit every shift.</p> <p>A current facility policy "Care of Resident Hemodialysis - A/V</p>						

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	Fistula/Shunt", revised on 9/1/11 and provided by the Administrator on 8/16/13 at 9:00 a.m., indicated "...Resident undergoing hemodialysis must have the access point (A-V fistula or A-V shunt) monitored every shift by a RN/LPN...."  3.1-37(a)				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review the facility failed to provide an assistive drinking device and showers for 1 of 1 residents who met the criteria for Activities of Daily Living. (resident #4)</p> <p>Finding includes:</p> <p>1. Review of the clinical record for resident #4 on 8/14/13 at 10:00 a.m. indicated he was admitted to the facility on 3/5/99 with diagnoses including but not limited to multiple sclerosis with quadriplegia, Iliac occlusion with stent 4/14/13, and sepsis secondary to urinary tract infection.</p> <p>On 8/14/13 at 10:15 a.m. review of the resident's written plan of care indicated the following dated 3/7/11:</p> <p>Risk for dehydration related to depression, history of urinary tract infection, multiple sclerosis, immobility, dependent on staff for all food and fluids. Needs fed per staff.</p>	F000312	F 312 Assistive Devices and Showers 1. Resident #4 assistive drinking device is in place for residents use. Shower scheduled reviewed so resident will receive two showers per week and as needed. Care plan updated. 2. Audits were completed on all residents to access for use of assistive devices. Audits were also completed on resident showers per time and frequency of choice. All Care Plans were updated per audits. Staff inserviced on protocol 3. Audits we be implemented for residents with assistive devices and shower preferences weekly times one month and monthly times 6 month. DCS or designee to monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>Will have no signs or symptoms of dehydration thru next review. 10/30/13</p> <p>First shift nursing staff will fill liquid dispensing device.</p> <p>Second shift nursing staff will fill liquid dispensing device.</p> <p>Will receive supplement as ordered.</p> <p>Encourage fluids</p> <p>Labs as directed</p> <p>Water pitcher at bed side offer drinks of water frequently during day between meals.</p> <p>Offer fluids frequently</p> <p>Assist resident with drinking and eating at meals and offer drinks of water between meals. He needs total staff assist to eat and drink.</p> <p>Observation of the resident on 8/14/13 at 1:30 p.m. did not indicate he had a liquid dispensing device on his wheelchair.</p> <p>Interview with the resident on 8/14/13 at 1:40 p.m. indicated he had had a</p>						

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	<p>drinking glass on his wheelchair with a straw that he could use by himself without the staff giving him a drink. He indicated it broke and he has not had it for about a year.</p> <p>On 8/14/13 at 2:30 p.m. interview with CNA #3 indicated the resident use to have a drinking device on his chair but she did not know what had happened to the drinking device.</p> <p>2. Interview with resident #4 on 8/14/13 at 10:00 a.m. indicated he does not always get a shower according to his schedule. The resident indicated if the facility nursing staff are "short" they give him a bed bath.</p> <p>Review of the clinical record for resident #4 indicated the following plan of care:</p> <p>Care Plan 3/7/11 Self Care Deficit related to decreased mobility, multiple sclerosis, fracture of the hip, pain, insomnia, depression, contractures, incontinence of bowel and supra pubic catheter use with history of urinary tract infections. Dependent on staff due to quadriplegia due to multiple sclerosis, unable to move extremities.</p>			

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	<p>Will be neatly groomed and dressed appropriately on a daily basis through next review. 10/30/13</p> <p>All transfers using hoyer lift and 2 staff assist.</p> <p>Ensure resident is sitting in his W/C with good body alignment</p> <p>Oral care twice daily</p> <p>Nail care per regular routine</p> <p>Staff to provide am care, pm care, and incontinent care daily</p> <p>Shower per schedule</p> <p>Resident to be dressed in personal clothing daily.</p> <p>Encourage resident to choose his own clothing</p> <p>Call light touch pad within reach and answered promptly</p> <p>Assist x 1-2 staff with all ADL (activities of daily living) care</p> <p>Fed by staff</p> <p>On 8/14/13 at 3:45 p.m. review of the</p>						

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	<p>resident's bathing documentation from 6/1/13 through 8/14/13 indicated the resident did not always get a shower two times a week. From 6/27/13 through 7/8/13, and from 7/12/13 through 7/21/13 the resident had not received a shower only bed baths.</p> <p>On 8/15/13 at 10:00 a.m. review of the facility policy "Bathing /Showering" with a revision date of 1/1/12, indicated assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident.</p> <p>3.1-38(c) 3.1-38(a)(3)(A)(B)(2)</p>			

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F000325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to assess, develop and implement dietary interventions for 2 residents (Resident #83 and Resident #85) of 4 residents who met the criteria for weight loss since admission, and 1 resident (#45) who had no weights and dietary assessments. This resulted in severe weight loss for Residents #83 and #85.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #83 on 8/15/13 at 3:18 p.m., indicated the following: diagnoses included, but were not limited to, abdominal pain, chronic back pain, hypertension, diabetes mellitus, pancreatitis, ascites (fluid in abdominal cavity), and urinary retention.</p>	F000325	F 325 Dietary interventions for weight loss 1. A review of # 83 nutritional assessment and weight loss were completed by RD and communicated to DCS and MD. Care plan updated. Resident # 85 and #45 no longer reside at facility. 2.Weights were obtained on all in house residents. All staff were inserviced on weight loss or gain and meal intake. The DCS and Dietary Manager will validate weekly that all weights are obtained as indicated. Audits were completed on all residents weights. All residents will be assessed by the Registered Dietician within 7 days of admission, quarterly, with significant change change, annually and as indicated with significant weight loss or gain. 3. Audits will be completed weekly times one month and then monthly times 6 months. DCS and Dietary Manager will monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6	09/20/2013			

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	<p>A physician's order for Resident #83, dated 5/30/13, indicated a Regular LCS (low concentrated sweets) NAS (no added salt) diet and SF (sugar free) shake with meals.</p> <p>An Initial and Annual Nutrition Assessment for Resident #83, dated 5/29/13, indicated an admission weight 112.3 pounds and a usual weight of 108 pounds. The assessment also indicated she had increased nutrient needs related to her diagnosis of chronic pancreatitis and was at risk for weight changes.</p> <p>A physician's order for Resident #83, dated 6/7/13, indicated Lasix (diuretic) 20 mg (milligrams) daily.</p> <p>Skilled Nursing Progress Notes for Resident #83, dated 6/11/13, indicated she was sent to the hospital ER (emergency room) for evaluation and treatment for increased pain.</p> <p>An Admission - Data Collection Form for Resident #83, dated 6/26/13, indicated she had returned to the facility from the hospital. The form indicated a weight of 110.8 pounds.</p> <p>Physician orders for Resident #83, dated 6/26/13, indicated a LCS NAS diet with SF health shake with meals.</p>		<p>months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	

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	<p>The orders did not include the Lasix.</p> <p>A Monthly Weights and Percentages for Resident #83 indicated the weight of 96.5 pounds on 7/20/13, or a loss of 14% since her admission on 5/24/13, indicating a severe weight loss. There were no other weights available in the clinical record from the admission weight of 112.3 pounds on 5/29/13 to the July, 2013 weight of 96.5 pounds. Review of the clinical record indicated there were no additional dietary interventions initiated to prevent further weight loss.</p> <p>Review of the Meal Intake Detail Report for Resident #83 indicated the following: for the breakfast meal - no meal intake was recorded for 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 5/30/13, 6/3/13, 6/4/13, 6/5/13, 6/7/13, 6/10/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 7/6/13, 7/7/13, 7/9/13, 7/11/13, 7/27/13, 8/3/13, 8/9/13, 8/12/13, and 8/13/13; for the lunch meal - no meal intake was recorded for 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 5/30/13, 6/3/13, 6/4/13, 6/5/13, 6/7/13, 6/10/13, 6/11/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 7/6/13, 7/7/13, 7/9/13, 7/11/13, 7/27/13, 8/3/13, 8/9/13, 8/12/13, and 8/14/13; for the dinner meal - no meal intake was was</p>						

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	<p>recorded for 5/24/13, 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 6/1/13, 6/2/13, 6/3/13, 6/4/13, 6/5/13, 6/6/13, 6/7/13, 6/8/13, 6/9/13, 6/10/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 7/1/13, 7/2/13, 7/3/13, 7/4/13, 7/5/13, 7/6/13, 7/7/13, 7/8/13, 7/9/13, 7/10/13, 7/11/13, 7/12/13, 7/13/13, 7/14/13, 7/15/13, 7/16/13, 7/17/13, 7/18/13, 7/19/13, 7/20/13, 7/21/13, 7/22/13, 7/23/13, 7/24/13, 7/25/13, 7/26/13, 7/27/13, 7/28/13, 7/30/13, 8/1/13, 8/2/13, 8/4/13, 8/5/13, 8/6/13, 8/7/13, 8/8/13, 8/10/13, 8/11/13, 8/14/13, and 8/15/13.</p> <p>A Nutritional Review for Resident #83, dated 8/14/13 and written by the Registered Dietitian, indicated a weight of 166 pounds plus chair. The review did not indicate the weight of the chair. Since the weight of the chair was not calculated, the weight of Resident #83 was not calculated. The review also indicated her intakes were 75-100% at mealtime, although there was no mention of the number of days missing from the Meal Intake Detail Report. The review further indicated there were no recommendations made from the Registered Dietitian.</p> <p>There were no additional weights to</p>			

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	<p>review for Resident #83.</p> <p>A current meal tray card for Resident #83 indicated she received a LCS NAS diet with a 4 ounce sugar free health shake with each meal</p> <p>A facility care plan for Resident #83, dated 5/24/13, indicated the problem area of at risk in nutrition/hydration. The goal for Resident #8 was not to have significant change in weight through next review. Approaches to the problem included, but were not limited to, diet per order, weigh weekly x 4 weeks then monthly or as ordered, and monitor intake and documentation on daily flow sheet.</p> <p>A facility care plan for Resident #83, dated 8/14/13, indicated the problem area of nutritional risk. Approaches to the problem included, but were not limited to, diet as ordered, monitor weight, and monitor intake.</p> <p>2. Review of the clinical record for Resident #85 on 8/15/13 at 10:42 a.m., indicated the following: diagnoses included, but were not limited to, pancreatic pseudocyst, chronic liver disease, fatty liver, alcohol abuse, ascites, decreased appetite, major depression/psychosis, and cirrhosis of liver.</p>				

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	<p>Resident #85 was admitted to the facility on 6/21/13 and was re-admitted to the facility on 6/25/13.</p> <p>Physician's orders for Resident #85, dated for the month of June, 2013, indicated he received a Regular diet. The order also indicated he received 20 mg Lasix daily and Remeron 30 mg HS (hour of sleep).</p> <p>A physician's order for Resident #85, dated 6/27/13, indicated the Remeron was for decreased appetite.</p> <p>An Initial and Annual Nutrition Assessment for Resident #85, dated 6/21/13, did not include a height and weight.</p> <p>A Nutritional Progress Notes for Resident #85, dated 6/24/13, indicated no height and weight were recorded on admission.</p> <p>A physician's order for Resident #85, dated 7/8/13, indicated to change Lasix to 40 mg daily.</p> <p>A Weekly Weights and Percentages for Resident #85 indicated a weight of 149.8 pounds on 7/20/13. There were no other weights prior to 7/20/13 recorded for Resident #85.</p>			

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	<p>A Weekly Weights and Percentages for Resident #85 indicated a height of 68 inches and a weight of 136.7 pounds on 8/7/13, a loss of 8% since the weight of 149.8 pounds on 7/20/13, indicating a severe weight loss.</p> <p>Review of the Meal Intake Detail Report for Resident #85 indicated the following: for the breakfast meal - no meal intake was recorded on: 6/22/13, 6/23/13, 6/24/13, 7/6/13, 7/7/13, 7/11/13, 7/16/13, 7/21/13, 7/28/13, 8/3/13, 8/5/13, 8/9/13, 8/11/13, and 8/13/13; for the lunch meal - no meal intake was recorded on: 6/22/13, 6/23/13, 6/24/13, 7/3/13, 7/6/13, 7/7/13, 7/11/13, 7/16/13, 7/21/13, 7/28/13, 8/3/13, 8/5/13, 8/9/13, 8/11/13, 8/12/13, and 8/13/13; for the dinner meal - no meal intake was recorded on: 6/22/13, 6/23/13, 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 7/1/13, 7/2/13, 7/3/13, 7/4/13, 7/5/13, 7/6/13, 7/7/13, 7/8/13, 7/9/13, 7/10/13, 7/11/13, 7/12/13, 7/14/13, 7/15/13, 7/16/13, 7/17/13, 7/18/13, 7/19/13, 7/20/13, 7/22/13, 7/23/13, 7/24/13, 7/25/13, 7/26/13, 7/27/13, 7/28/13, 7/30/13, 8/1/13, 8/2/13, 8/4/13, 8/6/13, 8/8/13, 8/10/13, and 8/11/13.</p>			
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	<p>A Nutritional Progress Notes for Resident #85, dated 8/12/13, indicated a weight of 136.7 pounds, or a loss of 8.4%, with a usual weight of 145 pounds. The note also indicated his Lasix was increased and weight loss was due to the diuretic. The note also indicated the resident described his appetite as "fine", but did not eat breakfast. The note did not consider any other reason for the weight loss, even though the resident was receiving Remeron for his appetite and did not mention the number of days missing from the Meal Intake Detail Report. The note further indicated there were no recommendations made to prevent additional weight loss.</p> <p>A facility care plan for Resident #85, dated 6/21/13, indicated the problem area of at risk for alteration in nutrition/hydration. The goal for Resident #85 was to not have a significant change in weight through next review. Approaches to the problem included, but were not limited to, diet per order, monitor intake, and weight weekly x 4 weeks then monthly and as ordered.</p> <p>The Certified Dietary Manager was interviewed on 8/12/13 at 3:00 p.m. During the interview he indicated the</p>			

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	<p>facility procedure for residents weights were for staff to obtain the weight on each resident as ordered, complete a weight sheet for each month, and provide the sheet to dietary for review. He also indicated the procedure was not being followed.</p> <p>The Administrator was interviewed on 8/13/13 at 8:30 a.m. During the interview she indicated newly admitted residents were to be weighed weekly unless there were specific circumstances not to weigh.</p> <p>The Regional Dietitian was interviewed on 8/13/13 at 9:30 a.m. During the interview she indicated newly admitted residents were to be weighed weekly and at the recommendation of the Registered Dietitian.</p> <p>A current facility policy "Weighing the Resident", revised on 1/1/09 and provided by the Administrator on 8/16/13 at 9:00 a.m., indicated "...At a minimum, all residents of the facility shall be weighed upon admission and monthly...Weights will be completed monthly and documented in the nurses notes...Review prior month's weight and the scale that was used...Should the weight on the scale show a significant difference (a gain</p>						

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	<p>or loss of 5% within thirty day, 7.5% in ninety days, or 10% in six months) notify the nurse who will also alert the dietary department on the communication form...When there is a significant variance from the previous recorded weight the scale should be re-balanced and the resident re-weighed...Record weight and alert nurse to any significant change...The nurse will: 1. Notify the physician of any significant weight change 2. Consult with the Director of Dietary Services and/or dietitian 3. Notify the MDS (Minimum Data Set) Coordinator in order to update the plan of care...The weight committee will review residents with a significant difference in weight...."</p> <p>3. During the Admission Record Review for Resident #45 on 8-13-2013 at 1:30 p.m., there was no documentation weights were recorded for the resident.</p> <p>An interview with the Corporate Dietitian on 8-13-2013 at 1:30 p.m., indicated she was unable to find any weights done by the facility since admission on 7-5-2013 or an admission dietary assessment done by the dietitian. She indicated the HCSG (Healthcare Services Group) dietitian was in the facility one time in July 2013. The Corporate Dietitian</p>			

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	<p>indicated the Corporate policy required completion of a dietary assessment within 7 days of admission.</p> <p>A "Dietary Services Agreement" provided by the Administrator on 8-14-2013 at 4:03 p.m., indicated "HCSG shall provide sufficient staffing to address the Facility's volume of admissions...and necessary nutritional assessments as required...."</p> <p>A policy "Clinical Dietary Policies and Procedures-Dietary Policy Status" dated 1-1-2007, provided by the Corporate Dietitian indicated "the Dietitian/DTR will complete a full nutritional assessment within the first 7 days and an Annual Reassessment. Residents at high nutritional risk will be assessed within 24-48 hours of admission....weight is also obtained by nursing when the resident is admitted and at least monthly thereafter...weight is also obtained by nursing when the resident is admitted and at least monthly thereafter...."</p> <p>3.1-46(a)(1)</p>			

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F000328 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 observation, interview and record review, the facility failed to ensure the respiratory status (respiratory rate, heart rate and breath sounds) of the resident were completed prior to and after the nebulizer treatment was administered for 1 of 1 resident observed during the medication pass. (Resident #65)</p> <p>Findings include:</p> <p>1. During an observation of the medication pass on 8-19-2013 at 12:00 p.m., LPN #11 was preparing to administer a breathing treatment. The LPN was observed to obtain Resident #65's blood pressure and pulse oximetry (a measurement of the oxygen level in the blood) prior to the breathing treatment. The LPN was observed to administer the Duoneb treatment. After the treatment, the LPN was observed to obtain Resident</p>	F000328	F 328 Nebulizer Treatment 1. Resident #65 nebulizer treatment and assessment reviewed, Care Plan updated 2. Charge nurses were inserviced on proper assessment technique of nebulizer treatments. 2. All resident with Nebulizer treatments were reviewed and Care Plans updated. Nurses were inserviced on assessments techniques for nebulizer treatments 3. DCS or designee will audit for compliance weekly times one month and then monthly times 6 months. The audits will alternate randomly to cover all shifts. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013			

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	<p>#65's blood pressure, pulse oximetry and breath sounds in the anterior, upper chest only. Breath sounds were not assessed prior to the treatment and the anterior lower lobes and posterior breath sounds were not assessed after the treatment</p> <p>Prior to the breathing treatment, an interview with LPN #11 on 8-19-2013 at 12:00 p.m., indicated she would obtain the resident's blood pressure and pulse oximetry</p> <p>The clinical record for Resident #65 was reviewed on 8-19-2013 at 1:45 p.m.</p> <p>The physician progress note dated 8-14-2013 indicated Resident #65 was to begin Duoneb treatments QID (every 6 hours) routinely for 7 days for an upper respiratory infection and chronic obstructive pulmonary disease.</p> <p>An interview with LPN #2 on 8-20-2013 at 9:06 a.m., indicated prior to and after a breathing treatment, the nurse should obtain a resident's pulse and pulse oximetry.</p> <p>A review of the "Hand Held Nebulizer" policy provided by the Director of Clinical Services on 8-19-2013 at</p>			

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	<p>2:15 p.m., indicated "...assess the resident...establish baseline respiratory rate, heart rate and breath sounds...administer treatment... assess the resident's response and effectiveness of treatment by assessing breath sounds and sputum production...."</p> <p>3.1-47(a)(6)</p>			

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F000333 SS=J	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to prevent a significant medication error for 1 Resident (#34). This resulted in Resident #34 requiring intravenous therapy and experiencing a temporary decline in mobility. The facility further failed to implement measures to properly identify Residents during medication administration to prevent future medication errors, potentially affecting all 46 of the 46 Resident's in the facility.</p> <p>The Immediate Jeopardy began on 8/10/12 at 8:15 a.m. when the facility failed to ensure a nurse could accurately identify a resident during medication administration resulting in medications being given to the wrong Resident. The Executive Director (ED) and the Interim Director of Clinical Services (DCS) were notified of the Immediate Jeopardy at 2:20 p.m. on 8/15/13. The Immediate Jeopardy was removed on 8/16/13, but non-compliance remained at the scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p>	F000333	<p>F 333 Medication Error 1.On 8/10/13 resident #34 (BIMS 14) notified of receipt of wrong medications. MD notified, sister notified Vital sign assessment conducted through 8/11/13 2.All in-house residents MARs/TARs were audited to validate picture were in place. 3.All licensed nurses to be educatted on Medication Administration and the five rights of Medication administration. Education includes Preventing Medication errors At-A-Glance (attachment #1) and identificationnof resident through picture on MAR/TAR. The Admission Coordinator or designee will be educated to take photograph of all new admissions and readmissions at the time of admission/readmission. The director of Clinical Services (DCS) and/or Assistant Director of Clinical Services (ADCS) will conduct Competency 6 (attachment #2) of the Clinical Nurse Skills Checklist with all current licensed nurses. Competency will be evaluated through return demonstration. All new hires (licensed nurses) will demonstrate competency in medication administration through Competency 6 of the Clinical Nurse Skills Checklist prior to administering medications without</p>	09/20/2013	

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	<p>Finding includes:</p> <p>During an interview on 8/12/13 at 11:07 a.m. with Resident #34, he indicated he was given his roommates medications on Saturday (8/10/13) morning when he was in the dining room. Resident #34 indicated he needed to have IV(intravenous) fluids to flush out the medication. The Resident indicated he took 9 pills that were not his medications. The Resident indicated he began to feel very weak and could not transfer to a wheelchair by himself and needed assistance of 2 staff. He also indicated he did not start feeling better until after 10:00 p.m. on 8/10/13. The Resident indicated the nurse that gave him the medications was in training, and the other staff nurse stood in the doorway of dining room and pointed to the table where he was seated. The Resident indicated the nurse did not verify who he was and he just glanced at the pills and swallowed them. After he swallowed the pills, he then realized the medications were not his usual medications because there was a purple capsule in the medication cup. He then reported to his usual nurse he was given the wrong medications. He indicated the nurse called the</p>		<p>direct supervision. 4. Medical Records will audit all new admissions/readmissions within 72 hours to validate that all MARs/TARs have a current photograph. The DCS will review and sign all new hires (licensed nurses) Competency 6 of the Clinical Nurse Skills Checklist to validate the new hire demonstrated competency prior to administering medications without direct supervision. All audits and Competency 6 of the Clinical Nurse Skills Checklist will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated. An ad hoc QAC meeting was held on 8/13/13 to review and approve the Action Plan. The Medical Director was notified of Action Plan on 8/13/13.</p>		

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	<p>Physician and reported he was given the wrong medications and the Doctor ordered an IV to be started. The Resident indicated the nurse did not verify his name. The Resident expressed concern this had happened and indicated he no longer felt safe to stay at the facility.</p> <p>An interview on 8/15/13 at 12:15 p.m. with LPN #2 indicated she had worked at the facility for a while and she knew the residents. She indicated she assisted new staff by pointing out the residents for them during administration of medications. She indicated they have put pictures in the MAR to identify the residents, but not all of the residents had photos on the MAR yet.</p> <p>A Review of Resident #34's clinical record indicated his diagnoses included but were not limited to coronary artery diseases (CAD), diabetes mellitus Type II, hypertension (high blood pressure), bipolar disorder, hyperlipidemia, hypothyroidism, dementia, syncope, obesity, history of falls and history of pulmonary embolus. Resident #34's BIMS (Brief Interview for Mental Status) was 14/15 which indicated he was alert and oriented.</p>			

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	<p>Review of Resident #34's nurses notes included the following: On 8/10/13 at 8:15 a.m., "...Writer approached resident asking if he was the (resident's roommate's name). Resident #34 smiled and accepted medications from writer. Resident took medications. Resident then after 15 minutes stated to another nurse that he knew he took his am meds from her at breakfast and thinks he took his roommate's pills from writer. Writer verified that this resident acknowledged himself as (roommates' name) and took medications handed to him. Resident asked why did he take medications if name was incorrect. Resident stated he didn't know. Dr. notified. Vital Signs being monitored. B/P (Blood Pressure) 90/35, P (Pulse)-81." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 9:45 a.m., "...B/P 85/45, P 82...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 10:00 a.m., "...Dr. returned call to facility. N.O. (Nursing Order) obtained for IV NS (Normal Saline Solution) at 100 cc/hr until B/P comes up and hold B/P medications until B/P comes up...." Nurse's Note signed by LPN #1.</p>						

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	<p>On 8/10/13, no time documented, "...B/P baseline 120/60 for resident, new orders. IV to be D/C (discontinued) when B/P reaches baseline or greater...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 11:30 a.m., "...IV nurse here for peripheral line placement. Site noted to resident's L (left) hand. IV fluids were initiated. B/P continues to be monitored q (every) hour. Last B/P 99/54, P 77. Resident in bed at this time. HOB (head of bed) up 30 degrees...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 2:00 p.m., "...B/P obtained again, Resident up in recliner chair in room. Resident alert and oriented x 3. Resident continues to answer questions appropriately. No apparent S/S (sign and symptoms) of injury. Resident also has been socializing with other residents and visitors in his room. IV patent to L hand and infusing at 100 cc/hr. No S/S phlebitis. Res assisted x 2 staff to bathroom. Res. voided quantity sufficient...." Nurse's Note signed by LPN #1.</p> <p>On 8/10/13, 5:35 p.m., "...Resident alert and talkative no C/O (complaints of) pain or discomfort continuing to</p>			

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	<p>monitor B/P...." Nurse's Note signed by LPN #2.</p> <p>The next nurses notes for Resident #34 available were dated 8/12/13 and included the following:</p> <p>On 8/12/13, 10:30 a.m., "...N.O. (new order) CBC (Complete Blood Count) and Chem 6 (Blood Chemistry Screen) on 8/13/13, D/C IV...."</p> <p>On 8/12/13, 11:00 a.m., "...Resident's Victoza (diabetes medication) (18 mg/3 ml pen) Give 1.8 mg(0.3 ml) daily clarification with pharmacy via nurse...."</p> <p>On 8/13/13, 2:30 p.m., :...D/C W/C (wheelchair), Bed alarm and check alertness d/t (due to) Resident up ad lib...."</p> <p>During an interview with the Interim DCS (Director of Clinical Services) on 8/15/13 at 11:28 a.m., the Interim DCS indicated there were no Nurse's Notes documented on 8/11/13.</p> <p>Review of Resident #63's MARs (Medication Administration Records) indicated these medication were given to Resident # 34 during 8:00 a.m. medication pass:</p>			

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	<p>1. Baclofen 10 mg 1 tab po TID (8 a.m., 4 p.m. and 8 p.m.) [muscle relaxant, anti spasm]. This medication was given to the wrong resident.</p> <p>2. Coreg 6.25 mg 1 tab po bid (8 a.m., 6 p.m.) [ beta blocker cardiac medication]. This medication was given to the wrong resident.</p> <p>3. Tab-A-Vit 1 tab po daily (8 a.m.) [vitamin supplement]. This medication was given to the wrong resident.</p> <p>4. Tradjenta 5 mg 1 tab po daily (8 a.m.) [anti-diabetic to lower BS]. This medication was given to the wrong resident.</p> <p>5. Gabapentin 600 mg 1 tab po BID (8 a.m. and 4 p.m.) [ anticonvulsant and for nerve pain]. This medication was given to the wrong resident.</p> <p>6. Levetracetam 500 mg 1 tab po q 12 hr (8 a.m. and 8 p.m.) [ ]. This medication was given to the wrong resident.</p> <p>7. Claritin 10 mg 1 tab po daily (8 a.m.) [allergy medication]. This medication was given to the wrong resident.</p>			

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	<p>8. Miralax powder 17 mg in juice or water po daily (8 a.m.) [for constipation]. This medication was given to the wrong resident.</p> <p>9. Zantac 150 mg 1 tab po bid(8 a.m. and 6 p.m.) [GI, reduction of acid production]. This medication was given to the wrong resident.</p> <p>10. Cymbalta 60 mg 1 tab po daily. (8 a.m.) [antidepressant]. This medication was given to the wrong resident.</p> <p>Review of Resident # 34 MARs indicated his medications were:</p> <p>1. Victoza 3-pak 10 mg/3 ml inject 1.8 ml SQ daily (8 a.m.) [anti-diabetic to lower BS (blood sugar)].</p> <p>2. Novolog SQ per sliding scale TID before meals. Resident received at 7 a.m., 11 a.m. and 5 p.m. on 8/10/13 [Insulin].</p> <p>3. Lantus 40 units SQ q A.M. and eve (8 a.m. and 5 p.m.) [Insulin].</p> <p>4. Advair 250-50 diskus inhale 1 puff BID( 2 x/day) (8 a.m. and 4 p.m.) [for asthma].</p>			

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	<p>5. Allopurinol 300 mg 1 tab po daily (8 a.m.) [for gout or kidney stones].</p> <p>6. Aspirin 81 mg EC 1 tab po QOD (every other day) (8 a.m.) was given on 8/10/13</p> <p>7. Coreg 3.125 mg 1 tab po BID (8 a.m. and 4 p.m.) held at 4 p.m. [beta blocker, cardiac med].</p> <p>8. Valium 2 mg 1 tab po TID (3 x/day) (8 a.m., 2 p.m., 8 p.m.) [for anxiety].</p> <p>9. Furosemide 40 mg 1 tab po BID (8 a.m. and 4 p.m.) [diuretic].</p> <p>10. Levothyroxine 137 mcg 1 tab po daily (7 a.m.) [for hypothyroidism].</p> <p>11. Cozaar 50 mg 1 tab po daily (8 a.m.) [for hypertension].</p> <p>12. Lovaza 1 gm 2 cap (2 gm) po BID (8 a.m. and 4 p.m.) [Omega-3].</p> <p>13. Metformin 500 mg 1 tab po daily (8 a.m.) [ for diabetes type II (Adult onset) control BS (Blood Sugar) with Insulin].</p> <p>14. Namenda 10 mg 1 tab po BID (8 a.m. and 4 p.m.) [for Alzheimer's].</p>			

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	<p>15. Gabapentin 300 mg 1 cap po daily at HS (bedtime) (9 p.m.) [anticonvulsant and for nerve pain].</p> <p>16. Aricept 10 mg 1 tab po daily (8 p.m.) [for dementia].</p> <p>17. Seroquel XR 200 mg 1 tab po HS (9 p.m.) [antipsychotic].</p> <p>18. Seroquel XR 50 mg 1 tab po HS (9 p.m.) [antipsychotic].</p> <p>19. Zocor 40 mg 1 tab HS (9 p.m.) [for hypercholesterolemia].</p> <p>20. Spireva 18 mcg CP- handinhaler 1 cap orally via handinhaler device q (every) day (8 p.m.) [for COPD].</p> <p>A review of the facility's Medication Administration Investigation, dated August 10, 2013, provided by the Interim DCS indicated, "...LPN #2 reported to ED LPN #1 had given the wrong medication to Resident #34. ED directed nurse to notify MD of the medication administration and the name of the medications...Record review indicated the resident received the following medications which were not ordered for him: Baclofen 10 mg, Carveil 6.25 mg, Tab-A-Vit; Tradjenta, Cymbalta 60 mg, Gabapentin 600</p>			

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	<p>mg, Levetiracetan 500 mg, Loratidine 10 mg, Miralax, Ranitidine 150 mg....LPN #2 indicated she identified the resident to LPN #1....LPN #1 indicated she had called the resident by (first name of Resident # 63) and Resident # 34 stuck his hand out and took the medication cup....It was determined the MAR for Resident #63 did not have a photograph for identification...."</p> <p>A review on 8/15/13 at 11:38 a.m. of the Attendance Log for Medication Administration dated 8/13/13, provided by the Interim DCS, indicated only 3 nurses were in-serviced on Medication Administration.</p> <p>On 8/15/13 at 12:00 p.m., a review of all of the current Residents' MARs and TARs indicated 30 of the 46 MARs did not have Residents' photographs for identification and 27 or 46 TARs did not have Residents' photographs for identification.</p> <p>The Immediate Jeopardy that began on 8/10/13 was removed on 8/16/13 when the facility added photograph identification to every resident's MARS and Inserviced all nursing staff on accurate identification of residents during medication administration.</p>			

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	<p>Noncompliance remained at the scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of ongoing monitoring of accurate medication administration.</p> <p>3.1-48(c)(2)</p>			

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F000353 SS=F	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to provide sufficient nursing staff to ensure timely care to meet the needs for 11 of 21 residents who met the criteria for sufficient nursing staff, with the potential to affect all 46 residents in the facility.</p> <p>Finding includes:</p> <p>Confidential interviews with 10 alert and oriented residents or their family/POA (Power of Attorney) were</p>	F000353	F 353 Nurse Staffing 1. Facility is now using agency to provide sufficient staffing for Nursing Department. Facility is continuing to interview and hire nursing staff that meet requirements of company. 2. Staffing for Nursing Department will be reviewed daily by DCS and Administrator to meet the resident needs. 3. DCS and Scheduler will review staffing needs daily and as needed for resident care. All Facility staff will be called to replace open positions. If unable to obtain facility staff Agency will be called for open position. 4. Five	09/20/2013	

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	<p>conducted from 8-12-2013 through the end of the survey, 8-21-2013. The alert and oriented residents had BIMS (Brief Interview Mental Status-used to assess cognitive status) scores of 13/15 and higher. The interview indicated the following:</p> <p>1. On 8-12-2013 at 11:07 a.m., in the first confidential interview, the resident and POA indicated the following:</p> <p>- "Pushed the call light for help; took an hour and a half before someone came and happened on nights and weekends."</p> <p>- "Pushed the call light for help to get off toilet and staff came, turned off the call light and said they would return. It took 45 minutes."</p> <p>- "Overheard staff in hall comment, I am not going to take care of them."</p> <p>- POA was contacted at 11 p.m. by resident and resident indicated staff left resident's roommate in soiled depends for over 3 hours.</p> <p>2. On 8-12-2013 at 8:41 a.m., in the second confidential interview, the resident indicated "facility was usually shorthanded; when 2 CNAs (Certified</p>		<p>residents per week will be interviewed related to sufficient staffing to ensure their needs are met. In addition Resident Council Memebers will be interviewed to ensure needs are met. Interviews will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>		

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	<p>Nursing Assistants) worked, it was not enough to meet the needs of residents as 1 resident who needed assistance, waited 3-4 hours for water."</p> <p>3. On 8-12-2013 at 9:37 a.m., in the third confidential interview, the resident indicated "the facility was short-staffed all the time."</p> <p>4. On 8-12-2013 at 9:47a.m., in the fourth confidential interview, the resident indicated "sometimes aides work short."</p> <p>5. On 8-12-2013 at 9:56 a.m., in the fifth confidential interview, the resident indicated "had to wait 30 - 45 minutes for assistance; sometimes fell asleep and did not know how long the wait was; staff responded to call light, turned it off and indicated they would return and staff did not return."</p> <p>6. On 8-12-2013 at 11:09 a.m., in the sixth confidential interview, the resident indicated "the facility was short CNAs everyday-sometimes only one CNA on the floor."</p> <p>7. On 8-12-2013 at 2:03 p.m., in the seventh confidential interview, the resident indicated "staff kept quitting or didn't show up to work--it</p>				

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	<p>happened last week that 2 nurses and 2 CNAs were here on evenings."</p> <p>8. On 8-12-2013 at 3:30 p.m., in the eighth confidential interview, the resident indicated "there was never enough staff available and unable to go outside to smoke; not enough staff in the morning to assist with bathing and dressing; had to wait 1 1/2 hours for staff assistance to get cleaned up and dressed."</p> <p>9. On 8-12-2013 at 5:11 p.m., in the ninth confidential interview, the POA indicated "the facility needed more staff to assist residents in the dining room and for grooming, as residents arrived at the dining room not groomed."</p> <p>10. On 8-13-2013 at 9:25 a.m., in the tenth confidential interview, the resident indicated "there was not enough staff during the evening/bedtime. Had to wait 2 hours for staff assistance to go to bed."</p> <p>11. During the eleventh confidential interview with an alert and oriented resident on 8-14-2013 at 11:47 a.m., the resident indicated the following:</p> <p>-"There was not enough staff on 3rd shift to get turned and sometimes had</p>			

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	<p>to lay for over 3 hours. Indicated during the night, sometimes only 1 aide worked"</p> <p>-"Told the DON (Director of Nursing) to get the place in order, quit letting the aides run the building. The aides come and go when they want."</p> <p>Confidential interviews were conducted with the staff during the survey from 8-12-2013 through 8-21-2013 with the following indicated:</p> <p>-On 8-14-2013 at 3:43 p.m., the nurse indicated "I'm so burned [out] I just can't stand it and I don't know what to do" The nurse indicated she had worked 3 days in a row for 12 hour shifts."</p> <p>-On 8-15-2013 at 9:10 a.m., the nurse indicated there was not enough CNAs to get residents the care they needed during some evenings and night shift. She indicated the residents have to wait until the CNAs can get to them.</p> <p>-On 8-15-2013 at 8:40 a.m., the Administrator indicated the DON (Director of Nursing) resigned during the evening of 8-14-2013.</p> <p>-On 8-16-2013 at 9:30 a.m., the CNA</p>			

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	<p>indicated 1 CNA for day shift called in today. The CNA indicated the procedure for replacement of staff was for nursing to start calling staff from a list they keep at the nurse's station and if no one was able to come, the 3 remaining CNAs split the workload.</p> <p>An observation of the nurse staff posting for 8-16-2013 at noon indicated 4 CNAs for 30 hours were on duty at the facility for the 1st shift.</p> <p>-On 8-16-2013 at 1:00 p.m., an interview with the Interim Director of Clinical Services (Interim DCS) indicated she was not aware of a CNA call in for the 1st shift which left 3 CNAs working instead of the 4 posted on the Nurse Staff Posting.</p> <p>-On 8-19-2013 at 10:39 a.m., an observation of a phone call received by the Administrator about a 2nd shift nurse calling in ill. An interview with the Administrator indicated the facility would contact other nursing staff not working to replace the nurse and then the PRN (as needed) nursing pool would be contacted. The Administrator indicated staff working 1st shift would have to stay over and work a 12 hour shift if a nurse was not available.</p>			

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	<p>Policies provided by the Administrator on 8-19-2013 at 8:41 a.m., indicated the following:</p> <p>-A policy titled "Staffing" dated 9-1-2011 indicated "staffing will be maintained by the facility...to provide for the needs of the residents at all times...staffing must be adjusted on a daily basis based on the current census...replacing call ins must be done...."</p> <p>-A policy titled "Scheduling" dated 9-1-2011 indicated "Clinical Services shall be responsible to provide for staffing in order to assign appropriate numbers and categories of staff, which will meet the needs of the residents...scheduling shall be based on the overall occupancy and acuity needs of the residents and in numbers, which shall provide safe, efficient and effective resident care...."</p> <p>3.1-17(a)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure staff washed their hands appropriately for the recommended amount of time potentially affecting 30 of 30 residents who ate in the main Dining Room. The facility also failed to ensure staff did not handle food from a resident's meal tray with bare fingers before giving it to the resident to eat potentially affecting 1 of 2 residents who were fed by staff in the main Dining Room, and 1 resident (#39) who required staff assistance for cutting of food.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the main Dining Room on 8/12/13 the following was observed:</p> <p>- At 12:08 p.m., LPN #9 was observed to wash her hands for 15 seconds. She was not observed to</p>	F000371	F 371 Hand Washing 1. A new Hand Washing policy has been implemented and all staff have been inserviced on policy and procedure. 2. New policy posted for proper procedure. 3. Hand washing audits will be completed on all staff. DCS or designee will complete audits on staff for technique,length of time and when to wash hands' Audits will be done on all shifts, weekly times one month and then monthly for 6 months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.	09/20/2013	

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	<p>lather her hands before rinsing. She immediately began serving meal trays to residents.</p> <p>- At 12:10 p.m., CNA (Certified Nursing Assistant) #10 was observed to wash her hands for 7 seconds. She immediately began serving meal trays to residents.</p> <p>- At 12:11 p.m., CNA #13 was observed to wash his hands for 5 seconds. He was not observed to lather his hands before rinsing. He immediately began serving trays to residents.</p> <p>- At 12:15 p.m., LPN #11 was observed to wash her hands for 9 seconds. She continued serving meal trays to residents.</p> <p>- At 12:16 p.m., CNA #10 was observed to wash her hands for 9 seconds. She continued serving meals trays to residents.</p> <p>- At 12:18 p.m., CNA #13 was observed to wash his hands for 10 seconds. He was not observed to lather his hands before rinsing. He continued serving meal trays to residents.</p> <p>-At 12:19 p.m., CNA #13 was</p>			

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	<p>observed to place his hand on a sandwich while cutting it in half for Resident #39.</p> <p>- At 12:20 p.m., CNA #13 was observed to pick up a dining room chair and move it next to Resident #4 to assist him in eating. The menu for Monday August 12, 2013, included an Italian Sausage sandwich on roll. CNA #13 immediately began feeding Resident #4 picking up the Italian Sausage sandwich with his bare hands for him to eat. He was not observed to wash his hands and don a pair of disposable gloves after handling the dining room chair. He was observed to have beads of perspiration on his forehead while feeding Resident #4. He was observed to take paper towels and wipe off the perspiration from his face. He was not observed to wash his hands after wiping the perspiration from his face before continuing to feed Resident #4.</p> <p>- At 12:21 p.m., CNA #10 was observed to wash her hands for 12 seconds. She continued serving meal trays to residents.</p> <p>2. During an observation of the breakfast meal in the main Dining Room on 8/12/13 the following was</p>			

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	<p>observed:</p> <ul style="list-style-type: none"> <li>- At 8:17 a.m., RN #12 was observed to wash her hands for 11 seconds. She continued serving meal trays to residents.</li> <li>- At 8:18 a.m., CNA #8 was observed to wash her hands for 13 seconds. She immediately sat down next to Resident #9 and began feeding her breakfast.</li> <li>- At 8:20 a.m., LPN #9 was observed to sit down next to Resident #4 and picked up his slices of toast with her bare hands to spread butter on the toast. She was observed to only use a small amount of hand sanitizer on her hands prior to picking up the slices of toast.</li> <li>- At 8:23 a.m., LPN #9 got up from the table next to Resident #4. She was observed to touch her uniform with both hands before sitting down again next to Resident #4 to continue feeding him breakfast. No hand wash was observed. She immediately fed him slices of toast and strips of bacon with her bare hands.</li> <li>- At 8:24 a.m., LPN #9 was observed to cough into her hand. She was not observed to get up from the table and</li> </ul>			
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	<p>wash her hands, but immediately picked up a strip of bacon with her bare hands for Resident #4 to eat</p> <p>- At 8:25 a.m., CNA #8 was observed to get up from the table next to Resident #9. She was observed to wash her hands for 14 seconds and immediately returned to the table to continue feeding Resident #9.</p> <p>- At 8:30 a.m., LPN #9 continually touched her bare hands to her face while feeding Resident #4 foods with her bare hands. She was not observed to wash her hands.</p> <p>Resident #4 was interviewed on 8/15/13 at 9:00 a.m. During the interview he indicated staff who fed him never used a protective barrier on their bare hands when picking up food to feed him.</p> <p>The Regional Dietitian was interviewed on 8/16/13 at 11:40 a.m. During the interview she indicated staff were to wash their hands for 20 seconds. She also indicated staff were not to handle food for the residents to eat with their bare hands.</p> <p>3. During an observation of the breakfast meal on 8/19/13 at 8:20 a.m., CNA #10 was observed to touch</p>			

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	<p>the arm of a resident's wheelchair seated at the table with Resident #4. She immediately proceeded to pick up a piece of bacon and feed it to Resident #4 with her bare hands.</p> <p>A current facility policy "Hand Washing Technique", revised on 9/1/11 and provided by the Regional Dietitian on 8/16/13 at 12:00 p.m., indicated "...All personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infections...Rub hands together vigorously for 10-15 seconds, generating friction on all surfaces of the hands and fingers...Rinse hand thoroughly to remove residual soap and then dry...." The policy did not reflect to wash hands for 20 seconds as indicated by the Regional Dietitian.</p> <p>A current facility policy "Handwashing", revised on 9/1/11 and provided by the Administrator on 8/19/13 and 8:34 a.m., indicated "...An essential component of infection control is handwashing. All staff members must wash their hands using the following procedures...Wet hands, wrists and forearms with warm running water...Apply antibacterial soap to palm of hand; join hands, palm to palm, working up a lather on</p>				

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	<p>hands, wrists and forearms...Rinse hands, wrists and forearms thoroughly under warm running water...." The policy did not indicate the length of time staff were to wash their hands.</p> <p>3.1-21(i)(2)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure open dates were written on 6 of 25 vials of insulin stored in 2 of 2</p>	F000431	F 431 MEDICATION OPEN DATES INSULIN 1. All open vials of insulin that affected residents (#6,19,90,91,and 92) have been removed 2. Charge	09/20/2013			

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	<p>medication carts which affected 5 of 16 residents who required insulin (Residents #6, #19, #90, #91 and #92)</p> <p>Findings include:</p> <p>During an observation on 8-20-2013 at 10:00 am to 10:17 a.m. of the East hall medication cart containing 14 insulin vials with LPN (Licensed Practical Nurse) #2, the following was observed:</p> <p>-Resident #19 had an opened vial of Levemir (insulin) 100 unit/ml (milliliter) with a dispensing date of 8-15-2013 and without an opened date recorded on the vial/storage box.</p> <p>-Resident #19 had an opened vial of Novolog 100 units/ml with a dispensing date of 10-25-2010 and without an opened date recorded on the vial/storage box.</p> <p>-Resident #90 had a vial of Novolog 100 units/ml with a dispensing date of 8-2-2013 and without an opened date recorded on the vial/storage box.</p> <p>-Resident #91 had a vial of Humalog 100 units/ml with a dispensing date of 8-2-2013 and without an opened date</p>		<p>Nurses were inserviced on Medication Storage and Labeling of multidose vials and discard after 28 days. 3. DCS or designee will audit medications that require dates when open and expiration of medication. Pharmacy will do monthly medication audits of medication carts and med room. Audits per DCS or designee will be weekly times one month and then monthly times 6 months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>				

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	<p>record on the vial/storage box.</p> <p>-Resident #92 had a vial of Levemir 100 units/ml with a dispensing date of 3-18-2013 and without a date opened recorded on the vial/storage box.</p> <p>During an observation on 8-20-2013 at 10:19 a.m. of the West hall medication cart containing 11 insulin vials with LPN #1, the following was observed:</p> <p>-Resident #6 had a vial of Novolog 70-30 mix with a dispensing date of 8-9-2013 and without a date opened recorded on the vial/storage box.</p> <p>An interview on 8-20-2013 at 1:20 p.m., with the Registered Pharmacist #16 indicated once insulin was opened and stored at room temperature, it was good for 28 days except for Levemir which is good for 42 days from the date opened.</p> <p>The Interim Director of Clinical Services provided a policy on 8-20-2013 at 1:00 p.m., "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 1-1-2013, indicated "...once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with</p>			

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	<p>respect to expiration dates for opened medications...facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...."</p> <p>3.1-25(j)</p>			

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F 441 Hand Washing During Medication Administration 1. A	09/20/2013			

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	<p>ensure handwashing/hand hygiene was done after and between insulin administration for 3 of 16 residents who required insulin and 1 of 46 residents who received oral medications. (Residents #34, #88, #65 and #20)</p> <p>Findings include:</p> <p>During an observation of insulin injections and oral medication pass on 8-14-2013 from 11:57 a.m. to 12:08 p.m. with LPN (Licensed Practical Nurse) #3, the following was observed:</p> <p>-At 11:57 a.m., LPN #3 prepared insulin for Resident #34, donned gloves and gave the insulin to the resident.</p> <p>-At Noon, LPN #3 prepared insulin for Resident #88, donned gloves and gave the insulin to the resident.</p> <p>-At 12:02 p.m., LPN #3 prepared insulin for Resident #65, donned gloves and gave the insulin to the resident.</p> <p>-At 12:08 p.m., LPN #3 gave prepared medications to Resident #20, donned gloves and instilled eye drops in each eye of the resident.</p>		<p>new Hand Washing policy has been implemented and all staff have been inserviced on policy and procedure. 2. New policy posted for proper procedure. Charge Nurses have been inservice on proper hand washing during medication administration. 3. Hand washing audits will be completed on all staff. DCS or designee will complete audits on staff for technique,length of time and when to wash hands' Audits will be done weekly times one month and then monthly for 6 months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>		

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	<p>LPN #3 was not observed to perform handwashing/hand hygiene after removing gloves or prior to preparing the insulin for the next resident.</p> <p>An interview on 8-19-2013 at 2:30 p.m. with LPN #1 indicated the procedure for administering insulin was to "wash hands prior to preparing insulin, don gloves and administer the insulin and wash hands after removing gloves."</p> <p>An interview with the Interim Director of Clinical Services on 8-20-2013 at 2:30 p.m., indicated the facility did not have a policy for handwashing/hand hygiene except what was in the Medication policy.</p> <p>A policy "Medications - Oral Administration of" dated 9-1-2007 was provided by the Administrator on 8-19-2013 at 5:16 p.m., indicated "...administer drug...wash hands...."</p> <p>3.1-18(l)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure resident wheelchair equipment was clean for 4 of 27 residents who required wheelchair cleaning. (Resident #10, #25, #45, 51)</p> <p>Findings include:</p> <p>1. During the environmental tour with the Housekeeping Supervisor and Maintenance Director on 8-16-2013 from 9 a.m. to 9:25 a.m., the following observations were made:</p> <p>-The wheelchair wheels and metal parts had an accumulation of dust and crumbs for Resident #25 and Resident #45 wheelchairs.</p> <p>-An interview with the Housekeeping Supervisor indicated nursing was responsible for cleaning equipment.</p> <p>2. An observation on 8-19-2013 at 8:57 a.m., indicated Resident #25's wheelchair had dust and crumb accumulation on the wheelchair metal and plastic surfaces.</p>	F000465	<p>F 465 Wheelchair Cleaning 1. All wheelchairs have been cleaned per cleaning schedule for residents #10, #25, #45 and # 51. 2. Night shift is responsible for cleaning wheelchairs. All wheelchairs are to be cleaned weekly per the cleaning schedule book. Licensed nurses are responsible to supervise and ensure equipment is cleaned per schedule. 3. DCS or designee will monitor cleaning schedule. Audits will be completed weekly times one month, then monthly times 6 months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	09/20/2013			

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	<p>3. An observation on 8-19-2013 at 9:00 a.m., indicated Resident #10's wheelchair had dust and crumb accumulation on the wheelchair metal and plastic surfaces.</p> <p>4. An interview on 8-12-2013 at 10:39 a.m. with Resident #51, who was alert and oriented and required use of a wheelchair, indicated the facility could keep the equipment and room cleaner.</p> <p>An interview with the Administrator on 8-20-2013 at 10:00 a.m., indicated the wheelchair cleaning schedule was done weekly on the residents shower day by the CNAs (Certified Nursing Assistant). The Administrator indicated the facility did not have documentation to indicate the wheelchair task was completed.</p> <p>A review of the "Cleaning list for 3rd shift CNA" provided by the Administrator on 8-20-2013 at 10:00 a.m., indicated "wheelchair cleaning according to list provided...wheelchairs are to be washed via schedule every night!! Wash with soap and water, sanitize...."</p> <p>A review of the policy "Care and Use</p>				

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	<p>of Equipment" dated 1-8-2013 and obtained from the Interim Clinical Nurse Consultant on 8-19-2013 at 4:08 p.m., indicated for ...wheelchairs...clean weekly with damp cloth and general disinfectant...clean PRN following food spillage or incontinence...."</p> <p>3.1-19(f)</p>			

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F000514 SS=E	<p>483.75(I)(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 interview and record review the facility failed to maintain complete meal consumption documentation on 2 residents (Resident #83 and Resident #85) reviewed for weight loss. The facility further failed to obtain admission weights and weekly weights x 4 weeks after admission for 14 of 30 residents reviewed as Admission Records (Resident #7, Resident #68, Resident #14, Resident #81, Resident #87, Resident #17, Resident #80, Resident #49, Resident #86, Resident #72, Resident #5, Resident #58, Resident #70, and Resident #12.</p> <p>Findings include:</p> <p>1. Review of the clinical record for</p>	F000514	F 514 Meal Consumption/Weight Loss 1. Resident #83 meal consumption and weight loss have been review, Care Plan updated. Resident #85 meal consumption and weight loss have been review, Care Plan updated. 2. On 8/13 to 8/17 the facility reviewed all residents weights for previous six months. Registered Dietician (RD) , to identify any weight and/or reweight in need of being obtained. Any reweight was obtained. Any resident with significant weight loss will be referred to RD and Nutritional Committee for recommendations, family and doctor will be notified. 3. Audits will be completed DCS or designee one time per week times one month and monthly times 6 months. RD will also complete quarterly audits for one year. 4. Audits will be reviewed in	09/20/2013			

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	<p>Resident #83 on 8/15/13 at 3:18 p.m., indicated a severe weight loss of 14% from her admission on 5/24/13 to 7/20/13.</p> <p>Review of the Meal Intake Detail Report for Resident #83 indicated the following: for the breakfast meal - no meal intake was recorded for 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 5/30/13, 6/3/13, 6/4/13, 6/5/13, 6/7/13, 6/10/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 7/6/13, 7/7/13, 7/9/13, 7/11/13, 7/27/13, 8/3/13, 8/9/13, 8/12/13, and 8/13/13; for the lunch meal - no meal intake was recorded for 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 5/30/13, 6/3/13, 6/4/13, 6/5/13, 6/7/13, 6/10/13, 6/11/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 7/6/13, 7/7/13, 7/9/13, 7/11/13, 7/27/13, 8/3/13, 8/9/13, 8/12/13, and 8/14/13; for the dinner meal - no meal intake was recorded for 5/24/13, 5/25/13, 5/26/13, 5/27/13, 5/28/13, 5/29/13, 6/1/13, 6/2/13, 6/3/13, 6/4/13, 6/5/13, 6/6/13, 6/7/13, 6/8/13, 6/9/13, 6/10/13, 6/11/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 7/1/13, 7/2/13, 7/3/13, 7/4/13, 7/5/13, 7/6/13, 7/7/13, 7/8/13, 7/9/13, 7/10/13, 7/11/13, 7/12/13, 7/13/13, 7/14/13, 7/15/13, 7/16/13, 7/17/13, 7/18/13, 7/19/13, 7/20/13, 7/21/13, 7/22/13,</p>		<p>the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	

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	<p>7/23/13, 7/24/13, 7/25/13, 7/26/13, 7/27/13, 7/28/13, 7/30/13, 8/1/13, 8/2/13, 8/4/13, 8/5/13, 8/6/13, 8/7/13, 8/8/13, 8/10/13, 8/11/13, 8/14/13, and 8/15/13.</p> <p>A facility care plan for Resident #83, dated 5/24/13, indicated the problem area of at risk in nutrition/hydration. The goal for Resident #83 was not to have significant change in weight through next review. Approaches to the problem included, but were not limited to, diet per order, weigh weekly x 4 weeks then monthly or as ordered, and monitor intake and documentation on daily flow sheet.</p> <p>A facility care plan for Resident #83, dated 8/14/13, indicated the problem area of nutritional risk. Approaches to the problem included, but were not limited to, diet as ordered, monitor weight, and monitor intake.</p> <p>2. Review of the clinical record for Resident #85 on 8/15/13 at 10:42 a.m., indicated no admission weight recorded and a severe weight loss of 8% from 7/20/13 to 8/7/13.</p> <p>Review of the Meal Intake Detail Report for Resident #85 indicated the following: for the breakfast meal - no meal intake was recorded on:</p>						

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	<p>6/22/13, 6/23/13, 6/24/13, 7/6/13, 7/7/13, 7/11/13, 7/16/13, 7/21/13, 7/28/13, 8/3/13, 8/5/13, 8/9/13, 8/11/13, and 8/13/13; for the lunch meal - no meal intake was recorded on: 6/22/13, 6/23/13, 6/24/13, 7/3/13, 7/6/13, 7/7/13, 7/11/13, 7/16/13, 7/21/13, 7/28/13, 8/3/13, 8/5/13, 8/9/13, 8/11/13, 8/12/13, and 8/13/13; for the dinner meal - no meal intake was recorded on: 6/22/13, 6/23/13, 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 7/1/13, 7/2/13, 7/3/13, 7/4/13, 7/5/13, 7/6/13, 7/7/13, 7/8/13, 7/9/13, 7/10/13, 7/11/13, 7/12/13, 7/14/13, 7/15/13, 7/16/13, 7/17/13, 7/18/13, 7/19/13, 7/20/13, 7/22/13, 7/23/13, 7/24/13, 7/25/13, 7/26/13, 7/27/13, 7/28/13, 7/30/13, 8/1/13, 8/2/13, 8/4/13, 8/6/13, 8/8/13, 8/10/13, and 8/11/13.</p> <p>A facility care plan for Resident #85, dated 6/21/13, indicated the problem area of at risk for alteration in nutrition/hydration related to pancreatitis/alcoholism/liver disease. The goal for Resident #85 was to not have a significant change in weight through next review. Approaches to the problem included, but were not limited to, diet per order, monitor intake and documentation on daily flow sheet, and weight weekly x 4 weeks then monthly and as ordered.</p>			

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	<p>The Administrator was interviewed on 8/20/13 at 9:15 a.m. During the interview she indicated staff documented meal consumption for each resident on the computer Care Tracker System. She also indicated staff were to document meal consumption for each resident after each meal.</p> <p>A current facility policy, "ADL Flow Record", with a review date of 1/3/13 and provided by the Administrator on 8/20/13 at 9:25 a.m., indicated "An ADL Flow Record will be completed for each resident daily to each shift by the Nurse Tech assigned to provide care...Actual meal consumption will be documented...."</p> <p>3. Thirty clinical records were reviewed as identified in the survey as Admission Sample Records. Fourteen residents of the thirty records reviewed, Resident #7, Resident #68, Resident #14, Resident #81, Resident #87, Resident #17, Resident #80, Resident #49, Resident #86, Resident #72, Resident #5, Resident #58, Resident #70, and Resident #12, did not contain admission and/or weekly weights times 4 weeks on the Weight Information sheets provided by the</p>						

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	<p>facility.</p> <p>The Weight Information sheets indicated there were no weights recorded for the following residents: Resident #68 (with an admission date of 5/1/13), Resident #14 (with an admission date of 3/5/13), Resident #87 (with an admission date of 7/3/13), Resident #80 (with an admission date of 4/15/13), Resident #86 (with an admission date of 7/2/13), Resident #58 (with an admission date of 3/13/13), Resident #12 (with an admission weight 3/18/13), and Resident #72 (with an admission date of 3/13/13).</p> <p>The Weight Information sheets indicated the following for: Resident #7 (with an admission date of 6/12/13 and only 1 weight recorded on 6/21/13), Resident #81 (with an admission date of 6/26/13 and only 1 weight recorded on 7/1/13), Resident #17 (with an admission weight of 5/15/13 and only 1 weight recorded on 4/15/13), Resident #49 (with an admission date of 5/19/13 and only 1 weight recorded on 5/24/13), Resident #70 (with an admission date of 5/18/13 and only 1 weight recorded on 5/24/13), and Resident #5 (with an admission date of 4/27/13 and only 2 weights recorded on</p>						

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	<p>5/5/13 and 6/5/13).</p> <p>The Certified Dietary Manager was interviewed on 8/12/13 at 3:00 p.m. During the interview he indicated the facility procedure for residents weights were for staff to obtain the weight on each resident as ordered, complete a weight sheet for each month, and provide the sheet to dietary for review. He also indicated the procedure was not being followed.</p> <p>The Administrator was interviewed on 8/13/13 at 8:30 a.m. During the interview she indicated newly admitted residents were to be weighed weekly unless there were specific circumstances not to weigh.</p> <p>The Regional Dietitian was interviewed on 8/13/13 at 9:30 a.m. During the interview she indicated newly admitted residents were to be weighed weekly and other residents were to be weighed weekly at the recommendation of the Registered Dietitian.</p> <p>A current facility policy "Weighing the Resident", revised on 1/1/09 and provided by the Administrator on 8/16/13 at 9:00 a.m., indicated "...At a minimum, all residents of the facility shall be weighed upon admission and</p>			

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	monthly...."  3.1-50(a)(1)			

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F000520 SS=J	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify and implement a plan of action for the identified concerns of following physician orders, the development and following of resident's care plans, lack of assessments, identify individual needs of residents, medication administration and storage of medications, complete nutritional assessments, food intake documentation and obtain resident's</p>	F000520	<p>F 520 Quality Assessment and Assurance Committee (QAA) 1. Medical Director was informed on 9/2/13 of citing of 8/20/13. The Medical Director communicates with the facility as needed. He communicates any issues or concerns identified through the community, the hospital and or facility. He routinely attends QA meetings, no less than quarterly.</p> <p>2. The QAA meets monthly, attendees include Administrator, DCS, Social Service Medical Director, Activity Director,</p>	09/20/2013

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	<p>weights, honoring resident's choices, provide adequate nurse staffing to provide resident care, infection control for hand hygiene. This deficient practice had the potential to affect 46 of 46 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview with the Executive Director on 8/20/13 at 1:25 p.m., indicated the Quality Assessment and Assurance Committee had not developed and implemented action plans to address deficient practice in the following areas: a. lack of development and following of resident's care plans, b. lack of nursing assessments and adequate documentation, c. significant medication administration errors and storage, d. not having complete nutritional assessment, documentation of food intake and obtaining residents' weights, e. honoring residents' choices, f. adequate nurse staffing and g. infection control for hand hygiene.</p> <p>There was no documentation the Executive Director and the Quality Assessment and Assurance Committee had a system in place to identify problems, to implement plans</p>		<p>Maintenance Director and MDS Coordinator. All audits and concerns will be addressed as needed and Action Plan put in place to resolve issue. 3. All facility residents were audited by 9/20/13 by MDS Coordinator to validate that all care plan interventions related to the provision of resident care, to include, but not limited to turning and positioning, weights, ADL's, showers, feeding, oral care, were implemented as indicated on care plan. Audits will be conducted through observation, record review, resident and staff review. DCS, Social Service or designee will conduct audits weekly times 1 month and then monthly times six months. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>				

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	<p>of action, and to monitor the implementation of the action plans through the Quality Assessment Assurance process.</p> <p>3.1-52(b)(2)</p>			

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F009999	<p>3.1-14 PERSONNEL</p> <p>1. (t) A physical examination shall be required for each employee of a facility within one(1) month prior to employment. The examination shall include a tuberculin skin test using the Mantoux method (5 TU PPD), administered by persons having documentation of training form a department-approved course of instruction in intradermal tuberculin skin testing reading, and recording unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one(1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. Tor health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve(12) months, the baseline tuberculin skin testing should employ</p>	F009999	<p>F 9999 Personnel Records 1. All Personnel records have been audited for Dementia training and Mantoux test. Staff #4, 5, 6 mantoux have been administered. 2. No residents were affected by practice 3. Facility has completed Dementia Training for all staff 9/20/13 anf Mantoux's all updated on all employees. Audits will be completed on all employees weekly times 1 month and then monthly times 6 months for 100% compliance. Human Resource or designee will monitor. 4. Audits will be reviewed in the monthly Quality Assurance Committee (QAC) monthly for 6 months and as needed thereafter to maintain 100% compliance. Action Plans will be developed as indicated.</p>	09/20/2013			

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	<p>the two-step method. If the first step is negative, a second test should be performed one(1) to three(3) weeks after the first step. the frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and review of employee files the facility failed to ensure 3 of 10 employees reviewed for tuberculin skin testing received a baseline tuberculin skin test and a second step tuberculin skin test when hired.</p> <p>Finding Includes:</p> <p>On 8/16/13 at 10:30 a.m. review of employee files indicated new employees #4, #5, and #6 had no documentation of receiving a baseline tuberculin skin test and a second step tuberculin skin test.</p> <p>Interview with the Administrator on 8/16/13 at 11:00 a.m. indicated she had no further documentation related to the employees receiving their tuberculin skin test.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3.1-14(p)(1)(E)</p> <p>(p) Initial orientation of all staff must be conducted and documented and shall include the following:</p> <p>(1) Instructions on the needs of the specialized population or populations served in the facility, for example:</p> <p>(E) Care of the cognitively impaired residents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and review of employee files, the facility failed to provide Dementia training for 10 of 10 employees who's files were reviewed.</p> <p>Finding includes:</p> <p>On 8/16/13 at 10:30 a.m. review of 10 employee files indicated no Dementia Training documentation for all 10 employees.</p> <p>Interview with the Administrator on 8/16/13 at 11:00 a.m. indicated she had no documentation of dementia training being done for the 10</p>						

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	employees who's records were reviewed.				