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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155490 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/21/2011 |
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| NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE | STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN47330 |
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| F0000 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00099285.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00099883.</p> <p>Complaint IN00099285-Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: November 13, 14, 15, 16, 17, 18 and 21, 2011</p> <p>Facility number: 000456 Provider number: 155490 AIM number: 100288750</p> <p>Survey team: Sharon Lasher, RN, TC Angel Tomlinson, RN Barbara Gray, RN Leslie Parrett, RN (November 13, 14, 15, and 16, 2011)</p> <p>Census bed type: SNF/NF: 118 Total: 118</p> <p>Census payor type:</p> | F0000 | By submitting the enclosed materials we are not admitting the turth or accuracy of any specific findings or allegations as of any proceedings and submit these responses pursuant to our regulatory obligations. | |

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>Medicare: 13 Medicaid: 97 Other: 8 Total: 118</p> <p>Stage 2 sample: 40</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 28, 2011 by Bev Faulkner, RN</p> | | | | |
| F0253 SS=E | <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided in 13 bedrooms on the west and south unit, 1 of 2 shower rooms in the west unit and 2 of 3 living areas on the west</p> | F0253 | <p>1. Housekeeping & Maintenance Supervisors were informed of findings and a plan was formulated to make improvements.2. No residents have been affected by any of the findings and improvements will be completed by 12/21.2011.3. Electric baseboard heaters have</p> | 12/21/2011 | |

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| | <p>unit and 3 of 5 dining areas on the west, north and south units; in that there were soiled walls, ceilings and floors for 3 of 4 units observed during the environmental tour (West, North and South units).</p> <p>Finding include:</p> <p>During observation on 11-21-11 beginning at 9:00 a.m., with the Housekeeper Supervisor, the following was observed.</p> <p>West Unit:</p> <p>The electrical baseboard heater in the West unit's front living area had a black substance on the heater and above it on the wall. The West unit had a musty and urine smell. Interview with the Housekeeping Supervisor, at this time, indicated she thought the smell might be coming from the basement that was located under the West unit.</p> <p>The rocking chair that was located in the front living area had a large, dark circular stain on seat cushion. The plastic love seat located in the West unit's front living area had a rip in the middle of the cushion.</p> | | <p>been painted. New furniture have been ordered for both common areas to be delivered Feb 2012. odor eating containers have been purchased and put in the basement. The exposed plumbing in the west dining room is the sprinkler system and has been painted to match the ceiling. The sink cabinet in the second dining room drawer was being repaired and was back in place before the survey team exited. The cabinets are not required to be locked, due to they are not use to store anything hazardous. These cabinates are not used so housekeeping did not check them. They were immediately cleaned and are being checked daily. The bottom shelf has been replaced. All doors have been repaired. All ceilings have been checked and painted if needed, The speaker wires in the hallway have been enclosed. Thermostats have new covers. Bedroom 8's plumbing under sink has been boxed in & painted. The border in rooms 4&5 did not have rips in them and was not falling down. There were areas above the windows where old curtain rods had been removed. Border has been removed and painted. All nails have been removed. New blinds were installed in room 1. Closet doors across from Nurses station has been repaired. North: All holes have been filled in and painted. The dry wall tape in the dining room is</p> | |

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| | <p>The first dining room on the West unit had exposed plumbing pipes and the thermostat on the wall was not enclosed. The electrical baseboard heater was black, dirty and stained.</p> <p>The second living area on the West unit had a recliner with a piece of tape peeling off behind the arm where the recliner had a hole.</p> <p>The sink cabinet next to the second dining area of the West unit was missing a drawer and the cabinet doors were unlocked. Inside the lower left side of the cabinet and top drawer were mouse droppings. The inside of the lower right cabinet had no bottom shelf.</p> <p>A door in the hallway of the West unit had two holes with exposed mounting hinges. There were peeling and chipped paint noted on the doors and walls of the hallway. The stain on the handrails was scuffed and worn off throughout the West unit hallway. There was a door in the hallway of the West unit marked with a black magic marker indicating laundry room and employee. The employee part of the writing had been marked out. Observation of the room behind this door was the unit's soiled utility room.</p> | | <p>intact and has texture paint over the tape. You can see tape lines in places due to the settling of the building. South Unit: Ceiling fans and ceiling have been cleaned. Doors in the small dining room and bathroom door in 304 have been repaired. Tiles have been replaced in rooms 313 & 204.4. The Administrator and Housekeeping Supervisor will make monthly inspections of facility. Maintenance and housekeeping staff will be notified of areas needing repair or cleaning. Maintenance and housekeeping will notify the Administrator when areas have been repaired or cleaned. Administrator will report to the Q.A. Meeting quarterly of any trends found. 5. 12/21/2011</p> | |

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| | <p>Bedroom #7 on the West unit had food and brown spots on the ceiling and chipped paint on the walls. The Housekeeping Supervisor indicated there used to be a resident in the room that threw food on the ceilings.</p> <p>There were brown food particles and splatter observed on the ceiling in Bedroom #5.</p> <p>In the hallway of the West unit there were call light wires exposed between Bedroom #4 and Bedroom #8. Bedroom #8 had exposed plumbing pipes and the ledge in bathroom had chipped and peeling paint. The wallpaper border in Bedroom #5 and #4 was ripped and coming off.</p> <p>The door to the bathroom in Bedroom 3 and Bedroom 2 had nails on the wall with nothing hanging on them and the doors were chipped and the stain was coming off.</p> <p>The window blind in Bedroom #1 was stained and broke and the ceiling drywall tape was bunched up and seams were showing. The stain on the closet door in Bedroom #1 had come off and was chipped. The two closet doors directly across from the nurses' station on the West unit were</p> | | | |

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| | <p>scratched and scuffed up. There were nails with nothing hanging on them on the walls throughout the West unit.</p> <p>North Unit:</p> <p>The North dining room's dry wall had holes in the ceiling and was stained. The drywall seams and tape were exposed in the ceiling on the North hall dining room. There were two ceiling tiles in North hall that had a yellow and brown stain on them.</p> <p>South Unit:</p> <p>The South dining room had two ceiling fans with a large amount of dust build up on them. The second dining room of the south unit had a door that chipped and the stain was coming off. The ceiling of Bedroom # 313 of the South unit was stained. The bathroom door in Bedroom #304 was chipped and the stain was coming off. The ceiling was stained in Bedroom #201.</p> <p>3.1-19(f)</p> | | | | |

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| F0279 SS=D | <p>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). Based on interview and record review, the facility failed to initiate a care plan for a resident with an elevated potassium for 1 of 22 residents reviewed for care plans in the stage 2 sample of 40. (Resident #9)</p> <p>Findings include:</p> <p>The record of Resident #9 was reviewed on 11/17/11 at 1:30 p.m.</p> <p>Resident #9's laboratory test for potassium, dated 10/5/11, indicated potassium 6.2, critical level, (normal</p> | F0279 | <p>1. Res has a history of high K+ levels. After a reveiw of the labs it was found that when the reident had a Pot Level of 6+ she also had a UTI. MD orders 10/5/2011 encourage fluids and added 120cc's with Medication pass on 11/28/2011. On 11/28/2011 it was found that resident had a UTI & started on an antibiotic. MD made rounds 11/28/2011 and ordered Kajexalote 15 grms p.o. daily and a BMP in 2 weeks. resident has a history of extremely poor fluid intakes, even though dietary provides 720cc's of fluids per meal, 20oz of water at bedside and fluids with medication passes. We have added 120cc of</p> | 12/21/2011 |

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| | <p>values 3.5 - 5.3).</p> <p>Resident #9's nursing notes, dated 10/5/11 at 11:15 p.m., indicated, "(local lab) phoned with critical KCL (potassium) results of 6.2. Residents KCL level has been 6.1 and MD has had no new orders. Will contact MD with KCL level at practical time."</p> <p>Nursing notes, dated, 10/5/11, no time, indicated "MD informed of 6.2 KCL level new order to encourage fluids."</p> <p>During interview with LPN #4 on 11/17/11 at 2:09 p.m., indicated Resident #9 has a history of high KCL. " In May she was in the hospital with high KCL and they gave her IV (intravenous fluids) and the KCL came down so the physician wanted us to increase her oral fluids. We have called him but he does want her to have another KCL level until January."</p> <p>Resident #9's laboratory test for potassium, dated 11/18/11, indicated potassium 6.3.</p> <p>Physician's orders, dated 11/18/11, indicated "120 cc (cubic centimeters) water with medication pass, document."</p> | | <p>cranberry juice with meals. Staff encourages fluids, but can not force resident to drink. She is alert. Careplan was written.2. A 100% audit was done by nursing to ensure careplans are in place for anyone having a critical lab.3. A stsemic change includes the residents with critical labs will be recorded on the 24 hour report. The 24 hour report will be reviewed daily (Monday-Friday) by the Director of Nursing or Administrator. The director of Nursing will check all critical labs to ensure a careplan is in place. All licensed staff will be in-serviced ny 12/21/2011 on the use of the 24 hour report.4. The Director of Nursing and/or designee will review 24 hour reports and provide a clinical record review of residents having a critical lab.The results of these reviews will be discussed at the quarterly Q.A. Meetings of any trends found.5.12/21/2011</p> | | |

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| | <p>During interview on 11/21/11 at 10:20 a.m., LPN #5 indicated since Resident #9's KCL was so high she called the physician on 11/18/11 and he ordered a KCL level.</p> <p>Resident #9's "Intake and Output by Day Chart" from 10/5/11 to 11/15/11, indicated 14 days with 24 hour intake of less than 500 cc.</p> <p>Resident #9's most recent care plans, dated 9/13/11, lacked a care plan for Resident #9's high KCL level.</p> <p>During interview with the MDS Coordinator on 11/21/11 at 2:00 p.m., indicated she was working on a care plan for Resident #9's high KCL level.</p> <p>The most recent care plan procedure provided by the Director of Nursing on 11/21/11 at 3:40 P.M., indicated the following: "Care Planning - All problems identified must be specifically care planned, including individualized nursing measures to be carried out to execute the plan... All goals must be measurable and interventions need to be care planned and match the interventions being carried out by staff... After completion of the Minimum Data Set assessment,</p> | | | |

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| | <p>additional problems/needs/strengths may be triggered that would need to be addressed on the resident's health care plan. Ongoing assessment of a resident status must also be reflected on the health care plan and should be reflected in other objectives as appropriate... Procedural Guidelines - 16.) Update care plans as changes in condition occur and treatment is altered...."</p> <p>3.1-35(a) 3.1-35(b)(1)</p> | | | | |

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| F0309 SS=D | <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 ensure the necessary care and services were provided related to ensuring adequate monitoring and increased fluid intake in order to manage a resident with a critically high potassium level and to follow up with effective interventions for 1 of 22 residents reviewed in the stage 2 sample of 40. (Resident #9)</p> <p>Findings include:</p> <p>The record of Resident #9 was reviewed on 11/17/11 at 1:30 p.m. The record indicated Resident #9's</p> | F0309 | <p>1. Resident has a history of high K+ levels. After a review of the labs it was found that when the resident had a Pot Level of 6+ she also had a UTI. MD order 10/05/2011 encourage fluids and added 120cc's of H2O each med pass on 11/18/2011. On 11/28/2011 it was found that the resident had a UTI and was started on an antibiotic. MD made rounds on 11/28/2011 and ordered Kajexalote 15 grams P.O. daily and BMP in 2 weeks. Resident has a history of extremely poor fluid intakes, even though dietary provides 720cc;s of fluids on each meal tray, 20oz of water at bedside and fluids with med pass. A 120cc's of cranberry</p> | 12/21/2011 | |

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| | <p>diagnoses included but were not limited to, disorder of kidney, coronary artery disease, hyperkalemia (high Potassium level in the blood), and diabetes.</p> <p>Resident #9's hospital history and physical notes, dated, 5/14/11, indicated "lab work...potassium is 6.2 and repeated was 6.0....Plan, we are going to have a 15 gram dose of Kay-Exalate (lower potassium) today to decrease the potassium."</p> <p>Physician's order, dated 10/5/11, "encourage fluids."</p> <p>Resident #9's laboratory test for potassium, dated 10/5/11, indicated potassium 6.2, critical level, (normal values 3.5 - 5.3).</p> <p>Resident #9's nursing notes, dated 10/5/11 at 11:15 p.m., indicated, "(local lab) phoned with critical KCL (potassium) results of 6.2. Residents KCL level has been 6.1 and MD has had no new orders. Will contact MD with KCL level at practical time."</p> <p>Nursing notes, dated, 10/5/11, no time, indicated "MD informed of 6.2 KCL level new order to encourage fluids."</p> | | <p>juice has been also added to each meal. Staff encourages fluid intake dly, but can't forde resident to drink. Res is alert.2.A 100% audit was done by the nursing staff to ensure that careplans were in place fior all critical lbs.3.Systemic change includes the residents with critical labs will be recorded on the 24 hour report. The 24 hour reports will be reviewed daily (Monday-Friday) by the Director of Nursing or Administrator. The Director of Nursing will check all critical labs to ensure a careplan is in place. All License stall will be in-serviced by 12/21.2011 on the use of the 24 hour report.4. The Director of Nursing and/or designee will review 24 hour reports and provide a clinical record review of the residents having a critical lab. The results of these reviews will be discussed at the Facility Quarterly Q.A. Meeting of any trends noted.5.12/21/2011</p> | | |

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| | <p>During interview with LPN #4 11/17/11 at 2:09 p.m., indicated Resident #9 has a history of high KCL. " In May she was in the hospital with high KCL and they gave her IV (intravenous fluids) and the KCL came down so the physician wanted us to increase her oral fluids. We have called him but he does want her to have another KCL level until January."</p> <p>Resident #9's laboratory test for potassium, dated, 11/18/11, indicated potassium 6.3.</p> <p>Physician's order, dated 11/18/11, indicated "120 cc (cubic centimeters) water with medication pass, document."</p> <p>During interview on 11/21/11 at 10:20 a.m., LPN #5 indicated since Resident #9's KCL was so high she called the physician on 11/18/11 and he ordered a KCL level.</p> <p>Resident #9's "Intake and Output by Day Chart" from 10/5/11 to 11/15/11, indicated 14 days with 24 hour intake of less than 500 cc.</p> <p>According to www.Livestrong.com/article/23330, dated 9/27/10, symptoms-of</p> | | | | |

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| | <p>having-too-much-potassium, indicated "Potassium is a mineral ion that, along with sodium is involved in the control and regulation of many bodily processes. Having too much potassium in the blood is known as hyperkalemia, a serious and potentially fatal condition that requires immediate medical attention. According to the Mayo clinic, the most common causes of hyperkalemia include: kidney disease type-1 diabetes and excessive consumption of potassium-containing foods and/or supplements."</p> <p>3.1-37(a)</p> | | | | |

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| F0315 SS=D | <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to thoroughly assess a resident's bladder function and develop a plan of care or approaches for bladder training for 1 of 4 residents who met the criteria for bladder function. (Resident #82)</p> <p>Findings include:</p> <p>Resident #82's record was reviewed on 11/18/11 at 1:16 P.M. Diagnosis included but was not limited to Neurogenic bladder (incomplete emptying of the bladder).</p> <p>A quarterly Minimum Data Set assessment, dated 9/10/11, indicated the following: Resident #82's brief interview for mental status indicated he was cognitively intact, he usually understood and understands, he</p> | F0315 | <p>1. Resident has been on a 2 hour toileting program. He is ask if he needs to toilet, if he tells staff no, staff checks resident and if found to be soiled, resident is changed. Resident is unaware of being soiled. Resident is tolieted when he asks, but per staff he rarely ask to be tolieted. His voiding pattern is 2 times on 1st and 2nd shiftwith good output, 1 time on 3rd. Resident is checked hourly on 3rd shift per family request. Has a PRN order for in/out cath. Resident has a good intake & output daily.2. A 100% audit was completed to ensure a careplan was in place for all incontinent residents and that current approaches are in place.3.The MDS Coordinator and/or designee will be educated regarding incontinence careplans. The MDS Coordinator will review telephone orders to ensure all changes in catheter order are addressed in the careplans. The Direector of Nursing and/or designee will review all 24hour</p> | 12/21/2011 |

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| | <p>required extensive assistance of 2 persons for bed mobility, transfers, and toileting, he did not walk, he was not on a toileting program, he was always incontinent of urine, and he did not have a catheter.</p> <p>A local hospital history and physical for Resident #82, dated 5/14/11 at 3:21 P.M., indicated he had a diagnosis of neurogenic bladder with intermittent straight catheterization.</p> <p>An Admission Resident Data Collection form for Resident #82, dated 6/14/11, indicated Resident #82 was transferred from a local hospital with a diagnosis of post right hip fracture, he was non-weight bearing, and he required total assistance for transfers. Resident #82 had a catheter.</p> <p>An Evaluation of Medical Justification for a catheter for Resident #82, dated 6/15/11, indicated a diagnosis of neurogenic bladder.</p> <p>An initial Bowel and Bladder assessment for Resident #82, dated 6/15/11, indicated the following: Foley catheter in place. The assessment indicated Resident #82 had a diagnosis of neurogenic bladder. Resident #82 was total</p> | | <p>reports for changes on catheter issues and/or incontinence and report those changes to the MDS Coordinator and/or designee. The MDS Coordinator will address all changes in the careplan.4. The MDS Coordinator and/or designee will monitor residents with incontinence issues to ensure a careplan is in place with appropriate interventions. The Direcetor of Nursing will report to the quarterly QA Committee of any trends noted.5. 12/21/2011</p> | | |

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| | <p>dependence to walk to the bathroom, transfer to the toilet, manage his clothing, and wipe himself. Resident #82 made poor decisions and required supervision.</p> <p>A Bowel and Bladder assessment for Resident #82, dated 9/15/11, indicated the following: Foley catheter in place. The assessment indicated Resident #82 had a diagnosis of neurogenic bladder. The bladder assessment was incomplete.</p> <p>A catheter care plan for Resident #82, dated 6/27/11, indicated the following: Problem - Resident #82 had a Foley catheter for a diagnosis of neurogenic bladder. He frequently pulled on the catheter causing hematuria. The Foley catheter was discontinued on 7/13/11. He would receive in and out straight catheterization every shift. His in and out straight catheterization was discontinued on 8/6/11.</p> <p>An interview with CNA #7 on 11/18/11 at 1:16 P.M., indicated Resident #82 was always incontinent</p> <p>An incontinent care plan for Resident #82, dated 11/18/11, indicated the following: Problem - Resident #82 was frequently incontinent of his bladder. He tells staff he doesn't</p> | | | |

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| | <p>have to go, then when he is toileted he has already went. Goal - The resident will have at least two episodes of bladder continence when toileted daily times 90 days.</p> <p>Interventions - Staff was to toilet the resident every 2 hours after waking in the A.M. Staff was to provide perineal care after each incontinent episode. Staff was to praise all efforts. Staff was to document the number of times he was incontinent every shift. Staff was to observe for signs and symptoms of urinary tract infection (fever, hematuria, sedimentation). Staff would straight catheterize him if he went without voiding for a shift.</p> <p>An interview with LPN # 6 on 11/21/11 at 9:19 A.M., indicated Resident #82 was incontinent of urine. LPN # 6 indicated Resident #82 did not notify staff of his need to toilet. LPN # 6 indicated Resident #82's urinary incontinent care plan was developed after it was brought to her attention on 11/18/11. LPN # 6 indicated the staff had not attempted to establish an incontinent bladder pattern on Resident #82 after his catheter was removed on 7/13/11. LPN # 6 indicated no urinary incontinence assessment had been completed for Resident #82 after his catheter had been removed on 7/13/11, except the</p> | | | | |

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| | <p>one dated 9/15/11, and that assessment was incomplete and incorrect because Resident #82's catheter had already been discontinued. LPN # 6 indicated the resident was placed on a toileting plan every 2 hours and as needed after his catheter had been discontinued.</p> <p>An interview with LPN # 6 on 11/21/11 at 11:09 A.M., indicated Resident #82 would ask to go to the bathroom sometimes, but rarely. LPN # 6 indicated "sometimes if they asked Resident #82 if he had urinated he would say 'no' and the staff would check him and he had." LPN # 6 indicated Resident #82 had usually already urinated when he was taken to the toilet. LPN # 6 indicated Resident #82 did not have urinary incontinent pattern.</p> <p>An interview with Resident #82's spouse on 11/21/11 at 12:54 P.M., indicated Resident #82's catheter was removed because he began urinating on his own. Resident #82's spouse indicated Resident #82 was able to communicate and understood communication. Resident #82's spouse indicated she knew Resident #82 was able to communicate when he needed to urinate because he</p> | | | | |

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| | <p>would tell her when she visited him. Resident #82's spouse indicated she could not say for sure if Resident #82 communicated the need to urinate to the staff. Resident #82's spouse indicated Resident #82 had informed her he had voiced the need to urinate a couple of times to the staff but was told he would have to wait because they were busy, and that resulted in Resident #82 urinating on himself. Resident #82's spouse indicated she thought that had probably "set in with him" and he felt like it wouldn't do any good. Resident #82's spouse indicated she had questioned Resident #82 why he didn't always tell staff he had to toilet and Resident #82 responded, "it won't do any good".</p> <p>The most recent Assessing and Managing Urinary Incontinence procedure provided by the Director of Nursing on 11/21/11 at 3:15 P.M., indicated the following: "Purpose - 1.) To provide the necessary information regarding the type of incontinence, frequency of incontinence, and pattern of incontinence. 2.) To allow for staff or resident intervention to manage incontinence. Policy - All residents with incontinence or an indwelling catheter are assessed within 7 days of admission and reassessed and evaluated for the</p> | | | |

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| | <p>need of a bowel/bladder training program or continued use of the catheter on a quarterly basis. For those residents qualifying for a bowel/bladder training program, their attending physician is notified and orders obtained as deemed necessary by the physician.</p> <p>Responsibility: Licensed Nurses and CNA's. Equipment - 1.) Bowel and Bladder assessment form. 2.) Incontinence Monitoring worksheet form or worksheet. Procedure - 1.) Review resident's medical chart including history and physical, lab test, and list of current medications. 2.) Complete the Bowel and Bladder assessment form. This requires observation and interviews with the resident and/or a family member. 3.) Determine the type of urinary incontinence and whether or not the resident is a candidate for bladder training program. 4.) Complete the bowel assessment portion, determine the need for a bowel training program and indicate if the resident is a candidate. 5.) Explain to the resident, family and all caregivers the reasons and procedure for the accurate seven day incontinence monitoring. 6.) During the seven day incontinence monitoring, document findings in the nurses notes. 7.) After the seven day incontinence</p> | | | |

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| F0323 SS=E | <p>monitoring is completed, determine retraining program to be utilized. 8.) Document if the resident is not a candidate for retraining on the resident's care plan and progress notes. 9.) Document the retraining program on the resident's care plan with established measurable goals. 10.) Document progress toward goals on a routine (weekly) basis...."</p> <p>3.1-41(a)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based observation and interview, the facility failed to maintain a safe enviroment for residents; in that there were no handrails next to the toilet for 2 of 4 bathrooms observed and</p> | F0323 | <p>1. The Maintenance Supervisor was informed of all issues found by the Aministrator and a plan for improvements was put into place.2. No residents were harmed by any of the issues</p> | 12/21/2011 | |

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| | <p>exposed wires in 1 of 4 units, exposed heating and plumbing pipes for 1 of 4 units observed, this had the potential to affect 14 residents in the facility population of 118 (west unit).</p> <p>Finding include:</p> <p>During observation on 11-21-11 at 9:00 a.m., with the Housekeeping Supervisor the following environmental safety issues were observed:</p> <p>1. There were no grab bars in main shower room of the West unit by toilet. There was no grab bar next to the toilet in the bath room of Bedroom # 8</p> <p>There were exposed plumbing and heating pipes through out the West unit. There were exposed wires in hallway of the West unit. In interview at this time, the Housekeeping Supervisor indicated the wires were from old exit signs.</p> <p>Interview with LPN #3 on 11-21-11 at 4:30 p.m., indicated there were 14 residents that lived on the west unit of the facility.</p> | | <p>found.3. A grab bar was installed in the west shower room immediately. Room 8 a bedside commode was put over the toilet. Due to a closet with sliding doors is next to the toilet a grab bar could not be installed.. The plumbing pipes under the sink were boxed in and painted. The plumbing pipes in the west dining room were painted the same as the ceiling, due to pipes are the sprinkler system.. There are no exposed heating pipes, this unit is total electric heat. The wiring in the hallway for paging system has been enclosed.4. Administrator and Housekeeping Supervisor will do monthly rounds and inform maintenance of any repairs that need to be done. Maintenance will inform the Administrator when repairs have been completed. Administrator will report to the quarterly QA Committee of any repairs that were found to be a safety issue.5. 12/21/2011</p> | | |

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| F0329 SS=D | <p>3.1-45(a)(1)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to attempt a gradual dose reduction for Ativan (antianxiety medication) for 1 of 3 residents that</p> | F0329 | 1. An order was received to reduce Resident 2's Ativan from 0.5 mg TID to Ativan 0.5mg BID.2. A 100% audit was completed by the Director of | 12/21/2011 | |

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| | <p>met the criteria for psychotropic medication use in stage 2 sample of 40 (Resident #2).</p> <p>Finding include:</p> <p>Review of the clinical record of Resident #2 on 11-16-11 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, depression, morbid obesity, Cerebral Vascular Accident (CVA) and anxiety.</p> <p>The Physician recapitulation for Resident #2 dated November 2011, indicated the resident was ordered Ativan 0.5 milligrams (mg) three times a day.</p> <p>The record review on 11-16-11 at 2:00 p.m., indicated there were no pharmacy recommendation for dose a reduction of the Ativan for Resident #2.</p> <p>Interview with the Unit Manager #2 on 11-16-11 AT 3:53 P.M., indicated the facility had not attempted a dose reduction on the Ativan for Resident #2. Unit Manager #2 provided the original physician order for Resident #2's Ativan 0.5 mg three times a day and it indicated it was started on</p> | | <p>Nursing and Pharmacy of psychotropic drugs to ensure drug reductions have been attempted.3. An order was received for Ativan 0.5mg TID to be reduced to Ativan 0.5 mg BID. Staff are monitoring for any adverse effects due to reduction.4. the Director of Nursing will review monthly pharmacy psychotropic medications to ensure drug reductions are being recommended. The Director of Nursing will report to the quarterly QA Committee any drug reduction missed by pharmacy.5. 12/21/2011</p> | | |

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| | <p>1-27-10.</p> <p>Interview with Unit Manager #2 on 11-17-11 at 9:54 a.m., Unit Manager # 2 indicated there were no pharmacy recommendations for a gradual dose reduction made for the Ativan for Resident #2.</p> <p>3.1-48(a)(2)</p> | | | | |

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| F0356 SS=A | <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure nursing staff information was posted during 1 of 7 survey dates.</p> <p>During observation on 11-13-11 at 10:30 p.m., there were no nurse staff</p> | F0356 | <p>1. Nurse staffing was posted the next morning across from the North Nurses Station.2. No resident was affected by the nurse staffing not being posted in the correct area.3. The Asst. Director of Nursing was informed that the nurse staffing sheet was to be put on the bulletin board across from the North Nurses</p> | 12/21/2011 | |

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| F0428 SS=D | <p>information posted in the building. Interview with LPN #1 on 11-13-11 at 10:40 p.m., indicated the nurse staff posting usually was on the North unit. LPN #1 was observed looking for nurse staffing posting and was unable to locate it. LPN #1 indicated she was not sure why it was not posted.</p> <p>Interview with the Director of Nursing (DON) on 11-13-11 at 10:50 p.m., indicated the nurse staffing was supposed to be posted on the North unit.</p> <p>3.1-13(a)</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the pharmacy identified and recommend</p> | F0428 | <p>Station and not the one behind the station. Staffing information is now being posted in the correct area.4. The Director of Nursing and/ or designee will check daily to ensure staffing information is posted. The Director of Nursing will inform ther Administrator if information has not been posted.5. 12/21/2011</p> <p>1. Pharmacy was informed of missed drug reduction.2. Pharmacy did a 100% audit of psychotropic drugs to ensure</p> | 12/21/2011 | |

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| | <p>to the facility physician the need to attempt a gradual dose reduction for a resident receiving Ativan (antianxiety medication) for 1 of 3 residents that met the criteria of psychotropic medication use in the Stage 2 sample of 40 (Resident #2).</p> <p>Finding include:</p> <p>Review of the clinical record of Resident #2 on 11-16-11 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, depression, morbid obesity, Cerebral Vascular Accident (CVA) and anxiety.</p> <p>The Physician recapitulation for Resident #2, dated November 2011, indicated the resident was ordered Ativan 0.5 milligrams (mg) three times a day.</p> <p>The record review on 11-16-11 at 2:00 p.m., indicated there were no pharmacy recommendation for a dose a reduction of the Ativan for Resident #2.</p> <p>Interview with the Unit Manager #2 on 11-16-11 at 3:53 P.M., indicated the facility had not attempted a dose reduction on the Ativan for Resident #2. Unit Manager #2 provided the</p> | | <p>reductions have been attempted.3. Resident 2's Ativan 0.5mg TID was lowered to Ativan 0.5 BID.4. Pharmacy to provide a report of request drug reductions monthly to the Director of Nursing. Director of Nursing and/or designee to follow up to ensure drug reduction was done or reason for it not being reduced. The Director of Nursing will report to the QA COmmittee quarterly of any missed request for drug reductions.5. 12/21/2011</p> | | |

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| F0469 SS=E | <p>original physician order for Resident #2's Ativan 0.5 mg three times a day and it indicated it was started on 1-27-10.</p> <p>Interview with the Unit Manager #2 on 11-17-11 at 9:54 a.m., Unit Manager # 2 indicated there were no pharmacy recommendation for a gradual dose reduction for the Ativan were made for Resident #2.</p> <p>3.1-25(i)</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, record review and interview, the facility failed to maintain an effective pest control program, as there were mouse dropping observed in the cabinet off the second dining room of the West unit for 1 of 4 units observed during</p> | F0469 | <p>1. Cabinaet and drawer were immediately cleaned.2. No residents were harmed by this issue. All cabinets were checked and no other issues were found.3. West housekeepers were informed that even though these areas are not being used, they</p> | 12/21/2011 | |

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| | <p>environmental tour. This had the potential to affect 14 residents who lived on the West unit in the facility population of 118 (West unit).</p> <p>Finding include:</p> <p>During environmental tour on 11-21-11 at 9:00 a.m., with the Housekeeping Supervisor there were rodent droppings in the cabinet and drawers of the second dining room of the West unit.</p> <p>Interview with the Administrator on 11-21-11 at 10:26 a.m., indicated a local pest control company was at the facility on 10-12-11. The Administrator indicated the local pest control company did the whole building and replaced the old baits for mice. Review of the documentation of the local pest control company, dated, 10-12-11, indicated there were no pest harborages found or reported. The Administrator indicated the local pest control company came every month and replaced old baits. There were no indication on the documentation where the baits were placed. The Administrator indicated baits were placed throughout the building and where residents would</p> | | <p>still need to check them and clean them. Maintenance put a sticky trap under the sink area. Housekeeping is to notify Maintenance if trap needs replaced. Pest control company will continue to make monthly visits and put sticky traps out throughout the building in places that do not affect th residents.4. The Administrator will do monthly checks of cabinaets on the west unit to ensure area is being cleaned and no traces of pest are present. The Administrator will report to the QA Committee quarterly of any issues with pest control.5.12/21/2011</p> | | |

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| | <p>not have access to them.</p> <p>Interview with LPN #3 on 11-21-11 at 4:30 p.m., indicated there were 14 residents living on the west unit.</p> <p>3.1-19(f)(4)</p> | | | | |