

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155444	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
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NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 N NORWOOD RD HUNTINGTON, IN 46750
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 24, 25, 28, 29, 30 and October 1, 2, 5, 2015.</p> <p>Facility number: 000463 Provider number: 155444 AIM number: 100290910</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 4 Medicaid: 40 Other: 8 Total: 52</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on October 9, 2015.</p>	F 0000		
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of failure to obtain an ordered laboratory test (Resident #2).</p> <p>Findings Include:</p>	F 0157	<p>Resident #2 's physician was made aware of missed Dilantin level in August by Director of Nursing. Dilantin level has since been drawn and adjustments made to her Dilantin dose.</p> <p>Resident #2 has new order to check Dilantin level on 10/20/15. Residents have the potential to</p>	11/02/2015

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	<p>Review of Resident #2's clinical record began on 9/25/15 at 1:32 p.m. Diagnoses included, but were not limited to, intellectual disability, dementia with behavioral disturbance, pseudobulbar affect, anxiety, convulsions, and breast cancer.</p> <p>Resident #2's current medications included, but were not limited to, buspirone (anti-anxiety) 15 mg 3 times daily, Cymbalta (anti-depressant) 60 mg once daily, Nuedexta (mood stabilizer) 20 mg-10 mg every 12 hours, Delsym (cough medication) 30 mg one hour prior to showers, and Phenobarbital 40 mg three times daily.</p> <p>A physician's progress note, dated 7/22/15, indicated Resident #2 was seen on that date for increased episodes of seizures. The physician ordered Dilantin (anti seizure) to be increased to 300 mg twice daily and Dilantin levels to be done in 4 weeks.</p> <p>Review of a "Medication Administration Record" dated August 2015 indicated the Dilantin level was not done due to being unable to obtain blood from the resident.</p> <p>There was no documentation in the clinical record regarding the physician being notified of the Dilantin level not</p>		<p>be affected by the same deficient practice. All physician's laboratory orders will be reviewed by DON/ADON by 11/2/2015. Nurses will be reeducated by DON or designee on practice of notifying MD of resident refusals or inability to obtain lab on 10/27/2015. DON or designee to review resident's Nurses Notes five days a week to monitor for resident refusals of labs. DON/designee to review Physicians orders and all labs due for the day in the clinical meeting to ensure results were received and MD notified. Daily review of Nurses Notes and MD orders will be done Monday through Friday. QA to be completed 1 time weekly for 4 weeks then monthly for 3 months, then quarterly for six months. Results forwarded to QA committee for further review and/or recommendation.</p>	

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F 0241 SS=D Bldg. 00	<p>being drawn.</p> <p>Resident #2's clinical record indicated a Dilantin level was not completed until 9/1/15. There was no documentation the physician had been notified by this date, nor had a new order been received.</p> <p>During an interview, on 9/30/15 at 3:17 p.m., LPN #4 indicated she had asked the oncoming shift to notify the physician of failure to obtain the Dilantin level. She further indicated she should have documented it in the nurse's notes, but did not document it.</p> <p>3.1-5(a)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, and record review, the facility failed to ensure residents were cared for in a dignified manner (Residents #2 and #13).</p> <p>Findings include:  During a dining observation in the</p>	F 0241	Residents will not be served meals unless staff is present to immediately assist with dining needs. Residents will be served their meals with all items removed from the tray and coverings removed. Residents will be assisted as soon as meal is delivered to ensure residents being served/fed hot meals.	11/02/2015

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	<p>assistive dining room, beginning on 10/2/15 at 12:21 p.m., the following observations were made of staff interactions while seated next to the residents:</p> <p>1. Resident #2's lunch plate and drinks were placed in front of her, with the cover left on the plate and plastic wrap covering the drinks.</p> <p>Review of Resident #2's clinical record began on 9/25/15 at 1:32 p.m. Diagnoses included, but were not limited to, intellectual disability, dementia with behavioral disturbance, pseudobulbar affect, anxiety, convulsions, and breast cancer.</p> <p>Resident #2 had a current, 9/15/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and required extensive assistance for ADLs.</p> <p>2. Resident #13, being assisted by LPN #2, had plastic wrap covering her drinks through the meal, until LPN #2 offered the drinks when the meal was completed.</p> <p>3. A resident was yelling, "I can't eat!". LPN #3 stated "Has anyone fed her?" LPN #2 indicated she thought Housekeeper #1 was "going to feed her".</p>		<p>Residents in assist dining room have the potential to be affected by the same deficient practice. Nursing staff will be re-educated on 10/27/2015 regarding dignity with dining, proper assistance techniques and facility will assign a manager to oversee the dining service at every meal through the week and 2 of 3 meals per day on the weekend. The nurse assigned to the dining room serves as the dining room manager in the absence of facility management.</p> <p>A staff in-service will be held by Director of Nursing, Assistant Director of Nursing and Social Services on 10/27/2015 to re-educate on dignity during dining and how to properly serve and assist with mealtimes. A member of the management team will be assigned dining room supervision at all meals through the week and two of the three meals on the weekends. The manager will ensure that all residents are being assisted timely in dining room and assisted with dignity. The nurse assigned to the dining room serves as the dining room manager in the absence of facility management. The dining room manager will complete a dining quality assurance audit tool when supervising the meal service. The results will be forwarded to the QA committee for review and/or recommendation.</p>	

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F 0279 SS=D Bldg. 00	<p>As LPN #2 began assisting the resident, the interim Dietary Manager approached the table and tested the temperature of the food on the plate. She then removed the plate and indicated she would bring a new plate, as the food was cold. A new plate was brought to the resident 12 minutes later.</p> <p>3.1-3(t)</p> <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). Based on interview, and record review,</p>	F 0279	Resident #2 Care Plan has been reviewed and revised by MDS	11/02/2015

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	<p>the facility failed to ensure care plans were updated to meet the individual needs of 1 of 28 residents reviewed for care planing. (Resident #28)</p> <p>Findings include:</p> <p>Review of Resident #2's clinical record began on 9/25/15 at 1:32 p.m. Diagnoses included, but were not limited to, intellectual disability, dementia with behavioral disturbance, pseudobulbar affect, anxiety, convulsions, and breast cancer.</p> <p>Resident #2 had a current, 9/15/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and required extensive assistance for ADLs. The MDS indicated the resident demonstrated behaviors daily.</p> <p>Resident #2's current medications included, but were not limited to, buspirone (anti-anxiety) 15 mg 3 times daily, Cymbalta (anti-depressant) 60 mg once daily, Nuedexta (mood stabilizer) 20 mg-10 mg every 12 hours, Delsym (cough medication) 30 mg one hour prior to showers, and Phenobarbital 40 mg three times daily.</p> <p>Resident #2 had a current care plan</p>		<p>coordinator on 10/21/2015 to reflect resident's dislike of showers and preference for bed bathing Residents that are on a behavior management program will be reviewed by Social service Director and DON or designee by 11/2/2015, to ensure that environmental/situational causes for behaviors are identified and their Care Plans will be reviewed. Residents with Behavior Care Plans will be reviewed in monthly behavior meeting. Resident's Care Plans will be reviewed quarterly by RAI director. Residents Behavior Care Plans will be audited /reviewed monthly by Social Service Director for three months. Results forwarded to QA committee to review and RAI director to review Care Plans quarterly thereafter.</p>	

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	<p>problem of becoming physically aggressive and a dislike of hands-on care. The current interventions included, but were not limited to, giving the resident choices, modifying environment, and guiding away from source of distress.</p> <p>Review of a "Behavior Management Team Review" document indicated the following:</p> <p>A note dated 8/25/15 indicated Resident #2 disliked showers and did not respond to interventions. The note further indicated the resident had difficulty making her needs and wants known, but disliked showers, and was to be offered a bed bath.</p> <p>A psychiatric progress note, dated 8/25/15, indicated the resident continued to yell out, especially before showers, and was frightful for others.</p> <p>During an interview, on 10/1/15 at 2:41 p.m., CNA #7 indicated Resident #2 only displayed behaviors of yelling with showers, but not with other care. CNA #7 indicated they were not aware of why Resident #2 received showers instead of bed baths.</p> <p>During an interview, on 10/1/15 at 2:45 p.m., CNA #1 indicated Resident #2</p>			

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F 0282 SS=D Bldg. 00	<p>yelled out a lot during showers, but accepted other care. CNA #1 indicated they were not aware of why Resident #2 received showers instead of bed baths.</p> <p>During an interview, on 10/1/15 at 3:00 p.m., the Social Service Director (SSD), indicated she did not know why Resident #2 received showers instead of bed baths. She further indicated the resident's episodes of yelling out would be alleviated by bed baths. She indicated the facility was looking at changing Resident #2's showers to bed baths, but had not updated her plan of care.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 interview and record review, the facility failed to ensure residents with orders for accurate intake and output monitoring received those services as ordered by the physician for 2 of 4 resident's reviewed for fluid monitoring (Resident #68 and #17) and blood</p>	F 0282	There are not any residents that currently have orders for intake and output monitoring. Residents with vital sign orders will be reviewed by DON/designee to ensure the orders are entered correctly to ensure the nurses document vital signs. Completion date 11/2/2015 Current	11/02/2015

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	<p>pressure monitoring for 1 of 5 resident's reviewed for unnecessary medications. (Resident #59)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #68 was reviewed on 9/29/15 at 11:56 a.m. Diagnoses for the resident included, but were not limited to, cerebral infarct, hypertension, diabetes mellitus, pain, anxiety, congestive heart failure, tracheostomy and gastrostomy tube.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 7/17/15, indicated the resident was severely cognitively impaired. Resident #68 received nothing by mouth.</p> <p>Review of a physician's progress note dated 7/10/15, indicated to anchor a Foley catheter to monitor fluid intake and output. The note indicated the resident had recent emesis, increased tracheal secretions and 3 + [plus] upper edema.</p> <p>Review of a physician's order dated 7/10/15, indicated a "Foley Catheter: Size 18 French 10 ML Balloon to Gravity Drainage." The diagnosis for the urinary catheter included "Other Disorders Of Urethra And Urinary Tract; Elevated White Blood Cell Count."</p>		<p>residents MD orders will be reviewed by DON/designee and ensure that they are entered correctly for all residents requiring vital sign monitoring. Physician's orders will be reviewed by DON/designee to ensure proper monitoring attached to orders and to ensure documentation is correct. Completion date 11/2/2015 Don/designee to review all physicians orders entered into Sigmacare to insure proper monitoring attached to ensure correct documentation obtained. QA tool to audit physician's orders and completion of associated documentation will be completed by DON/designee weekly for four weeks, then monthly for three month, then quarterly for six months. The results will be forwarded to the QA committee for review and/or recommendation.</p>	

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	<p>A progress note dated 7/17/15, indicated Resident #68 had bilateral lung infiltrates and was receiving antibiotics. The note indicated a Foley catheter was still in place. The catheter was discontinued on 7/23/15.</p> <p>Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) for July, no amount was recorded for either gastrostomy intake or urinary output from 7/10/15-7/23/15.</p> <p>Review of the nursing notes from 7/10-7/23/15, the following urinary output was noted:</p> <p>7/11/15-400 mL urine for 2nd shift. 7/12/15-1000 mL urine for 1st shift. 7/16/15-1200 mL urine for 1st shift. 7/19/15-700 mL urine for 2nd shift. 7/22/15- 400 mL urine for 1st shift.</p> <p>During an interview on 9/30/15 at 3:09 p.m., LPN #13 indicated the physician wanted to monitor accurate intake and output. She indicated since the resident was not alert and oriented, the physician ordered a Foley catheter. She indicated she put the order into the computer with a diagnosis of "disorder of the urethra" because no other diagnosis fit, but the</p>			

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	<p>physician wanted to monitor the exact volume of fluid because of the edema in her upper extremities.</p> <p>During an interview on 10/1/15 at 7:54 a.m., the MDS coordinator indicated she could not find any care plan related to a urinary catheter. She indicated a paper care plan should have been generated when a change in condition was noted.</p> <p>During an interview on 10/1/15 at 11:01 a.m., the Director of Nursing (DON), indicated the MAR and TAR did not indicated "output" on either report.</p> <p>During a second interview on 10/2/15 at 12:18 p.m., the DON indicated she could not find any additional information related to intake or output for Resident #68.</p> <p>Review of a current facility policy dated 8/01, titled "LTC Health Information Practice and Documentation Guideline", which was provided by the DON on 10/2/15 at 7:30 a.m., indicated the following:</p> <p>"6.8.2 Dictated Progress Notes: If a physician dictates a progress note, a brief note should be entered into the record at the time of the visit....If there has been an acute change in the resident's</p>			

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	<p>condition, the physician should write a note for the medical record...." 2. The clinical record for Resident #17 was reviewed on 9/29/15 at 11:59 a.m. Diagnoses for the resident included, but were not limited to, chronic kidney failure, hypertension, diabetes mellitus type II, dependence on renal dialysis and chronic obstructive pulmonary disease.</p> <p>A review of a Physician's order, indicated the resident had an order that included, "...Fluid Restriction of 1200 ml [milliliters]/24 hours per discharge orders [on] 10/14/13. Dietary to provide 240 ml at breakfast, 240 ml at lunch, and 240 ml at dinner to = 720 ml per day. Nursing to provide 480 ml - 120 ml with 8 a.m., 120 ml with 12 p.m., 120 ml with 4 p.m., 120 ml with 8 p.m..." The order was started on 10/14/13 and discontinued on 4/16/15.</p> <p>A review of Resident 17's current health plan, revised on 4/24/15, indicated problem: "...The resident needs dialysis (hemo) r/t [related to] renal failure. Interventions included, but were not limited to: "...Monitor intake..."</p> <p>A review of the January 2015 thru May 6, 2015 "Flow Sheet..." was provided by the MDS Coordinator on 10/1/15 at 10:30 a.m. It indicated the following:</p>			

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	<p>"...FLUID INTAKE..."</p> <p>January 1-31, 2015: A total of 8 of the 93 fluid intakes were charted at meal times.</p> <p>February 1-28, 2015: A total of 17 of the 84 fluid intakes were charted at meal times.</p> <p>March 1-31, 2015: A total of 26 of the 93 fluid intakes were charted at meal times.</p> <p>April 1-30, 2015: A total of 17 of 90 fluid intakes were charted at meal times.</p> <p>During an interview with the MDS Coordinator on 10/1/15 at 10:30 a.m., she indicated the "...Flow Sheet..." was completed by the CNA's and further indicated there were no fluid intakes from nursing found.</p> <p>No further information was provided upon exit on 10/5/15.</p> <p>A policy titled "Intake and Output (I&amp;O) dated 8/2014 provided by the DON (Director of Nursing) on 10/1/15 at 11:00 a.m. indicated the following:</p> <p>"...BASIC RESPONSIBILITY Nursing Staff</p>			

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	<p><b>POLICY</b></p> <p>It is the policy of this facility to monitor intake and output and accurately document when it is determined that monitoring is necessary to evaluate hydration status, compliance with fluid restrictions, or to assist in assessing and managing fluid needs.</p> <p><b>PURPOSE</b></p> <p>...To assist in assessing and managing fluid needs...</p> <p><b>...EQUIPMENT</b></p> <p>...Intake &amp; Output record...</p> <p><b>...PROCEDURE</b></p> <p>...4. Nursing personnel are responsible for recording intake and output when indicated for assigned residents..."</p> <p>3. The clinical record for Resident #59 was reviewed on 9/29/15 at 9:52 a.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease, hypertension and chronic obstructive pulmonary disease.</p> <p>A review of Physician's orders, dated 8/24/15 indicated the following:</p> <p>"...Monitor B/P [Blood Pressure] and Pulse weekly 2nd shift... Schedule:</p>			
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	<p>One-Time at 12/03/2014...Then Every 7 days..."</p> <p>"...push po [by mouth] fluids 240 ml [milliliters] QID [four times a day]... Schedule: Every Day at 8:00 am; 12:00 pm; 4:00 pm; 8:00 pm for 7 Days..."</p> <p>A review of Resident 59's "Clinical Monitoring Information..." provided by the ADON on 10/5/15 at 9:00 a.m. indicated blood pressure readings for 8/24/15 - 8/28/15. No blood pressure results were provided for the month of September 2015.</p> <p>A review of Resident #59's current health plan indicated problem: "...The resident has hypertension...Date Initiated: 08/28/2015...Interventions include but were not limited to: ...Obtain blood pressure readings..."</p> <p>During an interview with the DON on 10/2/15 at 2:50 p.m., she indicated there were no blood pressures completed weekly in September 2015 and order start date was 8/24/15. She further indicated the order was entered incorrectly into the electronic medical record. The DON indicated they did not add the monitoring for blood pressure...only a place for Nurse initials.</p>			

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F 0309 SS=D Bldg. 00	<p>The DON indicated the 240 ml fluid push order should have been documented on the MAR (Medication Administration Record), but was not; instead it was entered as a general order versus a medication order. She indicated that would have triggered the nurse to give the fluids and document it.</p> <p>No further information was provided at exit on 10/5/15.</p> <p>3.1-35(g)(1) 3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview, and record review, the facility failed to track behaviors, causes, and effective interventions for 1 of 5 residents reviewed for unnecessary medications (Resident #2).</p> <p>Findings include:  Review of Resident #2's clinical record</p>	F 0309	Resident #2 Care Plan was reviewed and revised on 10/21/2015 by DON and Social Services Director to reflect resident's dislike of showers and preference for bed bathing. Orders for behavior documentation in Sigmacare will be discontinued by DON/designee by 11/2/2015, as current policy is to document all	11/02/2015

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	<p>began on 9/25/15 at 1:32 p.m. Diagnoses included, but were not limited to, intellectual disability, dementia with behavioral disturbance, pseudobulbar affect, anxiety, convulsions, and breast cancer.</p> <p>Resident #2 had a current, 9/15/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and required extensive assistance for ADLs. The MDS indicated the resident demonstrated behaviors daily.</p> <p>Resident #2's current medications included, but were not limited to, buspirone (anti-anxiety) 15 mg 3 times daily, Cymbalta (anti-depressant) 60 mg once daily, Nuedexta (mood stabilizer) 20 mg-10 mg every 12 hours, Delsym (cough medication) 30 mg one hour prior to showers, and Phenobarbital 40 mg three times daily.</p> <p>Review of a "Behavior Management Team Review" documents indicated the following:</p> <p>A note dated 1/27/15, indicated the resident had non-sensical vocalizations and was "...disruptive to the environment...". The note further indicated the resident needed time to</p>		<p>behaviors in Point Click Care. Residents with behaviors have potential to be affected by the same deficient practice. Residents in the behavior management program will have their orders discontinued by DON/designee by 11/2/2015, from Sigmacare as facility policy changed. Behavior documentation added to Point Click Care by social service director.</p> <p>Nursing staff to be re-educated on behavior documentation and facility policy on 10/27/2015 by DON, ADON and Social Services director. Behavior documentation QA will be reviewed by Social Services, DON/designee monthly in behavior management meeting. Any issues will be brought to QA committee for review and planning.</p>	

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	<p>calm down.</p> <p>A note dated 2/24/15 indicated Resident #2's behaviors were loud, guttural vocalizations both when happy and angry, and worsened particularly during showers.</p> <p>A note dated 3/24/15 indicated Resident #2's behavior continued daily, when happy and when angry, and leaving the resident alone or spending 1:1 time with them decreased the verbalizations.</p> <p>A note dated 6/30/15 indicated Resident #2 did not respond to interventions when angry.</p> <p>A note dated 7/23/15 indicated Resident #2 did not respond to interventions when angry.</p> <p>A note dated 8/25/15 indicated Resident #2 disliked showers and did not respond to interventions. The note further indicated the resident had difficulty making her needs and wants known, but disliked showers, and was to be offered a bed bath. The note also indicated Resident #2's plan of care was to continue the following medications: Nuedexta, lorazepam, and add Delsym prior to showers.</p>			

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	<p>The "Behavior Management Team Review" notes reviewed indicated there were no behavior reports received from direct care staff.</p> <p>A psychiatric progress note, dated 6/23/15, indicated the resident was doing okay and yelled out occasionally.</p> <p>A gradual dose reduction request from the facility pharmacist on 7/28/15, signed by Review of Resident #2's medication history indicated they had also received lorazepam (anti-anxiety) 1 mg once daily on Monday, Wednesday, and Friday prior to showers, dental procedures, and podiatry appointments from 2/18/15 through 9/15/15. the psychiatric nurse practitioner, indicated Resident #2 continued to have behaviors daily, but was improved with current medications, and Nuedexta would be ordered.</p> <p>A psychiatric progress note, dated 8/25/15, indicated the resident continued to yell out, especially before showers, and was frightful for others. A new order was written for Delsym 30 mg one hour prior to showers for pseudobulbar affect.</p> <p>Review of Resident #2's medication history indicated she had also received lorazepam (anti-anxiety) 1 mg once daily on Monday, Wednesday, and Friday prior</p>			

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	<p>to showers, dental procedures, and podiatry appointments from 2/18/15 through 9/15/15.</p> <p>Review of Medication Administration Records for August and September 2015 indicated Resident #2 received both Delsym and lorazepam prior to their shower on 8/28/15, 8/31/15, 9/2/15, 9/7/15, 9/9/15, 9/11/15, and 9/14/15.</p> <p>Review of CNA documentation for August and September 2015 indicated Resident #2 had received a shower every Monday, Wednesday, and Friday.</p> <p>During an interview, on 9/30/15 at 10:01 a.m., LPN #5 indicated behaviors were documented on the Medication Administration Record, using a numbered system and comments field. She further indicated CNAs documented in the point of care software and reported behavior episodes to the nurses.</p> <p>During an interview with the Social Service Director, on 9/30/15 at 11:38 a.m., she indicated she was not sure where the nurses and CNAs documented behaviors, but she pulled the information from the point of care software. She further indicated the surveyors should ask the nurses and CNAs where they additionally document behaviors.</p>			

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	<p>During an interview, on 10/1/15 at 1:57 p.m., LPN #3 indicated Resident #2 yelled primarily during showers and the medications administered were not always helpful. She further indicated she only documented behaviors that were not resolved with interventions or were new. She indicated she wasn't sure what she needed to report and thought the Social Service Director documented most of the behaviors.</p> <p>During an interview, on 10/1/15 at 2:41 p.m., CNA #7 indicated Resident #2 only displayed behaviors of yelling with showers, but not with other care.</p> <p>During an interview, on 10/1/15 at 2:45 p.m., CNA #1 indicated Resident #2 yelled out a lot during showers, but accepted other care. CNA #1 indicated they did not document Resident #2's yelling as a behavior, as it only occurred with showers and the resident was receiving medication for it.</p> <p>During an interview, on 10/1/15 at 3:00 p.m., the Social Service Director (SSD), indicated she did not know why Resident #2 received showers instead of bed baths. She further indicated the resident's episodes of yelling out associated with showers were what was identified as</p>			

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F 0329 SS=D Bldg. 00	<p>Resident #2's behavior.</p> <p>Review of a policy, titled "Psychoactive Medication Management", dated August 2014, provided by the SSD on 9/30/15 at 2:00 p.m., indicated the following: "...it is the responsibility of the IDT [interdisciplinary team] to determine if the emotional or behavioral symptoms may be caused by...reversible environmental and/or psychological stressor...."</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p>			

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	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview, and record review, the facility failed to ensure use of non-pharmacological interventions prior to the use of psychotropic medications (Resident #2).</p> <p>Findings include:</p> <p>Review of Resident #2's clinical record began on 9/25/15 at 1:32 p.m. Diagnoses included, but were not limited to, intellectual disability, dementia with behavioral disturbance, pseudobulbar affect, anxiety, convulsions, and breast cancer.</p> <p>Resident #2 had a current, 9/15/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was severely cognitively impaired and required extensive assistance for ADLs.</p> <p>Resident #2's current medications included, but were not limited to, buspirone (anti-anxiety) 15 mg 3 times daily, Cymbalta (anti-depressant) 60 mg once daily, Nuedexta (mood stabilizer) 20 mg-10 mg every 12 hours, Delsym (cough medication) 30 mg one hour prior</p>	F 0329	<p>Resident #2 Care Plan has been reviewed and updated on 10/21/2015 by DON and Social Services Director. Resident will now be given bed baths instead of showers as her behaviors escalate during showers. Psychiatric Nurse Practitioner to conduct medication review for resident #2 on 10/27/2015. Residents with PRN psychotropic medications have the potential to be affected. These residents behavior documentation will be reviewed by DON and Social Service Director by 11/2/2015 and team will evaluate if Physician should be contacted to conduct a medication review for medication decrease or discontinuation.</p> <p>Nursing staff will be re-educated on 10/27/2015 by Social Service Director, DON and ADON regarding facility policy for behaviors, psychotropic drug use and documentation of non drug interventions and their efficacy prior to administering PRN psychotropics. DON/designee to complete a QA one time weekly for four weeks , then monthly for three months, then quarterly for six months to ensure documentation supports the need for psychotropic drug</p>	11/02/2015

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	<p>to showers, and Phenobarbital 40 mg three times daily.</p> <p>Review of a "Behavior Management Team Review" documents indicated the following:</p> <p>A note dated 1/27/15, indicated the resident had non-sensical vocalizations and was "...disruptive to the environment...". The note further indicated the resident needed time to calm down.</p> <p>A note dated 2/24/15 indicated Resident #2's behaviors were loud, guttural vocalizations both when happy and angry, and worsened particularly during showers.</p> <p>A note dated 3/24/15 indicated Resident #2's behavior continued daily, when happy and when angry, and leaving the resident alone or spending 1:1 time with them decreased the verbalizations.</p> <p>A note dated 6/30/15 indicated Resident #2 did not respond to interventions when angry.</p> <p>A note dated 7/23/15 indicated Resident #2 did not respond to interventions when angry.</p>		administration.	

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	<p>A note dated 8/25/15 indicated Resident #2 disliked showers and did not respond to interventions. The note further indicated the resident had difficulty making their needs and wants known, but disliked showers, and was to be offered a bed bath. The note also indicated Resident #2's plan of care was to continue the following medications: Nuedexta, lorazepam, and add Delsym prior to showers.</p> <p>The "Behavior Management Team Review" notes reviewed indicated there were no behavior reports received from direct care staff.</p> <p>A psychiatric progress note, dated 6/23/15, indicated the resident was doing okay and yelled out occasionally.</p> <p>A gradual dose reduction request from the facility pharmacist on 7/28/15, signed by Review of Resident #2's medication history indicated they had also received lorazepam (anti-anxiety) 1 mg once daily on Monday, Wednesday, and Friday prior to showers, dental procedures, and podiatry appointments from 2/18/15 through 9/15/15. the psychiatric nurse practitioner, indicated Resident #2 continued to have behaviors daily, but was improved with current medications, and Nuedexta would be ordered.</p>			

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	<p>A psychiatric progress note, dated 8/25/15, indicated the resident continued to yell out, especially before showers, and was frightful for others. A new order was written for Delsym 30 mg one hour prior to showers for pseudobulbar affect.</p> <p>Review of Resident #2's medication history indicated they had also received lorazepam (anti-anxiety) 1 mg once daily on Monday, Wednesday, and Friday prior to showers, dental procedures, and podiatry appointments from 2/18/15 through 9/15/15.</p> <p>Review of Medication Administration Records for August and September 2015 indicated Resident #2 received both Delsym and lorazepam prior to their shower on 8/28/15, 8/31/15, 9/2/15, 9/7/15, 9/9/15, 9/11/15, and 9/14/15.</p> <p>During an interview, on 10/1/15 at 1:57 p.m., LPN #3 indicated Resident #2 yelled primarily during showers and the medications administered were not always helpful. LPN #3 indicated Resident #2 generally accepts routine care without problem.</p> <p>During an interview, on 10/1/15 at 2:41 p.m., CNA #7 indicated Resident #2 only displayed behaviors of yelling with</p>			

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F 0332 SS=D Bldg. 00	<p>showers, but not with other care. CNA #7 indicated they were not aware of why Resident #2 received showers instead of bed baths.</p> <p>During an interview, on 10/1/15 at 2:45 p.m., CNA #1 indicated Resident #2 yelled out a lot during showers, but accepted other care. CNA #1 indicated they were not aware of why Resident #2 received showers instead of bed baths. CNA #1 further indicated the medications given prior to showers did not alleviate the resident's yelling.</p> <p>During an interview, on 10/1/15 at 3:00 p.m., the Social Service Director (SSD), indicated she did not know why Resident #2 received showers instead of bed baths. She further indicated the resident's episodes of yelling out would be alleviated by bed baths.</p> <p>3.1-48(a)(6)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to</p>	F 0332	Residents #4 and #22 have received their medications per	11/02/2015

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	<p>administer medications at the time ordered. There were 31 opportunities with 2 errors resulting in a 6.45% medications errors rate. The errors involved 2 residents (Resident #4 and #22) in a sample of 9.</p> <p>Findings include:</p> <p>1. During a medication administration observation on 10/1/15 at 7:28 a.m., LPN #11 verified that she had a total count of 11 pills for Resident #22. LPN #11 administered 11 oral pills to Resident #22. The following medications were administered:</p> <p>Novolog (insulin) Januvia (oral diabetic medicine) lisinopril (anti-hypertensive medicine) Colace (stool softener) Prilosec (to decrease stomach acid) senna (stool softener) glimepiride (oral diabetic medicine) bumetanide (diuretic) carvedilol (anti-hypertensive medicine) isosorbide (to treat chest pain) Ferrex (iron)</p> <p>Review of a current physician's order signed 9/30/15, indicated Resident #22 had an order for Uloric (a medication to treat gout) 40 mg daily at 8:00 a.m. LPN #12 failed to administer Uloric 40 mg on</p>		<p>physician's orders. Nurse that failed to administer Simvastatin to resident #4 has been counseled regarding the five rights of medication administration. The nurse that failed to administer Uloric to resident #22 is no longer an employee of the facility Residents whose medications are administered per the nurses have the potential to be affected by the deficient practice. DON/designee to conduct cart audit to ensure all ordered medications are available to administer to residents by 11/2/2015 Nurses will be re-educated on the five rights of medication administration and proper reordering procedures on 10/27/15. Med pass observation QA will be completed by DON/designee twice weekly on different nurses for four weeks. QA will then be done by DON/designee monthly for three months with results forwarded to QA committee and pharmacist to assist thereafter with random med pass audits.</p>		

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	<p>10/1/15.</p> <p>2. During medication administration observation on 10/1/15 at 3:03 p.m., LPN #12 indicated she was unable to find simvastatin (a medication used to lower high cholesterol) 10 mg for Resident #4. She indicated she would check to see if any additional medication was in the overflow area.</p> <p>LPN #12 was observed on the telephone at 3:13 p.m. at the nurses station.</p> <p>During an interview on 10/1/15 at 3:14 p.m., LPN #12 indicated she notified the physician the medication was unavailable and the medication was held per physician order. She indicated someone did not reorder the medication and it was not available to give to the resident.</p> <p>Review of a current physician's order signed 9/29/15, indicated Resident #4 had an order for simvastatin 10 mg daily in the evening.</p> <p>During an interview on 10/2/15 at 12:30 p.m., the Director of Nursing (DON) indicated she educated staff on documentation related to medication availability. She indicated LPN #12 should not have charted the medication</p>			

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	<p>was on hold, but the medication was not available.</p> <p>Review of a current facility policy dated 12/01/07 and revised 01/01/13, titled "General Dose Preparation and Medication Administration", which was provided by the Corporate Nurse on 10/2/15 at 2:00 p.m., indicated the following:</p> <p>"Applicability:</p> <p>This policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to Facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications.</p> <p>Procedure:</p> <p>1. Facility staff should comply with Facility policy...</p> <p>...4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limiting to the following:</p> <p>4.1 Facility staff should:</p> <p>4.1.1 Verify each time a medication is administered that is the correct</p>			

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F 0371 SS=F Bldg. 00	<p>medication, at the correct does, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth...."</p> <p>3.1-48(c)(1)</p> <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 Based on observation, interview, and record review, the facility failed to ensure food was stored under sanitary conditions and dishes were cleaned in a sanitary manner. These practices had the potential to affect 51 of 51 residents receiving meals from the facility kitchen.</p> <p>Findings include:</p> <p>The initial tour of the facility kitchen began on 9/24/15 at 8:50 a.m. The following concerns were observed:</p> <p>1. A 10 pound tube of ground meat was observed sitting on top of a large cardboard box containing bacon on a</p>	F 0371	<p>Staff will be re-educated on proper food storage by the Dietary Manager or designee by November 2, 2015 Ceramic cup has been removed Thermometer is now kept by steam table in sheath Staff will be re-educated on Dishwasher temps by Dietary Manager or designee. Staff will know to record temps before they start to wash dishes and know corrective action to be taken if temps are not within acceptable range All residents have the potential to be affected by deficient practice Refrigerator audits will be done daily by the Dietary Manager or designee for two weeks to ensure appropriate food storage is</p>	11/02/2015			

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	<p>shelf in the walk-in refrigerator. A large amount of red fluid was pooled on top of the box, running down the front of the box, and pooling onto the floor of the refrigerator, in front of the entrance to the walk-in freezer. Dietary Aide #1 indicated the meat had been set out to thaw for the evening meal. There was no tray beneath the tube of meat.</p> <p>2. A small, ceramic cup sat on the left side of the steam table, containing a pen, marker, and food thermometer. The cup was soiled on the outside with a greasy film. The inside of the cup contained blackened debris, which had collected in the bottom of the cup.</p> <p>3. Dietary Aide #2 was observed running a tray of dishes through the dishwasher. The rinse temperature of the dishwasher reached 164 degrees Fahrenheit. When the surveyor asked Dietary Aide #2 to confirm the temperature reading, they ran the dishwasher again, with the rinse temperature reaching 176 degrees Fahrenheit. Dietary Aide #2 pushed the tray of dishes to the side and placed another tray of dishes into the dishwasher. The rinse temperature reached 160 degrees Fahrenheit and 178 degrees Fahrenheit on a subsequent tray of dishes.</p>		<p>occurring After two weeks will move to weekly audits done by Dietary Manager Audits will be shared with QA committee for review Weekly audits will continue monthly per company policy</p> <p>Pen basket to be put on weekly cleaning schedule to be put through the dishwasher by staff washing dishes</p> <p>Dishwasher temps will be recorded before starting to wash dishes by staff washing dishes Dietary Manager to randomly visually audit staff doing proper temp recording at least two times per week for three weeks then one time per week for three weeks All audits will be shared with QA committee to determine if further attention needed</p> <p>All audit sheets will be given to the QA committee monthly for review for 3 months, then quarterly for six months at which time QA committee will determine if further action required</p>	

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	<p>Dietary Aide #2 indicated they thought the rinse temperature only needed to reach 160, but they were not sure, and they ran the dishwasher twice to start with to heat up the rinse water.</p> <p>Dietary Aide #1 indicated the rinse water needed to reach 180 and had to be run "a few times" to get it to the correct temperature.</p> <p>During an interview, on 9/24/15 at 9:44 a.m., the interim Dietary Manager and Registered Dietician indicated the dishwasher had been run 8 times and was now reaching 180 degrees Fahrenheit. They further indicated the dishwasher needed to be serviced.</p> <p>Review of a policy, titled " Dish Machine Temperatures", dated February 2009, provided by the acting Certified Dietary Manager on 10/5/15 at 10:06 a.m., indicated the following: "...To ensure proper sanitization of dishes, glassware, and flatware...High Temperature...rinse temperatures no less than 180 degrees F...."</p> <p>The 3-compartment sink basins labeled "rinse" and "sanitize" were observed with a sticky area to the back of the basin, each the size of a ruler. The sticky area to the "rinse" basin was grey in color,</p>			

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F 0431 SS=D Bldg. 00	<p>with small pieces of debris stuck in it. The sticky area to the back of the "sanitize" basin was light red in color, with small pieces of debris stuck in it.</p> <p>The interim Dietary Manager indicated the red color was from the chemical used to sanitize dishes in that compartment and stickers had been recently removed from the basins.</p> <p>3.1-21(i)(3)</p> <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</p>			

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	<p>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 properly ensure medication carts were free of loose pills for 3 of 3 carts observed during medication storage (Hall's 100, 200 and 300). The facility also failed to ensure topical powders were properly labeled in a treatment cart for 1 of 3 treatment carts observed (Hall 300).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During inspection on 10/2/15 at 10:52 a.m., of the 300 Hall medication cart, 1 unidentified pill was found in medication cart. The pill was loose inside the cart.</li> <li>2. During inspection on 10/2/15 at 11:01 a.m., the 300 Hall treatment cart was found to have 3 bottles of Nystop (topical powder anti-fungal anti-biotic), opened with no open date listed on the package.</li> </ol>	F 0431	<p>Loose pills removed from the medication carts 10/2/2015 by Director of Nursing. Treatments without opened dates on them were removed from cart by Director of Nursing/ADON 10/2/2015. Residents have the potential to be affected due to medications and treatments being in the medication and treatment carts. All carts immediately audited to ensure proper drug storage. Nurses will be educated on 10/27/2015 by DON/ADON on drug storage, disposal and labeling requirements. DON/designee to complete Cart audit weekly for one month to ensure loose pills are not in the medication carts and treatments are labeled correctly. Carts will be audited by pharmacy extender monthly to ensure proper drug and treatment storage. Results of QA Cart Audits will be forwarded to the QA committee for review and/or recommendations</p>	11/02/2015

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	<p>3. During inspection on 10/2/15 at 11:04 a.m., the 100 Hall medication cart, 3 unidentified pills were found in the cart. The pills were loose inside the cart.</p> <p>4. During inspection on 10/2/15 at 11:07 a.m., the 200 Hall medication cart was found to have 1 unidentified pill, 2 Lasix (diuretic) pills and 1 Colace (stool softener) pill.</p> <p>During an interview on 10/2/15 at 11:07 a.m., LPN #10 indicated the loose pills should be flushed down the toilet. She indicated the facility did not have a "drug buster" and staff were to flush the pills.</p> <p>Review of a current facility policy dated 12/1/08 and revised 01/01/13, titled "Storage and Expiration of Medication, Biologicals, Syringes and Needles", which was provided by the Corporate Nurse on 10/2/15 at 2:00 p.m., indicated the following:</p> <p>"Applicability: This policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles.</p> <p>Procedure: 1. Facility should ensure that only</p>			

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	<p>authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law.</p> <p>...6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limiting to the following:</p> <p>6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injections site...</p> <p>6.2 Dispose of unused medication portions in accordance...</p> <p>17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regular scheduled basis."</p> <p>3.1-25(k) 3.1-25(o)</p>			

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F 0514 SS=C Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure accurate documentation for urinary output and blood pressure monitoring in the residents clinical record for 1 of 1 residents reviewed for urinary catheter use and 1 of 5 residents for unnecessary medications. (Resident's #18 and #19)</p> <p>Findings include:</p> <p>1. Review of Resident #18's clinical record began on 9/25/15 at 1:01 p.m. Diagnoses included, but were not limited to, depression, constipation, urinary retention, and anxiety.</p> <p>Resident #18 had a current physician's order, dated 8/6/15, for a Foley catheter</p>	F 0514	<p>Resident #18 does have an indwelling foley catheter. The physician ordered to discontinue urinary output 10/6/15. Company policy does not support the need for urinary output for catheters as a general practice. Resident #19 has an order to monitor Blood Pressure and Pulse with hold parameters. Nurse that administered medication with vitals is no longer an employee at the facility.</p> <p>Residents with Blood Pressure meds with hold parameters have the potential to be affected Residents orders will be audited by DON/designee by 11/2/2015 and orders will be adjusted to mandate the nurses to enter vital signs before they can proceed with their med pass. Nurses will be re-educated</p>	11/02/2015

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	<p>for the diagnosis of urinary retention and to monitor urinary output every shift.</p> <p>Review of a "Medication Administration Record" dated August 2015, indicated no urinary output was documented on the following dates: 8/6/15 -8/13/15, 8/17/15 day shift, 8/18/15 evening shift, and 8/31/15 evening shift.</p> <p>2. Review of Resident #19's clinical record began on 9/25/15 at 1:25 p.m. Diagnoses included, but were not limited to, dementia, psychosis, congestive heart failure, hypertension, and cerebrovascular disease.</p> <p>Resident #19 had a current physician's order for carvedilol (blood pressure) 12.5 mg twice daily, hold for systolic blood pressure less than 100 or pulse less than 50.</p> <p>Review of a "Medication Administration Record" dated August 2015, indicated LPN #8 had given the medication with no blood pressure or pulse reading for 12 of 62 administrations.</p> <p>Review of a "Medication Administration Record" dated September 2015, indicated LPN #8 had given the medication with no blood pressure or pulse reading for 5 of 60 administrations.</p>		<p>on hold parameters of medication and proper documentation with vital signs by DON/ADON on 10/27/2015</p> <p>QA will be completed weekly for four weeks, monthly for three months, then quarterly for six months. All results will be forwarded to QA committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155444	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2015
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F 9999  Bldg. 00	<p>Resident #19 had a current physician's order for benazapril (blood pressure) 40 mg once daily, hold for systolic blood pressure less than 100 or pulse less than 50.</p> <p>Review of a "Medication Administration Record" dated August 2015, indicated LPN #8 had given the medication with no blood pressure or pulse reading for 6 of 31 administrations.</p> <p>Review of a "Medication Administration Record" dated September 2015, indicated LPN #8 had given the medication with no blood pressure or pulse reading for 5 of 30 administrations.</p> <p>During an interview, on 10/1/15 at 1:57 p.m., LPN #8 indicated she was aware of the physician's orders but she didn't always have time to document the vitals in the clinical record.</p> <p>3.1-50(a)(2)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be</p>	F 9999	DON has had her physical, first and second step TBs Employee #2 we started over with a first and 2nd step TB. Employee #3 has	11/02/2015

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	<p>required for each employee of the facility within one (1) month prior to employment. The examination shall included a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. This result 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>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure tuberculin skin tests were completed for 3 of 10 employee records reviewed for tuberculin skin tests and pre-employment physicals were completed for 1 of 5 employee records reviewed for physicals. (Director of Nursing, Employee #2 and Employee #3)</p> <p>Findings include:</p>		<p>had her first and 2nd step TB All residents could be affected by deficient practice New Hire Orientation and Checklist form will be completed by Human Resources Supervisor for all new employees prior to new hire being allowed to start work All items must be completed and E.D. has signed form 2nd step TBs will be tracked by ADON/designee All new hire personnel files will be audited by E.D. monthly for three months, quarterly for six months and audit outcomes shared at QA meetings and determination if continued audit then necessary</p>		

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	<p>Review of Employee records began on 7/28/15 at 9:30 a.m. The following noncompliance was found:</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing (DON) employment record did not indicate completion of a pre-employment physical nor a tuberculin test.</li> <li>2. Employee #2's employment record did not indicate completion of a second step tuberculin test.</li> <li>3. Employee #3's employment record did not indicate completion of a first or second step tuberculin test.</li> </ol> <p>Review of a policy titled, "New Hire &amp; Orientation Checklist (Facilities)", dated 2/10/15, and received from the Interim Administrator, on 10/5/15 at 10:22 a.m., indicated the following:</p> <p>"This checklist is designed to ensure that you and a company representative have discussed the terms and conditions of employment listed below. Please sign at the bottom once your orientation has been completed. This original checklist will be retained in your personnel file.</p> <p>...17. I have provided a current TB Skin Test or chest x-ray (if applicable).</p>			

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	<p>...19. I have provided a current Physical Examination (if applicable)."</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 9/28/15 at 3:12 p.m., she indicated employee #2 had her first step tuberculin test done, but she could not find any information related to the second step being completed. She also indicated she could find no information related to employee #3 as having either the first or second step tuberculin test. She indicated the employee has since been terminated to an unrelated issue.</p> <p>During an interview on 9/29/15 at 12:03 p.m., the Nurse Consultant indicated the corporation could not find either the physical or tuberculin test for the DON.</p>			