

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2012
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NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 1, 2, 3, 4, and 5, 2012</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Survey team: Betty Retherford, RN, TC Karen Lewis, RN Ginger McNamee, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 2 Medicaid: 50 Other: 1 Total: 53</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 10, 2012 by Bev Faulkner, RN</p>	F0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal laws. Please accept this plan of correction as our credible allegation of compliance.</p>	

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

TITLE

(X6) DATE

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

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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure bowel monitoring was completed for 3 of 10 residents (Resident #'s 22, 15, and 39) reviewed for bowel monitoring and administration of physician ordered interventions for constipation and failed to ensure monitoring was completed following a change in condition for 1 of 3 residents reviewed with a decline in condition. (Resident #52)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #22 was reviewed on 10/2/12 at 4:00 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, non insulin dependent diabetes mellitus, Alzheimer's dementia, history of bladder tumor, chronic kidney disease, and chronic constipation.</p> <p>An annual Minimum Data Set (MDS)</p>	F0309	<p>F 309A1. Corrective Action for Residents Affected: A bowel assessment was completed for Residents #22, #15, and # 39 and the physician was contacted. Resident # 52 was a closed record.2. Other Residents Having the Potential to Be Affected and Corrective Action Taken: All residents' bowel records were reviewed. Any areas of concern were addressed. Records were reviewed for residents with change of condition, for proper follow up documentation and assessment. Any areas of concern were addressed.3. Measures to ensure that this practice does not recur: The Bowel Movement/Assessment procedure was reviewed and updated. (Attachment A). The Bowel Monitoring record was reviewed and updated. (Attachment B) The new record will be put into place after nursing staff re-education. An in-service for nursing department was conducted on 10/19/12 regarding the updated policy and</p>	10/19/2012			

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	<p>assessment, dated 7/31/12, indicated Resident #22 was severely cognitively impaired, incontinent of bowel, and required extensive assistance of the staff for transfers and toileting.</p> <p>A health care plan problem, dated 7/5/12, indicated the resident suffered from chronic constipation due to decreased activity and medications use. Approaches for this problem included, but were not limited to, "monitor bowel movements, administer medications as ordered, and advise charge nurse if the resident does not have a bowel movement every three days for further evaluation and possible PRN (as needed) medication administration and physician and responsible party notification."</p> <p>Physician's orders, dated 8/15/12, indicated the resident had the following bowel related orders:</p> <p>Bisacodyl (a laxative medication) 5 milligrams (mg) 1 tablet every morning for constipation. Miralax powder (a laxative medication) 17 grams (gm) in 8 ounces of water daily for constipation. Colace (a stool softener) 100 mg twice daily for constipation. Lactulose (a laxative medication)</p>		<p>new bowel monitoring record, as well as the proper documentation and assessment of residents with any change of condition (Attachment E). The DON or designee will audit all bowel records using (Attachment C) BM Record Audit and physicians' orders using (Attachment D) Physician Order Monitoring and nurses notes at least 5 X weekly to determine compliance.4. This Corrective Action Will Be Monitored By: The results of these audits will be brought to the QA committee meetings and reviewed monthly for 3 months and then quarterly.5. Date Corrected: 10/19/2012</p>		

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	<p>solution 15 milliliters/10 grams twice daily for constipation. Milk of Magnesia 30 milliliters once daily as needed for constipation. Mineral Oil enema 133 milliliters rectally daily as directed as needed for constipation.</p> <p>The original date of all of the above orders were prior to 8/13/12.</p> <p>The August 2012 bowel monitoring records for Resident #22 indicated the resident did not have a bowel movement on August 13, 14, 15, and 16, 2012. (A time period of 4 days.) Zeros were present in the documentation area for all three shifts on those dates. The clinical record lacked any documentation of PRN (as needed) medications having been given to treat constipation. The nursing notes lacked any resident assessments related to the lack of bowel movements.</p> <p>The resident was readmitted to the facility from the hospital on 9/9/12 following treatment of fall and femur fracture.</p> <p>The orders for Lactulose and Dulcolax (Bisacodyl) 5 mg tablet were changed upon readmission to a PRN (as needed) basis for constipation.</p>				

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	<p>An additional order was received upon readmission for a Bisacodyl suppository (a stimulant laxative) to be given rectally every other day as needed for constipation.</p> <p>The September 2012 bowel monitoring records for Resident #22 indicated the resident did not have a bowel movement on 9/21, 22, 23, and 24/12. (A time period of 4 days.) Zeros were present in the documentation area for all three shifts on those dates.</p> <p>The September and October 2012 bowel monitoring records for Resident #22 indicated the resident did not have a bowel movement on 9/27, 28, 29, 30, 10/1, 2, and 3/12. (A time period of 7 days.) Zeros were present in the documentation area for all three shifts on those dates.</p> <p>The clinical record lacked any documentation of PRN medications having been given to treat constipation for the September and October time periods noted above. The nursing notes for these time periods lacked any resident assessments related to the lack of bowel movements.</p> <p>During an interview with the Director</p>				

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	<p>of Nursing (DoN) and RN Consultant #1 on 10/3/12 at 11:10 a.m., additional information was requested related to the lack of bowel movements and/or nursing assessments having been completed for the above noted time periods.</p> <p>During an interview with 10/5/12 at 9:25 a.m., the DoN indicated she had no additional information to provide related to bowel monitoring for Resident #22.</p> <p>2.) The clinical record for Resident #15 was reviewed on 10/3/12 at 10:20 a.m.</p> <p>Diagnoses for Resident #15 included, but were not limited to, Alzheimer's disease, dementia, and bipolar disorder.</p> <p>A quarterly MDS, dated 6/27/12, indicated the resident needed the assistance of the staff for transfers and toileting.</p> <p>The signed September 2012 recapitulation of physician's orders for Resident #15 included the following bowel related orders:</p> <p>Milk of Magnesia 30 milliliters as</p>			

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	<p>needed for constipation.</p> <p>Fleet enema (a stimulant enema) one rectally daily as needed for constipation.</p> <p>Dulcolax suppository (a stimulant suppository) 10 mg 1 rectally as needed for constipation.</p> <p>The original date of the three orders above was 12/21/11.</p> <p>The August 2012 bowel monitoring records for Resident #15 indicated the resident did not have a bowel movement on August 21,22, 23, and 24, 2012. (A time period of 4 days.) Zeros were present in the documentation area for all three shifts on those dates. The clinical record lacked any documentation of PRN medications having been given to treat constipation. The nursing notes lacked any resident assessments related to the lack of bowel movements.</p> <p>The September and October 2012 bowel monitoring records for Resident #15 indicated the resident did not have a bowel movement on September 28, 29, 30, and 10/1/12. (A time period of 4 days.) Zeros were present in the documentation area for all three shifts on those dates. The clinical record lacked any</p>			

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	<p>documentation of PRN medications having been given to treat constipation. The nursing notes lacked any resident assessments related to the lack of bowel movements.</p> <p>During an interview with the Director of Nursing (DoN) and RN Consultant #1 on 10/3/12 at 11:10 a.m., additional information was requested related to the lack of bowel movements and/or nursing assessments having been completed for the above noted time periods.</p> <p>During an interview with 10/5/12 at 9:25 a.m., the DoN indicated she had no additional information to provide related to bowel monitoring for Resident #15.</p> <p>3.) The clinical record for Resident #39 was reviewed on 10/3/12 at 1:36 p.m.</p> <p>Diagnoses for Resident #39 included, but were not limited to, Huntington's disease, delusions, anxiety, and chronic back pain.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 8/9/12, indicated Resident #39 was severely cognitively impaired and required assistance of the staff for toileting and transfers.</p>			

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	<p>A health care plan problem, dated 8/10/12, indicated Resident #39 had a potential for constipation related to medication regimen, decreased mobility, and Huntington's disease. One of the goals for this problem indicated the resident would have a soft formed bowel movement at least every three days. One of the approaches for this problem was "If no BM (bowel movement) for three days, complete further evaluation and administer medications as ordered."</p> <p>A recapitulation of physician's orders, dated 8/1/12, indicated Resident #39 had the following bowel related orders:</p> <p>Docusate (a stool softener) 100 milligrams (mg), one capsule by mouth once daily. The original date of this order was 8/5/08.</p> <p>Bisacodyl (laxative) 10 mg suppository, insert 1 suppository rectally daily as needed for constipation. The original date of this order was 2/18/09.</p> <p>Enema (laxative), 1 rectally every day as needed for constipation. The original date of this order was 6/9/09.</p>			

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	<p>Milk of Magnesia (laxative) 30 milliliters (ml) daily at bedtime as needed for constipation. The original date of this order was 11/8/08.</p> <p>The bowel movement records for July, August, September and October 2012 indicated the resident did not have a bowel movement for the following time periods:</p> <p>July 12-17, 2012- all zeros recorded. A time period of 5 days without a recorded bowel movement.</p> <p>July 30-August 4, 2012- all zeros recorded. A time period of 6 days without a recorded bowel movement.</p> <p>August 28- October 2, 2012- all zeros recorded. A time period of 5 days without a recorded bowel movement.</p> <p>The nursing notes and medication administration records (MAR) lacked any information related to any suppository, enema, or Milk of Magnesia having been given during these time periods.</p> <p>During an interview with the Director of Nursing (DoN) and the Administrator on 10/5/12 at 9:55 a.m., additional information was requested related to the lack of bowel monitoring</p>						

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	<p>and administration of physician ordered interventions having been completed for the time periods noted above.</p> <p>The facility failed to provide any additional information related to the lack of bowel monitoring noted above as of exit on 10/5/12.</p> <p>4.) The undated "Bowel Movement/Assessment Procedure" was provided by RN Consultant #1 on 10/5/12 at 8:35 a.m. The policy indicated the following:</p> <ol style="list-style-type: none"> 1. The nursing assistants will record the resident bowel movements on the Bowel Tracking Record. This will include the size and consistency of the BM [bowel movement.] 2. The day shift will review the record to identify any residents who have not had a bowel movement in 3 days (9 shifts) who may require intervention. This information will be recorded on the 24 hr [hour] report sheet. 3. If a resident is identified on the report the nurse will review the residents records and interview with the resident, if appropriate, to validate the resident has not had a BM and their current comfort/discomfort status. 			

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	<p>4. The nurse will administer the prescribed PRN [as needed] medication if indicated.</p> <p>5. follow up documentation will be completed to determine the effectiveness of the medication.</p> <p>6. The resident will remain on the 24 hr report until resolved.</p> <p>7. The MD [medical doctor] will be notified if indicated.</p> <p>5.) The clinical record for Resident #52 was reviewed on 10/2/12 at 3:39 p.m.</p> <p>Diagnoses for Resident #52 included, but were not limited to, dementia, congestive heart failure, and diabetes.</p> <p>A nurses note, dated 8/24/12 at 6:30 a.m., indicated the resident had a change of condition. The resident was noted to have crackles (abnormal breath sounds) in the lungs and a mild fever. The Nurse Practitioner was notified and a new order for a chest x-ray was obtained and completed. On 8/25/12 at 5:30 a.m., the Nurse Practitioner was informed</p>				

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	<p>of the chest x-ray results, which showed mild pulmonary vascular congestion in both lower lung fields. A new order for Lasix (a diuretic) 20 milligrams daily and blood tests in 1 week were ordered by the Nurse Practitioner.</p> <p>The clinical record lacked any other nursing notes dated 8/25/12 and 8/26/12. The clinical record lacked any information related to monitoring of the resident's condition, lung sounds, and vital signs for those dates. The next nursing note was dated 8/27/12 at 4:55 a.m.</p> <p>During an interview with the RN Consultant #1 on 10/3/12 at 10:54 a.m., additional information was requested related to the nursing assessments for Resident #52 for the above time frame.</p> <p>The facility failed to provide any additional information related to the lack of nursing assessments noted above as of exit on 10/5/12. The revised 1/08, "Nursing Department Charting Policy and Procedure" was provided by RN Consultant #1 on 10/5/12 at 8:35 a.m., and indicated the following:</p> <p>"Purpose: To accurately document in an organized manner all pertinent</p>				

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	<p>information related to the resident in the nurses' notes and other designated sections of the clinical record.</p> <p>Pertinent Charting (PRN:) [as needed] Includes but is not limited to the following:...</p> <p>Any condition change. Refer to shift change report sheet for follow-up to changes....Always chart occurrences and incidents when they happen, giving a snapshot to enhance the portrait of the resident..."</p> <p>3.1-37(a)</p>				

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, sanitary and comfortable environment in regards to resident bathrooms, walls, and doors for 20 of 53 residents residing in the facility.</p> <p>Findings include:</p> <p>During the environmental tour conducted with the Administrator and Maintenance/Housekeeping Supervisor on 10/4/12 at 3:20 p.m., the following was noted:</p> <p>Room 101- The floor tiles around the toilet were stained and the inside of the toilet bowl was stained. (Private bathroom for 1 resident.)</p> <p>Room 102- The wall by the footboard of Bed 1 was scraped and missing paint. (Room shared by 2 residents.)</p> <p>Room 104- The wall by the window was scraped and missing paint. (Room shared by 2 residents.)</p> <p>Room 106- The floor tiles around the bottom of the toilet in the bathroom</p>	F0465	<p>F465 1. Corrective Action for Residents Affected: No residents were affected by this alleged negative practice. Room 101 the floor in the bathroom was stripped and waxed removing stains. The toilet bowl was cleaned removing stains. Room 102 the wall by the bed was repaired and painted. Room 104 the wall by the window was repaired and painted. Room 106 the floor in the bathroom was stripped and waxed removing stains. The caulk around stool was repaired. The area under soap dispenser was cleaned and a drip tray was placed under the soap dispenser. Room 202 the wooden entrance door was sanded and stained. Room 203 the wooden entrance door was sanded and stained. The bathroom wall across from the stool was repaired and painted. Room 209 the dark scuffs and holes in the wall were repaired and painted. The wooden entry door was sanded and stained. Room 210 the door frame was repainted. The string to the bathroom call light was replaced. Room 213 the patched area of drywall was repaired and painted. The wood entry door was sanded and stained. The bathroom floor</p>	10/19/2012	

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	<p>were stained and the caulking was pulling away from the stool . The floor tiles in the corner of the bathroom underneath the soap dispenser were stained and discolored. (Bathroom shared by 2 residents.)</p> <p>Room 202- The wooden entrance door of the room was nicked and missing pieces on both sides of the lower edges. (Room shared by 2 residents.)</p> <p>Room 203- The wooden entrance door of the room was nicked and missing pieces on both sides of the lower edges. (Room shared by 2 residents.) The bathroom shared by Rooms 202 and 203 had dark scuff marks on the wall across from the toilet. (Bathroom shared by 4 residents.)</p> <p>Room 209- There were dark scuff marks on the wall to the left as one entered the room. There were four small holes in this wall. The lower portion of the wood on the outer edges of the entry door was nicked and there were missing portions of the wood. (Only one resident room.)</p> <p>Room 210- There was gouged paint on the bathroom door frame. The</p>		<p>was stripped and waxed removing the stains. The call light string in the bathroom was replaced. 2. Other Residents Having the Potential to Be Affected and Corrective Action Taken: No other residents were affected by this alleged negative practice. Room 101 the floor in the bathroom was stripped and waxed removing stains. The toilet bowl was cleaned removing stains. Room 102 the wall by the bed was repaired and painted. Room 104 the wall by the window was repaired and painted. Room 106 the floor in the bathroom was stripped and waxed removing stains. The caulk around stool was repaired. The area under soap dispenser was cleaned and a drip tray was placed under the soap dispenser. Room 202 the wooden entrance door was sanded and stained. Room 203 the wooden entrance door was sanded and stained. The bathroom wall across from the stool was repaired and painted. Room 209 the dark scuffs and holes in the wall were repaired and painted. The wooden entry door was sanded and stained. Room 210 the door frame was repainted. The string to the bathroom call light was replaced. Room 213 the patched area of drywall was repaired and painted. The wood entry door was sanded and stained. The bathroom floor was stripped and waxed removing the stains. The call light</p>		

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	<p>string on the call light by the toilet was soiled and discolored. (Shared bathroom with Room 211 and used by 4 residents.)</p> <p>Room 213- There was a patched area of drywall by the sink that had not been painted. The wood door entering the room was nicked on the inner and outer frame with missing wood. (Room shared by two residents.) There were stained floor tiles around the bathroom shared with Room 212. The string of the call light by the toilet was stained and discolored. (Bathroom used by 4 residents.)</p> <p>The Administrator made a list of the concerns noted above during the tour and indicated the environmental issues would be addressed.</p> <p>3.1-19(f)</p>		<p>string in the bathroom was replaced. 3. Measures to ensure that this practice does not recur: The new maintenance Director was re-educated on the Preventative Maintenance monthly rounds form Attachment #1,2,3,&4. Maintenance Director/Designee will monitor all areas and document on said form monthly. Monthly Preventative Maintenance record will be forwarded to the QA committee monthly. Any negative findings will be forwarded to the Administrator immediately and will result in re-education and/or disciplinary action 4. This Corrective Action Will Be Monitored By: Maintenance Director/Designee will monitor all areas and document on Preventative Maintenance monthly rounds form monthly. Monthly Preventative Maintenance record will be forwarded to the QA committee monthly. Any negative findings will be forwarded to the Administrator immediately and will result in re-education and/or disciplinary action. This monitoring will be ongoing. 5. Date Corrected: 10/19/2012</p>		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 1 of 3 hospice (Resident #22) residents reviewed for bowel monitoring and for 1 of 1 residents reviewed who called emergency services and left the building per ambulance. (Resident #60)</p> <p>1.) The clinical record for Resident #22 was reviewed on 10/2/12 at 4:00 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, non insulin dependent diabetes mellitus, Alzheimer's dementia, history of bladder tumor, chronic kidney disease, and chronic constipation.</p>	F0514	<p>F514 1. Corrective Action for Residents Affected: A bowel assessment was completed for resident #22 and the physician was notified. Hospice re-education was completed for documentation of bowel movements on facility bowel record. Resident # 60 record was reviewed. It was noted that nursing documented residents call to 911, and trip to the Emergency Room were documented on a behavior memo.2. Other Residents Having the Potential to Be Affected and Corrective Action Taken: All residents' bowel records were reviewed. Any areas of concern were addressed. All residents with like behaviors, records were reviewed with no concerns noted.3. Measures to ensure that this practice does not recur: The Bowel</p>	10/19/2012	

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	<p>The clinical record indicated Resident #22 was admitted to hospice services on 9/16/12 following a decline in condition.</p> <p>Hospice Aide notes indicated the Hospice Aide visited the resident twice weekly. The clinical record contained hospice aide "Patient Care Notes" for 9/21, 9/25, 9/28, 10/1, and 10/4/12.</p> <p>The 9/25/12 Hospice Care Note indicated Resident #22's last bowel movement was on 9/24/12. The resident clinical record lacked any record of the resident having a bowel movement on 9/24/12.</p> <p>The 9/28/12 Hospice Care Note indicated Resident #22's last bowel movement was on 9/27/12. The resident clinical record lacked any record of the resident having a bowel movement on 9/27/12.</p> <p>The 10/1/12 Hospice Care Note indicated Resident #22's last bowel movement was on 9/29/12. The resident clinical record lacked any record of the resident having a bowel movement on 9/29/12.</p> <p>During an interview with RN</p>		<p>Movement/Assessment procedure was reviewed and updated. (Attachment A). The Bowel Monitoring record was reviewed and updated. (Attachment B) The new record will be put into place after nursing staff re-education. An in-service for nursing department was conducted on 10/19/12 regarding the updated policy and new bowel monitoring record, as well as the proper documentation and assessment of residents with any change of condition as well as proper documentation for a resident leaving facility(Attachment E).The DON or designee will audit all bowel records using (Attachment C) BM Record Audit and physicians' orders using (Attachment D) Physician Order Monitoring and nurses notes at least 5 X weekly to determine compliance. 4. This Corrective Action Will Be Monitored By: The results of these audits will be brought to the QA committed meetings and reviewed monthly for 3 months and then quarterly. 5. Date Corrected: 10/19/2012</p>		

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	<p>Consultant #1 on 10/3/12 at 1:55 p.m., additional information was requested related to the bowel movements documented on hospice aide visits for dates the hospice aide was not in the building and which were not recorded on the resident's bowel monitoring records.</p> <p>During an interview with 10/5/12 at 9:25 a.m., the DoN indicated she had no additional information to provide related to hospice aide notes and bowel monitoring for Resident #22.</p> <p>The undated "Bowel Movement/Assessment Procedure" was provided by RN Consultant #1 on 10/5/12 at 8:35 a.m. The policy indicated the following:</p> <ol style="list-style-type: none"> 1. The nursing assistants will record the resident bowel movements on the Bowel Tracking Record. This will include the size and consistency of the BM [bowel movement.] 2.) The clinical record for Resident #60 was reviewed on 10/4/12 at 10:07 a.m. <p>Diagnoses for Resident #60 included, but were not limited to, bipolar disorder, anxiety, mental retardation, and hypertension.</p>						

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	<p>During an interview 10/2/12 at 9:15 a.m., Resident #60 indicated she had recently had a problem with her right foot and had called 911 from her room and was taken to the local hospital. She was uncertain of the date, but had returned to the facility on the same day.</p> <p>A social service note, dated 8/30/12, indicated the resident had called 911 and went to the hospital on the previous day. [This was an error, the date the resident went to the hospital was later determined to have been on 8/28/12.]</p> <p>A nursing note, dated 8/27/12 at 10:00 a.m., indicated the resident had been seen by the dentist on that date. The next entry was dated 9/2/12 at 1:00 a.m. and did not pertain to any emergency room visit.</p> <p>The nursing notes for Resident #60 lacked any information related to the resident having called 911 and being taken to the hospital on 8/28/12. The nursing notes lacked any information related to the resident returning to the facility following the emergency room treatment with orders for Ultram (a pain medication) to be given every four hours as needed for pain. The Ultram order, dated 8/28/12, was on a</p>						

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	<p>prescription slip and was present in the physician order section of the clinical record.</p> <p>During an interview with the RN Consultant #1 on 10/4/12 at 3:30 p.m., additional information was requested related to documentation of the resident leaving the facility on 8/28/12 on a 911 basis.</p> <p>During an interview with the Assistant Director of Nursing on 10/4/12 at 3:44 p.m., she indicated the nurses should document when a resident is out of the facility.</p> <p>The facility failed to provide any other information related to the lack of documentation for the resident as of exit on 10/5/12.</p> <p>The revised 1/08, "Nursing Department Charting Policy and Procedure" was provided by RN Consultant #1 on 10/5/12 at 8:35 a.m., and indicated the following:</p> <p>"Purpose: To accurately document in an organized manner all pertinent information related to the resident in the nurses' notes and other designated sections of the clinical record.</p>						

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	<p>Pertinent Charting (PRN:) [as needed] Includes but is not limited to the following:...</p> <p>Any incident or accident occurrence or follow-up of occurrence (each shift X [times] 24 hours IF NO INJURY or each shift X 72 hours WITH INJURY.....Shift</p> <p>Charting: Charting each shift will be completed on all residents experiencing a condition change until stable....Always chart occurrences and incidents when they happen, giving a snapshot to enhance the portrait of the resident...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			