

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00121136.</p> <p>Complaint IN00121136 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: 6/10, 6/11, 6/12, 6/13, 6/14, 6/17, 6/18, 6/19, 2013</p> <p>Facility number: 000100 Provider number: 155191 AIM number: 100266130</p> <p>Survey team: Gwen Pumphrey RN, TC Gloria Reisert, MSW Debbie Peyton, RN Nicole Wright, RN Joan Laux, RN (6/12, 6/13, 6/14, 6/17, 6/18, 6/19/2013)</p> <p>Census bed type: SNF/NF: 82 Residential: 73 Total: 155</p> <p>Census payor type: Medicare: 14 Medicaid: 59 Other: 82</p>	F000000	<p>Dear Ms. Rhodes, Please find the Form CMS-2567 with the plan of correction for the deficiencies sited during our recertification and Indiana State Licensure survey conducted at Westminster Healthcare Center on June 10th through June 17th 2013. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker, Administrator Westminster Healthcare Center preparation and execution of this plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Healthcare Center ("Facility") is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Healthcare Center allegation of Compliance. Date of Compliance: July 19, 2013.</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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	<p>Total: 155</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 7/01/13 by Suzanne Williams, RN</p>			
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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident received notice before being moved to another room. This deficient practice affected 1 of 2 residents reviewed for notice before a room change. (Resident #83)</p> <p>Finding includes:</p> <p>During an interview with Resident #83 on 6/10/13 at 3:38 p.m., she indicated that she had had several room changes in the last 9 months. When queried as to whether she knew when and where the room changes were going to occur before hand, the resident indicated that she had not been told and that the moves just happened.</p> <p>During an interview with the Social Worker on 6/18/13 at 9:20 a.m., she indicated that Resident #83 has had some room changes on a temporary basis due to resident bathrooms being renovated. She indicated "We did not issue room change notices - nursing contacted families to let them know of the moves and they</p>	F000247	<p>Please consider paper compliance for F247. Corrected Action Taken for Residents Affected-Social Service Director will follow up with resident #83 regarding current room situation and roommate compatibility. Social Service Director will document meeting with #83. How Other Residents Having The Potential To Be Affected Will Be Identified-Social Service Director/Designee will follow up with each resident who has had a room change within the last 30 days to ensure resident satisfaction and document. If a resident is unable to respond to or understand the question, the resident's responsible party will be contacted. Sytemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-Social Service Director/Designee to audit documentation for each resident room change for policy compliance and resident satisfaction for the next 90 days effective 7/19/13. A written "Intrafacility Transfer Notice" will be given to all residents the day of the room change effective 7/19/13. All licensed staff will be in-serviced on the revised room change procedure policy,</p>	07/19/2013			

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	<p>documented it in their notes."</p> <p>At 2:30 p.m., the Social Worker presented a copy of a nursing note dated 2/20/13 at 9:30 a.m. which indicated "Called POA [Power of Attorney] regarding room change to 214-1, ok [with] move." Documentation was lacking of the resident having been spoken to regarding the room change. Documentation was also lacking as to why the room change was occurring.</p> <p>Review of the 12/22/12 Annual Minimum Data Set Assessment [MDS] indicated the resident scored a 14/15 on the BIMS test [Brief Interview Mental Status] which indicated she was cognitively intact and able to make decisions. The 3/24/13 Quarterly MDS indicated the resident scored a 11/15 on her BIMS test which indicated she had some cognitive impairment with recall, but was able to be understood and understand others.</p> <p>Review of the facility's current policy titled "Room To Room Transfers" as presented by the Social Worker on 6/18/13 at 10:35 a.m., included, but was not limited to: "1. The resident and/or family (POA) must be consulted about the room change and</p>		<p>notifications, and "Intrafacility Transfer Notice" by 7/19/13. Compliance Will Be Reported at The Monthly Quality Assurance Meeting By-Social service Director/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed 7/19/13</p>	

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	<p>agree with the change. Document approval. 2. Inform them of the room being transferred to and introduce them to the roommate...."</p> <p>3.1-3(v)(2)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to provide medically-related Social Services in that 1 of 1 resident randomly reviewed for dental services failed to have follow up dental visits scheduled and family consent obtained for new dentures to be made. (Resident #70)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #70 on 6/14/13 at 10:42 a.m., indicated the resident had diagnoses which included, but were not limited to: aneurysm, gastroesophageal reflux disease, chronic ischemic heart disease, and seizure disorder.</p> <p>Review of the 4/4/13 Annual Minimum Data Set [MDS] Assessment indicated the resident scored a 15/15 on her BIMS [Brief Interview Mental Status] which indicated she was cognitively able to make decisions; had no mood or behavior issues; had no weight loss in last 6 months and had no dental issues, chewing or</p>	F000250	<p>Please consider paper compliance for F250. Corrective Action Taken For Residents Affected-Social Service Director interviewed resident #70's POA regarding replacement of dentures. POA stated it was the resident's decision. Resident #70 was interviewed and declined replacing dentures. Social Service Director to ensure resident #70 is included on the list for next dental visit. Social Service Director to document. How Other Residents With The Potential To Be Affected Will Be Identified-Social Service Director/Designee will audit all current resident medical records for dental consents and dental progress notes to ensure all resident's dental needs have been addressed, monitored by a dentist, and in compliance with state regulation. Residents will be added to the dental list as needs are reported or otherwise identified. Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-Social Service Director/Designee will meet with dental provider before and after each visit to discuss consults, consents, and any resident needs</p>	07/19/2013	

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	<p>swallowing issues.</p> <p>An 8/28/12 Care Plan written by the dietitian indicated: "Resident receives a mechanically altered diet related to absence of dentures. Goal - Will not have any chewing or swallowing problems not addressed without interventions. Approaches - Provide diet as ordered by MD; observe/report/review swallowing and chewing at meals for consistency changes as needed; observe and report any significant weight loss."</p> <p>A 4/1/13 Dietary note indicated "Pt [patient] receiving a mech [mechanical] soft diet but has no dentures, meal intakes are good, wt [weight] is down approx [approximately] 6# since last year...Will continue to monitor."</p> <p>During an interview with Resident #70 on 6/11/13 at 2:19 p.m., she indicated "My dentures have been missing since October and I have not seen the dentist since."</p> <p>During an interview with the Social Worker on 6/17/13 at 10:35 a.m., she indicated "Somehow they got lost and [name of dental group] came in and made new impressions, but family</p>		<p>for, or consideration of dentures and outside services. Staff will be in-serviced on notifying Social Service Director of dental issues concerning residents by 7/19/13. Social Service Director/Designee will audit each resident's medical record for dental visits and/or dental concerns during each careplan conference meeting for the next 90 days effective 7/19/13. Compliance Will Be Reported At The Monthly Quality Assurance Meeting By-Social Service Director/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed By 7/19/13</p>		

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	<p>refused to sign for liability and payment so new ones were not made. The resident is a little confused and it actually was in April, not October."</p> <p>Review of the dental group audit book, completed by the Social Worker, indicated the following notes were made:</p> <ul style="list-style-type: none"> - "4/1/12 spoke with [name of dental group representative] who stated they did not see resident for impressions due to getting a new denied consent. Social Services disputed denied consent as our records indicate total care resident. [Name of dental group representative] to send copy of denied consent. Family called and message left." - "7/10/12 Liability letter sent (sent to get family to sign permission to treat resident even if insurance is to pay - per Social Worker) ; 7/16/12 - left message with family to f/u [follow-up] on letter." <p>During the interview with the Social Worker, she indicated "I thought I charted further but guess I did not f/u [follow up] on the dentures."</p> <p>On 6/17/13 at 11:30 a.m., the Staff</p>			

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	<p>Development Coordinator presented a copy of the signed Job Description for the Social Worker dated 11/12/07. Review of this Job Description at this time included, but was not limited to: "Purpose:...The Social Service Director will assure that the medically related emotional and social needs of the resident are attained/maintained on an individual basis...24. Will work with the facilities [sic] consultants as necessary and implement recommended changes as required...39. Is responsible for ensuring that complete, accurate and comprehensive Social Service progress notes that are completed on all...significant changes...and as needed according to and within the time frame that is specified by current state and federal rules and regulations, and per facility policy and procedures..."</p> <p>3.1-34(a)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan based on a resident assessment for comfort care and falls. This deficient practice affected 2 of 35 residents whose care plans were reviewed (Resident #100 and #51).</p> <p>Findings include:</p> <p>Review of medical record on 6/14/13 at 10:37 a.m. indicated Resident #100 was admitted in 2011 for rehabilitation. Resident #100 has a</p>	F000279	Please consider paper compliance for F279Corrective Action Taken For Residents Affected-Initiation of the Comfort Measures Careplan for resident #100Fall Risk Careplan was initiated for resident #51 on 6/9/13How Other Residents Having The Potential To Be Affected Will Be Identified-Current residents medical records will be audited for comprehensive careplans and corrected by 7/19/13 by the Unit Coordinators/Designee.Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-The interdisciplinary team	07/19/2013	

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	<p>prior history of coronary artery disease, mitral valve prolapse, dementia, anemia, and sepsis. Resident #100 has a "Do Not Resuscitate" physician's order dated 1/7/11. The Code Status Sheet last updated on 1/24/13 indicated the "Do Not Resuscitate" order was still in effect. A physician order dated on 6/15/11 indicated the resident was to receive comfort measures only.</p> <p>Review of the care plan indicated the resident had a care plan for comfort measures that was discontinued. The last update was noted on 1/30/13.</p> <p>Review of the progress notes, dated 5/13/13, 4/1/13, 2/13/13, 12/31/12, 11/23/12, 10/16/12, 09/11/12, 8/8/12, and 7/4/12 all indicated the physician was seeing the resident for comfort care.</p> <p>Review of the quarterly MDS (Minimum Data Set) assessment dated 4/13/2013 indicated Resident #100's BIMS (Brief Interview for Mental Status) score was 3, with a range of 00-15. This score indicated cognitive impairment. The resident's functional status indicates the resident required extensive assistance. The assessment also indicated the resident was always</p>		<p>will be in-serviced on the policy and procedure for "Resident Careplanning" by 7/19/13. The Careplan Coordinator/Designee will audit each resident's chart for comprehensive careplans, compare with CAA summary and triggered items during the careplan conference meeting and document for 90 days effective 7/19/13. Compliance Will Be Reported At Quality Assurance Meeting Monthly By-Director of Nursing/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed By 7/19/13</p>		

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	<p>incontinent, denied pain, and was at risk for developing a pressure ulcer.</p> <p>An interview with LPN #7 on 6/14/13 at 1:39 p.m. indicated Resident #100 was receiving comfort care only. LPN #7 indicated no care is provided by another provider and that the resident is no longer weighed or has vital signs checked.</p> <p>On 6/18/13 at 9:32 a.m. during an interview CNA #1 was not aware Resident#100 had a physician's order for comfort measures only. When asked to describe the type of care the resident received, CNA#1 indicated the resident was a "total care patient" requiring extensive assistance. CNA#1 was not able to indicate what comfort measures entailed. CNA#1 then asked LPN#7 who explained Resident #100 did not receive any vital signs or weights. CNA#1 then responded that Resident#100 was not on the list of residents to get vital signs or weights.</p> <p>2. During an observation on 6/10/13, at 1:20 p.m., Resident #51 was observed resting in bed with sensor alarm in place.</p> <p>During an interview on 6/11/13, at 2:44 p.m., LPN #8 indicated that Resident #51 fell on 6/9/13 while</p>			

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	<p>getting out of bed to go to the bathroom unassisted. She sustained a skin tear to the left elbow and bruising to the left side of her back. LPN #8 indicated the resident was sent to the emergency room for evaluation, and all testing completed was negative.</p> <p>Record review on 6/13/13, at 2:50 p.m., indicated an admission date of 5/6/13, and diagnoses including, but not limited to, senile dementia, depressive disorder, macular degeneration, and generalized muscle weakness. A Fall Risk Assessment on admission indicated a score of 9. The resident was reassessed on 6/9/13, after her fall, and given a score of 17. A score above 10 indicated the resident was a risk for falls. A Fall Intervention record, dated 5/6/13, indicated interventions of: encourage use of call light for assistance, occupational therapy and physical therapy to screen, and sensor alarm to bed at night for safety.</p> <p>Review of admission orders dated 5/6/13, included but were not limited to, up ad lib and sensor alarm to bed at night for safety. Telephone order, dated 5/8/13 indicated an order for sensor alarm to bed and wheelchair,</p>			

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	<p>and to check placement and function every shift. History and Physical dated 5/9/13, and signed by physician, indicated the resident was admitted to nursing home due to falls at home. MDS (Minimum Data Set) dated 5/12/13 indicated the resident was a 1 person assist for bed mobility, transfers, walking in room, and toilet use. An OBRA (Omnibus Budget Reconciliation Act of 1987) admission assessment, dated 5/12/13, indicated the CAA (care area assessment) summary for falls was marked for "care area triggered" and "addressed in care plan."</p> <p>Nurses note dated 6/9/13, at 2:35 a.m., included but was not limited to, "at 2:15 a.m., while responding to resident's bed alarm sounding, heard a loud thud from resident's room. Upon entering, noted resident sitting in front of bedside dresser with wheelchair in front of her." Resident indicated that she needed to go to the bathroom. The note also indicated the resident was wearing gripper socks and the call light was in reach and clipped onto the side rail.</p> <p>Care plan dated 6/9/13, indicated a problem of risk for falls related to cognitive impairment and fall with injury. Approaches included, but</p>			

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	<p>were not limited to, updated fall assessment each quarter and as needed, sensor alarms as needed to bed and or wheelchair, physical therapy and occupational therapy to evaluate and treat as indicated, gripper socks when in bed, and paddle call light. No care plan for falls risk was observed in chart prior to 6/9/13.</p> <p>A policy and procedure for "Resident Care planning" was provided by the Director of Nursing on 6/17/13, at 4:20 p.m., and identified as their current policy. The policy included, but was not limited to, "1. The admitting nurse initiates 3 care plans upon admission. 2. The Unit Coordinator completes the nursing portion of the careplans during the admission audit process. 3. MDS completes any additional needed careplans for nursing during the 14 day assessment per the MDS manual and the problems identified through the care area assessments."</p> <p>3.1-35(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update a resident's care plan when his status changed from short term rehab to long term placement. This deficient practice affected 1 of 35 residents whose care plans were reviewed. (Resident #60)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #60 on 6/17/13 at 2:16 p.m. indicated he had diagnoses which included, but were not limited to: nonspecific psychotic disorder, muscle disorder, senile dementia,</p>	F000280	Please consider paper compliance for F280. Corrective Action Taken For Residents Affected-Resident #60 careplan goal of returning home has been revised per wife's wishes. How Other Residents Having The Potential To Be Affected Will Be Identified-The careplans of all short term stay resident's will be audited for accuracy by 7/19/13. Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-The Social Service Director/Designee will audit resident's medical records for careplans addressing short/long term stay during careplan conference meeting for the next 90 days. Any revisions	07/19/2013	

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	<p>generalized pain, chronic ischemic heart disease, and chronic obstructive pulmonary disease.</p> <p>A 2/26/13 care plan by Social Services with an update on 5/1/13 indicated "Resident hopes to return home.; Goal: resident will complete therapy and return home. Approaches: 1. encourage resident to stay as long as PT/OT [Physical Therapy and Occupational Therapy] feels he needs to be here; 2. SS [Social Services] to offer discharge meeting with resident and family; 3. SS to arrange home health or any needed equipment; 4. PT/OT to take resident home for 'trial run' if indicated."</p> <p>The 3/16/13 Social Service Discharge Plan update indicated that the resident was to remain for LTC [long term care] due to no longer being appropriate for returning to AL [Assisted Living]. Documentation was lacking of the care plan being updated to reflect the change in status.</p> <p>On 6/17/13 at 4:20 p.m., the DoN [Director of Nursing] presented a copy of the facility's current policy and procedure titled "Resident Care Planning." Review of this policy at</p>		<p>will be completed at that time. The Careplan Coordinator/Designee will compare the CAA summary and triggered items to the actual careplans during the careplan conference meeting effective 7/19/13 for the next 90 days. Compliance Will Be Reported At Quality Assurance Meeting Monthly By-Social Service Director/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed By 7/19/13</p>		

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	<p>this time included, but was not limited to: "...4. Each department is responsible for their own assessment and placement of the appropriate, individualized care plans. 5. Care plans are updated quarterly, annually, with each significant change, and PRN...."</p> <p>During an interview with the Social Worker on 6/19/13 at 9:30 a.m., she indicated that each department was responsible for updating their own care plans and that nursing would sometimes update them if there was a change in condition before the regular care plan meetings. She also indicated Resident #60 was now long term care since unable to return to his prior residence.</p> <p>3.1-35(d)(2)(B)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the residents' drug regimen was free from duplicate hypnotic and anti-depressant medications without sufficient reasoning. This deficient practice affected 2 of 10 residents reviewed for unnecessary medications. (Residents #36 and #40).</p> <p>Findings included:</p>	F000329	Please consider paper compliance for F329. Corrective Action Taken For Residents Affected-Resident #36 was seen by contracted Psychiatric Group on 7/2/13. Physician's order to discontinue Wellbutrin on resident #36 effective 7/2/13 was noted. Behavior/Intervention Monthly Flow Sheet initiated 7/1/13 for resident #36. Resident #40 seen by contracted Psychiatric Group on 7/2/13. Physician's order to discontinue Melatonin and Elavil on resident #40 effective 7/2/13	07/19/2013			

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	<p>1. Review of the clinical record for Resident #36 on 6/17/13 at 11:18 a.m., indicated the resident had diagnoses which included, but were not limited to: depression, chest pain, joint/leg pain, chronic ischemic heart disease, and angina pectoris.</p> <p>Review of the Physician telephone orders for April 2013 indicated the following orders were obtained:</p> <ul style="list-style-type: none"> - 4/1/13 - new order for Wellbutrin 150 mg [milligrams] qd [every day] for depression. - 4/2/13 - [The name of the Psychiatric group the facility had a contract with] to evaluate and treat. - 4/10/13 - Zoloft 50 mg - 1 qd for depression. <p>Review of the nursing notes between 3/1 and 4/30/13 failed to locate documentation of the resident exhibiting any signs and symptoms of depression which necessitated the implementation of two anti-depressants.</p> <p>Review of Social Work documentation between 7/30/12 and 5/2/13 also lacked documentation of the resident experiencing signs or symptoms of depression.</p>		<p>was noted.Behavior/Intervention Monthly Flow Sheet Initiated 7/1/13 for resident #40.How Other Residents Having The Potential To Be Affected Will Be Identified-Current resident's medical records will be audited for use of unnecessary drugs by 7/19/13.Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-Monthly documented exit meeting with contracted Psychiatric Group with Social Services, Director of Nursing, and/or Unit Coordinators/designees.Unit Coordinators will audit the Pharmacy Consultant Recommendations to ensure the physicaian documents the clinical rationale when responding effective 7/19/13 for 90 days. Licensed nurses will be in-serviced by 7/19/13 for "Medication Management" covering antidepressant and hypnotic therapy, documentation, and non-pharmacological interventions.Pharmacy consultant to audit medical records monthly for recommendations regarding unnecessary drugsThe Corrective Action Will Be Monitored By-Director of Nursing/DesigneeCompliance Will Be Reported At The Monthly Quality Assurance Meeting By-Director of Nursing/DesigneeThis monitoring and reporting to the Quality Assurance Committee will</p>				

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	<p>Review of the 5/2/13 and 2/2/13 Quarterly Minimum Data Set [MDS] Assessments indicated the resident scored a 15/15 on his BIMS [Brief Interview Mental Status] to indicate the resident was cognitively intact and able to make self understood and understand others. He also had no mood or behavior issues.</p> <p>In an interview with the Social Worker on 6/18/13 at 8:50 a.m., she indicated "He has been much happier since he has found a girlfriend here. Not sure why the 2 anti-depressants were added on him within a week."</p> <p>At 9:40 a.m., the Social Worker indicated "I checked with [name of unit manager] and it seems the daughter was concerned that when he was hospitalized in July 2012, he was taken off his Wellbutrin that he had been on for many years and she felt like in April 2013, he might have been a bit depressed as he was going to be staying long term and felt that he might need the medication. Then when they contacted the psychiatric group a few days later, the psychiatrist said Zoloft and Wellbutrin go together very well and ordered Zoloft also. Then the psychiatrist saw him the next month and said to leave</p>		<p>continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed By 7/19/13.</p>		

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	<p>him on the medication and just monitor him."</p> <p>Documentation of the resident being monitored for signs and symptoms of depression could not be located. Documentation was also lacking of non-pharmacological interventions being used before implementing both anti-depressants.</p> <p>On 5/3/13, the Consultant Pharmacist made a recommendation to consider treating with one anti-depressant as there was no studies to show 2 anti-depressants were better than one or to provide documentation as to why 2 anti-depressants were needed. On 5/7/13, the physician disagreed and indicated it was ordered per the psychiatrist and did not want to change at this time.</p> <p>During an interview with the Social Worker on 6/18/13 at 10:45 a.m., she indicated that the physicians tended to not want to touch the psychiatric medications ordered and will leave it up to the psychiatrist to make all changes. She also indicated there was no follow up documentation with the psychiatrist for justification for continued use of both anti-depressants.</p>				

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	<p>2. Review of the clinical record for Resident #40 on 6/13/13 at 2:52 p.m., indicated the resident had diagnoses which included, but were not limited to: depressive disorder, insomnia, blindness/low vision, generalized pain, and Alzheimer's disease.</p> <p>Review of the June 2013 Monthly Physician Orders indicated the resident had the following orders: - 3/14/13 Ambien 10 mg - 1 Q HS [every night] for insomnia - 4/25/13 Melatonin 5 mg - 1 Q HS - for insomnia - 5/13/13 Amitriptyline 10 mg - 1 Q HS - for insomnia</p> <p>On 6/3/13, a new order was received for "May be seen by [name of psychiatric group] for eval and tx [evaluation and treatment]."</p> <p>Review of the nursing notes between 4/30/13 and 5/30/13, indicated the following entries were documented: - "5/1/13 9:45 p.m. - seems to be having trouble sleeping, has tried to get up several times this shift looking for his pants, had to be reminded it wasn't time to get up yet and went back to sleep easily." - "5/10/13 9:45 p.m. - has been very restless this evening trying to get out</p>			

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	<p>of bed several times, when asked where he is going, responds he is getting up and getting his clothes - reminded it was late and he needed to be sleeping now, assisted back to bed and easily fell asleep resting."</p> <p>- "5/12/13 1:10 am - res [resident] once again restless taking o2 off and wanting to get up, when reminded of time, res agreeable to going back to sleep."</p> <p>- "5/13/13 - NO for Amitriptyline r/t [related to] insomnia."</p> <p>- "5/15/13 10 p.m. - Amitriptyline given at HS per order & effective, resident resting quietly abed."</p> <p>- "5/30/13 2 a.m. - resident restless d/t [due to] roommate up all night - res tried to get up several times thinking it was time for breakfast, easily re-directed but q [every] time staff in room with roommate, resident would get up again and need explanation as to why to go back to sleep."</p> <p>The 3/24/13 Admission Minimum Data Set [MDS] Assessment indicated: - understands and is understood - BIMS score = 3 - impaired cognitive</p>			

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	<p>functioning</p> <ul style="list-style-type: none"> - no s/s [signs/symptoms] of delirium - no mood issues including no difficulty falling or staying asleep - no behavior issues - no presence of pain issues <p>On 5/16/13, the Consultant Pharmacist made a recommendation for the physician to consider changing the medications (hypnotics) to PRN from routine or to provide documentation of why the risks vs benefits for not making the changes. The physician responded on 5/29/13 "Do not change." Documentation was lacking of risks vs [versus] benefits to justify reasoning for continued use at routine.</p> <p>Review of the Social Worker notes between 3/20/13 and 6/18/13, failed to locate documentation of the resident experiencing difficulty sleeping or having behavioral issues.</p> <p>Documentation was also lacking of the resident having been assessed for causative factors of insomnia and non-pharmacological interventions being utilized before the implementation of the 2 additional hypnotics.</p> <p>Review of the 3/11/13 care plan for</p>			

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	<p>"Insomnia" indicated the goal was for "Will maintain an adequate amount of sleep 6-8 hours nightly." Approaches included: "1. Administer meds per MD orders. 2. Encourage relaxation techniques. 3. Make sure resident is comfortable before leaving room. 4 Contact MD as needed. 5. Amitriptyline 10 mg - 1 PO [by mouth] Q HS." This intervention was added on 5/13/13. Documentation was lacking of these non-pharmacological interventions having tried before obtaining new orders for 2 sedatives/hypnotics.</p> <p>In an interview with the Social Worker on 6/18/13 at 8:50 a.m., she indicated "The resident is blind so he really has no perception of day and night and is a bit confused. Not sure why he was ordered 3 hypnotics within 2 months and using all three at same time."</p> <p>At 9:40 a.m., the Social Worker indicated "[name of nurse manager] said he was up and down frequently, yelling out, restless. That's why the hypnotics were ordered." She also indicated there should have been consistent documentation of the episodes if the hypnotics were going to ordered and utilized as well as non-pharmacological intervention.</p>						

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	<p>On 6/17/13 at 1:15 p.m., the Director of Nursing presented a copy of the facility's current policy titled "Medication Monitoring/Medication Management". Review of this policy at this time included, but was not limited to: "...2. Sedative/Hypnotics: a...the nursing center should attempt to taper the medication quarterly unless contraindicated...The physician has documented the clinical rationale for why any attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder,..b. Indications:..Before initiating medications to treat insomnia, other factors potentially causing insomnia should be evaluated. These guidelines apply to any medication that is being used to treat insomnia. Initiation of medications to induce or maintain sleep should be preceded or accompanied by other interventions to try to improve sleep..."</p> <p>On 6/18/13 at 11:00 a.m., the DoN presented a copy of the facility's current policy titled "General Guidelines for the Use of Chemical restraints". Review of this policy at this time included, but were not limited to: "...General Guidelines: 1.</p>			

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	<p>Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics and "other" drugs that affect behaviors...3. Chemical restraints shall be used only after alternative methods have been tried unsuccessfully and only upon the written order of a physician that specifies the circumstances for the drug's use...7. Facility staff (such as licensed nurses, certified nursing assistants, activity therapists, social workers and other staff members) will monitor the resident's medical symptoms, condition, circumstances and environment in order to evaluate the appropriateness of restraint use...11. Nursing services, social services and other members of the interdisciplinary team will address the behaviors in the progress notes, care plans, or other forms per facility Behavior Monitoring/Management Program. Medication use is not the sole approach for behavioral intervention. Other interventions will be identified in the care plan...."</p> <p>3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(6)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to ensure male dietary employees with facial hair wore protective coverings to prevent food contamination during 3 of 4 kitchen observations. This deficient practice affected 81 of 82 Health center residents.</p> <p>Findings include:</p> <p>1. During the initial tour of the kitchen on 6/10/13 at 10:20 a.m., the following was observed: - the Dietary Manager and Dietary Aide #1 both had facial hair which was not covered with any type of protection. The Dietary Manager was also on tour of the kitchen, including by the stove and food preparation areas currently being used by the cook staff, and the walk-in refrigerators and freezers. Dietary Aide #1 was observed prepping resident meals trays in anticipation of lunch.</p>	F000371	<p>Please consider paper compliance for F371The three light fixtures above the steam table were cleaned and painted the day of survey on 6/19/13 and included the hanging poles and round fixture attachment to the ceiling. No residents found to be affected by the alleged deficiency. All staff to be in-serviced on the facility work order policy by 7/19/13. The three light fixtures will be cleaned weekly by housekeeping staff. This will be monitored weekly by the housekeeping supervisor. Housekeeping staff will be in-serviced by 7/19/13. The cleaning of the three lights have been added to the weekly dining room cleaning schedule. This will be reported by the housekeeping supervisor/designee at the monthly QA meetings. This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 90% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation.</p>	07/19/2013	

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	<p>2. During the lunch observation on 6/10/13 between 11:00 a.m. and 12:10 p.m., the following was observed:</p> <ul style="list-style-type: none"> - 11:06 a.m. - the Dietary Manager and Dietary Aide #1 both had no facial hair covering. The Dietary Aide was observed rolling silverware, and sorting tray cards on the counter across from the steam table from which the cook was serving from. The Dietary Manager was made aware at this time of staff with facial hair not being covered and indicated he was aware and that he would go get some. No attempts were made to obtain facial hair coverings during the lunch time meal observation. - 11:20 a.m. - Dietary Aide #2 was observed walking around kitchen and was gathering serving utensils from the dish rack and the storage drawers for the Assisted Living meal service. No facial hair protective covering was observed in place on the Dietary Aide as he gathered the serving items. In an interview with the Dietary Manager at this time, he indicated the Dietary Aide worked in Assisted Living serving the meals. - 11:31 a.m. - Dishwasher #1 was observed to be scraping plates in preparation for loading and running 		<p>Systemic changes will be completed by 7/19/13. The ceiling vents above the counter, as well as, above the ice machine were cleaned on the day of survey 6/19/13. No residents were found to be affected by the alleged deficiency. The ceiling vents were placed on a quarterly cleaning schedule to be completed by maintenance staff. Housekeeping staff will dust all ceiling vents and sprinkler heads weekly. Maintenance will audit monthly all ceiling vents for dust and clean dusty vents immediately throughout the facility. Housekeeping supervisor/designee will monitor weekly for dusty vents/sprinkler heads. Maintenance and housekeeping staff will be in-serviced by 7/19/13. Housekeeping supervisor will report findings at monthly QA meeting. This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 90% is met for three consecutive months. Once threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed By 7/19/13. There were no residents adversely affected by the alleged deficiency of facial hair covering, crumbs inside the cabinets, and dust on the vents and light fixtures. Beard nets were</p>				

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	<p>the dish machine. He was also observed unloading and stacking the clean dishes. No protective face hair covering was observed in place.</p> <p>- 11:33 a.m. - Dietary Aide #1 was observed scooping ice into coolers and then taking the carts of ice and drinks to the skilled and 100 units.</p> <p>During an interview with the Dietary Manager at 12:15 p.m. on 6/10/13, he indicated: "I noticed it was not on the dress code policy about facial hair coverings. I don't know if anyone talks to the men about covering their facial hair during orientation. Will have to talk to the Staff Development Coordinator to see if there is anything in the orientation packet."</p> <p>The Dietary Manager also presented at this time a copy of the facility's current policy titled "Dietary Uniform Policy." Review of this policy at this time failed to address the need for facial hair covering of those male staff members while working in the dietary department.</p> <p>At 1:00 p.m., the Dietary Manager presented a copy of the facility's current policy titled "Personnel Standards". Review of this policy at this time included, but was not limited</p>		<p>provided on the day of survey and in-services given to all male employees. The crumbs were cleaned from inside the cabinets and teh dust cleaned from the vents and light fixtures on the day of the survey. There have been no reports of any adverse effects from this alleged deficiency by residnets or facility nursing staff. Beard protection was provided on the day of survey and required to be worn by affected male employees. A new policy regarding facial hair was written and passed out to all male members of the dietary staff requiring facial hait to be covered at all times while in the food service area. Male staff were in-serviced during survey on when beard protection was needed and how to wear it. This in-service will be repeated by 7/19/13. Holders for the hair and beard nets will be purchased and mounted in a conspicuous location outside each entrance to the kitchen along with instructions. An in-service will be held for all dietary employees concerning the location of the hair and beard nets. This will be completed by 7/19/13. Inspection audits will be held 3 times per week by the dietary manager, dietician, or designee for a period of one quarter to ensure appropriate protective coverings are worn at all times. Audits will be submitted at the regular QA meetings for 3 months by the</p>				

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	<p>to: "Policy Statement: Dietary personnel shall follow sanitary standards. Policy Interpretation and Implementation:...2. The following standards have been adopted by the dietary department: a. Hair nets or hats, covering all of the hair, must be worn at all times while on duty..."</p> <p>At 2:44 p.m. - the Dietary Manager indicated "I developed my own policy effective today to cover the issue of facial hair and will have all my male dietary people sign it."</p> <p>3. During a random Kitchen observation on 6/19/13 at 11:15 a.m., Dietary Aide #1 entered the kitchen, placed a hairnet on his head and then proceeded to enter into the dry storage room and gathered condiments for the resident trays. No protective covering was placed over the aide's beard. The dietary staff were observed to be in the middle of health center tray service at the time.</p> <p>When brought to the attention of the Assistant Dietary Manager on 6/19/13 at 11:30 a.m. of the 11:15 a.m. observation, she indicated that she had reminded the Dietary Aide to not forget his beard covering and that he assured her he would put it on.</p>		<p>dietary manager/designee. Inspection audits will be held 3 times per week by the dietary manager, dietician, or designee for a period of one quarter to ensure the kitchenette is cleaned according to the schedule. Audits will be submitted at the regular QA meetings for 3 months by the dietary manager/designee. This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Sytemic changes will be completed by 7/19/13. Please consider paper compliance.</p>				

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	3.1-21(i)(3) 5.1-5(i)			

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F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review and interview, the facility failed to obtain dental services for routine oral health screenings on a resident who was edentulous. This deficient practice affected 1 of 1 resident randomly reviewed for dental services (Resident #70).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #70 on 6/14/13 at 10:42 a.m., indicated the resident had diagnoses which included, but were not limited to: aneurysm, gastroesophageal reflux disease, chronic ischemic heart disease, and seizure disorder.</p> <p>A 4/12/12 Dental Note indicated "impressions done upper and lower as resident lost her dentures." No</p>	F000412	Please consider paper compliance for F412. Corrective Action Taken For Residents Affected-Social Service Director interviewed resident #70's POA regarding replacement of dentures. POA stated it was the resident's decision. Resident #70 was interviewed and declined replacing dentures. Social Service Director to ensure #70 is on the list for next dental visit. Social Service Director to document. How Other Residents With Potential To Be Affected Will Be Identified-Social Service Director/Designee will audit all current resident medical records for dental consents and dental progress notes to ensure all resident's dental needs have been addressed, monitored by a dentist, and in compliance with state regulation. Residents will be added to the dental list as needs are reported or otherwise identified. Systemic Changes Being Made To Ensure The	07/19/2013			

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	<p>other dental notes could be located.</p> <p>During an interview with Resident #70 on 6/11/13 at 2:19 p.m., she indicated "My dentures are missing since October but I can eat just fine - don't want to get another pair as it is too much trouble with the fittings. I'm not having any trouble eating. Have not seen the dentist since."</p> <p>During an interview with the Social Worker on 6/17/13 at 10:35 a.m., she indicated she did not follow up with the resident and family to continue having the resident be seen by the dentist.</p> <p>During an interview with LPN#1 on 6/17/13 at 4:05 p.m., she indicated "Yes, even if a resident is edentulous, they are still seen by the dentist for oral health checks."</p> <p>3.1-24(a)(1) 3.1-24(a)(3)</p>		<p>Deficient Practice Will Not Recur-Social Service Director/Designee will meet with dental provider before and after each visit to discuss consults, consents, and any resident needs for, or consideration of dentures and outside services. Staff will be in-serviced on notifying Social Service Director of dental issues concerning residents by 7/19/13. Compliance Will Be Reported At The Monthly Quality Assurance Committee Meeting By-Social Service Director/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once threshold is met for three consecutive months, a recommendation will be made to the Quality Assurance Committee for discontinuation. Systemic Changes Will Be Completed 7/19/13</p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were thoroughly acted upon, to consider a reduction in the number of anti-depressant medicines a resident took and to change a resident's 3 sedative/hypnotic medications from routine to PRN [as needed]. This deficient practice affected 2 of 10 residents reviewed for unnecessary medications. (Residents # 36 and #40)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #36 on 6/17/13 at 11:18 a.m., indicated the resident had diagnoses which included, but were not limited to: depression, chest pain, joint/leg pain, chronic ischemic heart disease, and angina pectoris.</p> <p>Review of the Physician telephone</p>	F000428	<p>Please consider paper compliance for F428. Corrective Action Taken For Residents Affected-Resident #36 was seen by contracted Psychiatric Group on 7/2/13. Physician's order to discontinue Wellbutrin on resident #36 effective 7/2/13 was noted. Behavior/Intervention Monthly Flow Sheet initiated 7/1/13 for resident #36. Resident #40 seen by contracted Psychiatric Group on 7/2/13. Physician's order to discontinue Melatonin and Elavil on resident #40 effective 7/2/13 was noted. Behavior/Intervention Monthly Flow Sheet initiated 7/1/13 for resident #40. How Other Residents Having The Potential To Be Affected Will Be Identified-Current residents medical records will be audited for drug regimen review and physician documented clinical rationale by 7/19/13. Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-Monthly documented exit meeting with contracted Psychiatric Group with Social</p>	07/19/2013			

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	<p>orders for April 2013 indicated the following orders were obtained:</p> <ul style="list-style-type: none"> - 4/1/13 - new order for Wellbutrin 150 mg [milligrams] qd [every day] for depression. - 4/2/13 - [The name of the Psychiatric group the facility had a contract with]. - 4/4/13 - Zoloft 50 mg - 1 qd for depression. <p>On 5/3/13, the Consultant Pharmacist made a recommendation to consider treating with one anti-depressant as there was no studies to show 2 anti-depressants were better than one or to provide documentation as to why 2 anti-depressants were needed. On 5/7/13, the physician disagreed and indicated it was ordered per the psychiatrist and did not want to change at this time.</p> <p>During an interview with the Social Worker on 6/18/13 at 10:45 a.m., she indicated that the physicians tended to not want to touch the psychiatric medications ordered and will leave it up to the psychiatrist to make all changes. She also indicated there was no follow up documentation with the psychiatrist for justification for continued use of both</p>		<p>Services, Director of Nursing, and/or Unit Coordinators/Designees. Unit Coordinators will audit the Pharmacy Consultant Recommendations to ensure the physician documents the clinical rationale when responding effective 7/19/13 for 90 days. Licensed nurses will be in-serviced by 7/19/13 for "Medication Management" covering antidepressant and hypnotic therapy, documentation, and non-pharmacological interventions. The Corrective Action Will Be Monitored By-Director of Nursing/Designee Compliance Will Be Reported At The Quality Assurance Committee Meeting By-Director of Nursing/Designee This monitoring and reporting to the Quality Assurance Committee will continue until threshold of 95% is met for three consecutive months. Once the threshold is met for three consecutive months, a recommendation will be made for discontinuation. Systemic Changes Will Be Completed By 7/19/13.</p>		

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	<p>anti-depressants.</p> <p>2. Review of the clinical record for Resident #40 on 6/13/13 at 2:52 p.m., indicated the resident had diagnoses which included, but were not limited to: depressive disorder, insomnia, blindness/low vision, generalized pain, and Alzheimer's disease.</p> <p>Review of the June 2013 Monthly Physician Orders: - 3/14/13 Ambien 10 mg - 1 Q HS [every night] for insomnia - 4/25/13 Melatonin 5 mg - 1 Q HS - for insomnia - 5/13/13 Amitriptyline 10 mg - 1 Q HS - for insomnia</p> <p>On 5/16/13, the Consultant Pharmacist made a recommendation for the physician to consider changing the medications (hypnotics) to PRN from routine or to provide documentation of why the risks vs benefits for not making the changes. The physician responded on 5/29/13 "Do not change." Documentation was lacking of risks vs benefits to justify reasoning for continued use at routine.</p> <p>On 6/17/13 at 1:15 p.m., the Director of Nursing presented a copy of the</p>			

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	<p>facility's current policy titled "Medication Regimen Review and Reporting." Review of this policy at this time included, but was not limited to: "Policy:...The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are communicated to those in authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion...6. Resident-specific MRR [Medication Regimen Reviews] recommendations and findings are documented and acted upon by the nursing center and/or physician...8...Recommendations shall be acted upon within a reasonable time frame. a. Physician may accept and act on a recommendation or reject a recommendation and provide an explanation for disagreement..."</p> <p>3.1-25(i)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interviews, the facility failed to</p>	F000441	Please consider paper compliance for F441.Corrective	07/19/2013			

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	<p>maintain infection control procedures, and a safe and sanitary environment, related to disposing of a syringe and its contents, during 1 of 1 intravenous medication administration observation. (Res #162)</p> <p>Findings include:</p> <p>During an observation on 6-17-13 at 11:20 a.m. of IV [intravenous] Vancomycin administered to Resident #162 by LPN #1, the IV port was observed to be cleaned with an alcohol wipe, a 10 milliliter syringe connected, and 5 milliliters of normal saline pushed from a 10ml prepackaged syringe. LPN#1 then discarded the half empty syringe in the trash can at the resident's bedside.</p> <p>The policy and procedure for IV medication administration was received from the DON (Director of Nursing) on 6-17-13 at 2:15 p.m., and indicated to discard any excess flush solution, and dispose waste per OSHA, CDC, and facility policy. Review of the facility's Infection Control Policy did not indicate anything about disposal of syringes.</p> <p>During interview with LPN #5 on 6-17-13 at 2:57 p.m., she indicated,</p>		<p>Action Taken For Resident Affected-Resident #162 was not affected by the alleged deficient practice.LPN educated who performed the alleged deficient practice on 6/17/13.How Other Residents Having The Potential To Be Affected Will Be Identified-No other residents were affected by the alleged deficient practice.Systemic Changes Being Made To Ensure The Deficient Practice Will Not Recur-All licensed nurses will be in-serviced on the policy and procedure "Handling and/or Disposing of Used Needles" by 7/19/13.The Corrective Action Will Be Monitored By-The Infection Control Nurse will complete random audits for syringe disposal compliance for 90 days effective 7/19/13.Compliance Will Be Reported At The Monthly Quality Assurance Committee Meeting By-Infection Control Nurse/DesigneeThis monitoring and reporting to the Quality Assurance Committee will continue until threshold of 100% is met for three consecutive months. Once threshold is met for three consecutive months, a recommendation will be made for discontinuation.Systemic Changes Will Be Completed By 7/19/13.</p>		

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	<p>per facility policy, to discard any leftover solution in the toilet and flush, and then discard the syringe in the sharps container.</p> <p>Interview with LPN #6 on 6-17-13 at 3:02 p.m., indicated she discards of syringes in the sharps container; if solution is still in the syringe she indicated she also puts that in the sharps container.</p> <p>Interview with LPN#7 on 6-17-13 at 3:28 p.m., indicated she puts the syringe in the sharps container, even if there is solution left in the syringe.</p> <p>Interview with the DON on 6-17-13 at 3:23 p.m., when asked about the procedure for discarding of a syringe after a flush is done, she indicated disposal in the sharps container is what they [facility] teach them and that pharmacy does the teaching for the facility. She indicated when there is a solution left in the syringe, dispose of it in a toilet and flush, and then discard the syringe in the sharps container.</p> <p>3.1-18(b)(1)</p>			

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R000000	The following state residential findings are cited in accordance with 410 IAC 16.2-5.	R000000	Dear Ms. Rhodes, Please find the Form CMS-2567 with the plan of correction for the deficiencies sited during our recertification and Indiana State Licensure survey conducted at Westminster Healthcare Center on June 10th through June 17th 2013. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker, Administrator Westminster Healthcare Center preparation and execution of this plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Healthcare Center ("Facility") is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Healthcare Center allegation of Compliance. Date of Compliance: July 19, 2013.		

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Dining Room was free from dust build-up on outside and inside ceiling vents during 1 of 1 kitchenette/nourishment room observation. The facility also failed to ensure the resident room hall doors and nursing station door, hallway ceiling light fixtures and ceiling tiles, and wall paper were clean and in good repair during 2 of 2 environmental tours. This deficient practice affected 73 of 73 residents currently residing in Assisted Living.</p> <p>Findings includes:</p> <p>1. During a tour of the Assisted Living Dining Room on 6/19/13 between 8:40 a.m. and 9:25 a.m., the following was observed: - 7 of 7 large round ceiling vents had a light coating of blackish greasy to touch dust on the vents. A one foot circumference of the ceiling was also observed to have a light to moderate coating of black dust. The inside of the 7 ceiling vents were observed to have a moderate to heavy build-up of</p>	R000144	<p>Please consider paper compliance for R144, Sanitation and Safety Standards. The seven large round ceiling vents, as well as, the ceiling area around the vents were cleaned on the day of survey 6/19/13. There were no residents found to be affected by the alleged deficiency. The ceiling vents were placed on a quarterly cleaning schedule to be completed by maintenance staff. The cleaning of the inside of the duct work will be cleaned professionally and will be completed by 7/19/13. Maintenance will audit all ceiling vents for dust and clean such vents immediately throughout Assisted Living facility. Maintenance will audit all vent and sprinkler heads monthly and will report at monthly QA meetings including the ceiling area around vents. Maintenance staff will be in-serviced by 7/19/13. Housekeeping staff will dust all ceiling vents, sprinkler heads, and light fixtures weekly. Housekeeping supervisor will audit weekly. Housekeeping staff will be in-serviced 7/19/13. Housekeeping supervisor will report findings of audits monthly at QA meeting. Maintenance staff inspected all light fixtures on the</p>	07/19/2013

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	<p>black dust. These ceiling vents were observed to be directly above resident dining tables.</p> <p>In a interview with Housekeeper #1 on 6/19/13 at 8:50 a.m., she indicated "On Wednesdays we do power cleaning in which 3 of us come in here and dust and wipe down everything. We try to sweep the vents and the ceiling around the vents as we can. If we can't get it clean, the we notify maintenance to come and paint so it looks better."</p> <p>At 9:08 a.m., the unit coordinator presented a copy of the facility's current policy titled "Cleaning Schedules." Review of this policy at this time included, but was not limited to: "Policy Statement: Cleaning schedules are developed and implemented to ensure that our facility is maintained in a clean and comfortable manner. Policy Interpretation and Implementation: 1. Cleaning schedules are developed and implemented to assure that each area of our facility is maintained in a safe, clean, and comfortable manner..."</p> <p>In an interview with the Director of Maintenance on 6/19/13 at 9:15 a.m., he indicated that he and his staff were</p>		<p>day of survey 6/18/13 and removed all insects inside of light fixtures. Maintenance will monitor all ceiling light fixtures for insects weekly and remove as necessary. All staff will be in-serviced that they are to put in work orders for maintenance if lights are observed to have insects inside the covers by 7/19/13. Maintenance Director/designee will monitor light fixtures weekly and report findings at monthly QA meetings. No residents were affected by the alleged deficiency. Maintenance Director/designee will audit all entry doors for peeling, chipped paint, or gouges to be painted and repaired by 7/19/13. All doors will be audited monthly by maintenance supervisor/designee to ensure compliance. This will be reported monthly by maintenance supervisor/designee at monthly QA meetings. All staff to be in-serviced to put in work orders when chipped, peeling paint, and gouges appear by 7/19/13. No residents were affected by the alleged deficiency. All cracked and water stained ceiling tiles were replaced by maintenance on the day of survey. A monthly audit by maintenance staff to include cracked and water stained ceiling tiles will be conducted to ensure compliance and findings will be reported at monthly QA meetings by Maintenance Director/designee. All staff will be in-serviced by 7/19/13 to report all</p>				

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	<p>not as up to date with the cleaning tasks of the ceiling vents and light fixtures as needed, especially after the recent fire. When shown the inside of the ceiling vents, he indicated that he would have to get them professionally cleaned.</p> <p>At 9:20 a.m., the housekeepers were observed to be sweeping the ceiling around the vents with dust flying around, but the dark dust remained on the ceiling.</p> <p>2. On 6/18/13 between the hours of 2:00 p.m. and 3:00 p.m. the following was observed:</p> <p>First floor ceiling light fixtures in hallways had dust accumulated on</p>		<p>cracked/water stained ceiling tiles by filling out maintenance work orders. There were no residents affected by this alleged deficiency. The peeling wallpaper will be repaired by 7/19/13. Maintenance Director/designee will audit all areas of wallpaper monthly to ensure compliance. All staff will be in-serviced by 7/19/13 regarding the need to process work orders when peeling wallpaper is observed. All areas of wallpaper were audited by maintenance and no other areas were identified. Results of monthly audits will be reported by Maintenance Director/designee at the monthly QA meetings. No residents were affected by the alleged deficiency. Facility work orders policy/system will be in-serviced to all staff 7/19/13. Maintenance Director/designee and Administrator/designee will review all work orders daily Monday through Friday. Work order system will be monitored by Maintenance Director/designee and Administrator daily. Maintenance Director/designee will report monthly work order efficiency at QA meetings. No residents were affected by the alleged deficiency.</p>	

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	<p>outside of the light covering. Dead insects were observed on the inside of light coverings.</p> <p>Entry doors leading into Rooms 2126, 3127, 3201A, 3210, and 3211 had peeling, chipped paint, and gouges from middle to bottom of doors. Second floor nurse's station entry door had cracked and chipped paint.</p> <p>Ceiling tiles were cracked between room 3304 and 3306B.</p> <p>Water stains were observed on ceiling tiles, where ceiling meets wall, on second floor between Room 3210 and 3208B.</p> <p>Peeling wall paper was located near "up/down" button on wall next to elevator on first floor.</p> <p>The Director of Maintenance indicated, during an interview on 6/19/13 at 9:15 a.m., that maintenance cleans hall lights every 3 to 6 months. "Hall lights were cleaned a couple weeks ago." The Director of Maintenance further indicated the procedure to have something cleaned or fixed was for resident or staff to call in an order to his department. "The ceiling tiles were supposed to be corrected. I (Director of Maintenance)</p>			

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	<p>told staff to fix." He indicated a maintenance staff person is not doing repairs as ordered and he (Director of Maintenance) was "working on the issues."</p> <p>During an interview, 6/19/13 at 10:47 a.m., the Director of Maintenance indicated "The torn wallpaper around the elevator is due to the fire they (the facility) had months ago." He had not seen it and no one had brought it to his attention.</p> <p>On 6/19/13 at 9:08 a.m., review of "Maintenance Service Policy Statement" indicated: "The maintenance department is responsible for maintaining the buildings in good repair...providing routinely scheduled maintenance service to all areas...others that may become necessary or appropriate."</p> <p>On 6/19/13 at 10:19 a.m., record review of "Maintenance Policy and Procedure" indicated: "Any work order that has not been completed after two days will be handed over to the Administrator by the receptionist for follow-up...Administrator will meet with Maintenance Supervisor on all uncompleted work orders for justification and action plans."</p>						

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	<p>On 6/19/13 at 10:19 a.m., review of "Maintenance Employee Job Description" indicated: "All tasks assigned will be completed in a prompt, efficient, and safe manner...ability to take instructions and follow established procedures."</p> <p>On 6/19/13 at 10:19 a.m., review of Service Request and Work Order dated 4/25/13 indicated a request to paint overhead in activity room. Record review of Work Order dated 6/14/13 indicated a 2nd request for the above order.</p> <p>3. During a tour of the kitchenette and nourishment room off the main dining room on 6/19/13 between 8:30 a.m. and 9:00 a.m., the following was observed:</p> <ul style="list-style-type: none"> - 4 of 4 lower cabinets in the kitchenette had food crumbs and debris in the front of the cabinets when the doors were opened. - 3 of 3 light fixtures above the steam table had brownish sticky dust on top of the light fixtures, the hanging poles and the round fixture attachment to the ceiling. The 3 lamp shades had brown/tan streaks on them. - the sprinkler head above the steam table was observed to have a heavy 			

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	<p>coating of brown greasy dust covering it which swayed in the breeze of the running ceiling vent.</p> <p>- the ceiling vent above the counter which held the resident dishes and microwave had a heavy coating of brownish dust inside the vent slats.</p> <p>- the ceiling vent directly above the ice machine in the nourishment room next to the kitchenette had a heavy coat of gray dust covering the vent slats and was observed to be running at the time.</p> <p>During an interview with Housekeeper #1 on 6/19/13 at 8:50 a.m., she indicated "Dietary was responsible for anything that had to be cleaned inside the kitchenette as we are not allowed in there."</p> <p>During an interview with Dietary Aide #3 on 6/19/13 at 8:55 a.m., she indicated "Maintenance was responsible for cleaning all vents and light fixtures. We clean the cabinets in the kitchenette. I am usually the one who does it weekly but there is no specific cleaning schedule for it and I do it on different days as I can."</p> <p>During an interview with the Assistant Dietary Manager on 6/19/13 at 9:10</p>			

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	<p>a.m., she indicated that the ceiling vents in the kitchenette and the nourishment room did need to be cleaned as well as the cabinets.</p> <p>In an interview with the Director of Maintenance on 6/19/13 at 9:15 a.m., he indicated that he and his staff were not as up to date with the cleaning tasks of the ceiling vents and light fixtures as needed, especially after the recent fire.</p>			

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R000298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the consultant pharmacist made recommendations regarding inaccurate medication labeling for 1 of 5 residents observed during 1 of 2 medication passes. (Resident #10)</p> <p>Findings include: On 6-19-13 at 8:40 a.m., during a medication administration observation for Resident #10, observation of the container for the residents Detrol indicated "Detrol 1mg by mouth daily". LPN #2 indicated the resident actually gets the medication every other day. She indicated "The box is wrong." The same situation was noted for the Mucinex. The container reads</p>	R000298	Please consider paper compliance for R298Resident #101. Corrective action for the resident found to be affected by the alleged deficient practice:It is the policy of Westminster Assisted Living to ensure all residents have the correct medication, correct dosage and strength, given at the correct time and route.2. To identify other residents having the potential to be affected by the alleged deficient practice and corrective action for the alleged deficient practice:Resident #10 was given the correct dosage at the right time every other day according to the MAR.All residents have the potential to be affected by the alleged deficiency.The licensed staff and QMA's were in-serviced by the facility pharmacy consultant on 6/25/13. All	07/19/2013			

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	<p>"Mucinex 600mg by mouth daily". The nurse indicated the medication is given every other day.</p> <p>During review of Resident #10's medical chart on 6-19-13 at 8:55 a.m., the orders read: Detrol 1mg [milligrams] po [by mouth] every other day ordered on 5-8-12; Mucinex 600mg [milligrams] po [by mouth] every other day ordered on 5-8-12. No pharmacy review was noted to indicate any discrepancies were seen between what was ordered by the doctor and what was printed on the medication containers. There was no recommendation from the reviewing pharmacist to change the medication containers due to being incorrect. The last pharmacy review was conducted in May 2013.</p> <p>During an interview with LPN #3 on 6-19-13 at 9:15 a.m., she indicated the process for checking in medications from pharmacy includes 2 nurses checking the medications, one nurse has the container of medications and one nurse has the shipping manifest. They check the medication, the milligrams and the quantity of each medication. When asked if the route and how often the medication was to be given were checked, she indicated not at this</p>		<p>licensed staff and QMA's will be in-serviced by by 7/19/13 on Mediacion Administration, cart inspections, and Medication Label to MAR to Chart matching. Medication pass audit on all licensed staff and QMA's will be completed to ensure the 3 check system is being used during mediacion administration. Completion date: 7/19/13. Complete audit on all residents for matching Label to MAR to Chart was completed by Director of Assisted Living and/or designee. Completed 7/2/13. Pharmacy Consultant will continue to have random inspection of medication storage areas, cart, and rooms at least every 60 days to check for proper storage, cleanliness, and dating of medications. This is a random check, not a three way audit, nor complete check of all medication on the Assisted Living Unit.No residents have been affected by alleged deficiency.3. Measures that will be put into place to or systmic changes that will be made to ensure that the deficient practice does not recur.Revised policy and procedure for medication delivery and proper labeling wrote 6/20/13 with in-service given 6/25/13. Copy of pharmacy manifest to be given to each charge nurse or QMA upon delivery of medication. Charge nurse/QMA to check each medication received with Label to MAR to Chart before placing</p>		

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	<p>time. She indicated that the medications are then placed on the nurse's medication cart and the nurse puts them away. She indicated that the nurse checks the container against the doctor's order on the MARs [medication administration record].</p> <p>During an interview with LPN#4 on 6-19-13 at 9:30a.m., she indicated if there is an issue when cross checking the container of medications with the MAR's, they [the nurse] immediately call the pharmacy to verify the order and what was sent or call and verify the order with the doctor. When shown the container for the Mucinex and the Detrol, LPN#4 retrieved the resident's medical chart and verified that the order is written for both medications to be given every other day and she verified that the containers for both medications read daily. She indicated she would call the doctor right away and clarify the medications.</p> <p>On 6-19-13 at 9:50a.m., LPN#4 indicated she spoke to Resident #10's doctor and the order was clarified for the Detrol and placed a new sticker on the container and a new order to discontinue the Mucinex was received.</p>		<p>medication in the Med Cart. Copy of manifest with licensed staff or QMA signature declaring medication label has been checked and correct is to be given to Director of Assisted Living/Designee.4. Corrective actions will be monitored to ensure the deficient practice will not recur.Audit will be completed by the Director of Assisted Living/designee on three medications delivered each day Monday through Friday, except Holidays to ensure Label to MAR to Chart checks are being completed correctly.All audits will be combined into a monthly report. The finding will be reported at the Quality Assurance Committee Meeting.5. Dat the systemic changes will be completed: 7/19/13.6. Westminster Assisted Living would like to request paper compliance to be considered for this tag: 7/19/13.</p>				

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	Review of the policy and procedure for 'Ordering and Receiving Non-Controlled Medications' on 6-19-13 at 10:30a.m., indicate when receiving medication from pharmacy that the facility 'verifies medications received with the prescribers orders, promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor'. The Mucinex was received on 5-10-13 and the label was incorrect and was not verified or corrected. The Detrol was received on 6-3-13 and the label was incorrect and was not verified or corrected.			

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R000301	<p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, record review and interviews, the facility failed to ensure proper labeling of medication for 1 of 5 residents observed during 1 of 2 medication passes. (Resident #10)</p> <p>Findings include:</p> <p>On 6-19-13 at 8:40a.m., during a medication administration observation for Resident #10, observation of the container for the residents Detrol indicated "Detrol 1mg by mouth daily". LPN #2 indicated the resident actually gets the medication every other day. She indicated "The box is wrong." The same situation was noted for the Mucinex. The container reads "Mucinex 600mg by mouth daily". The nurse indicated the medication is</p>	R000301	Please consider paper compliance for R301. Resident #101. Corrective action for the resident found to be affected by the alleged deficient practice:It is the policy of Westminster Assisted Living to ensure all residents have the correct medication, correct dosage and strength, given the correct time and correct route.2. To identify other residents having the potential to be affected by the alleged deficient practice and corrective action for the alleged deficient practice:Resident #10 was given the correct dosage at the correct time of every other day according to the MAR.On 6/19/13 the physician was notified at time of alleged deficiency to verify the two orders as being every other day. A direction change label was placed on the Detrol. Mathes Pharmacy was	07/19/2013			

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	<p>given every other day.</p> <p>During review of Resident #10's medical chart on 6-19-13 at 8:55a.m., the orders read: Detrol 1mg [milligrams] po [by mouth] every other day ordered on 5-8-12; Mucinex 600mg [milligrams] po [by mouth] every other day ordered on 5-8-12. No pharmacy review was noted to indicate any discrepancies were seen between what was ordered by the doctor and what was printed on the medication containers. There was no recommendation from the reviewing pharmacist to change the medication containers due to being incorrect. The last pharmacy review was conducted in May 2013.</p> <p>During an interview with LPN #3 on 6-19-13 at 9:15a.m., she indicated the process for checking in medications from pharmacy includes 2 nurses checking the medications, one nurse has the container of medications and one nurse has the shipping manifest. They check the medication, the milligrams and the quantity of each medication. When asked if the route and how often the medication was to be given were checked, she indicated not at this time. She indicated that the medications are then placed on the nurse's medication cart and the nurse</p>		<p>notified of their error and the original physician's order for Detrol was faxed to Mathes. The Mucinex was discontinued at that time of physician notification. All residents have the potential to be affected by alleged deficiency. The licensed staff and QMA's were in-serviced by the facility pharmacy consultant on 6/25/13. All licensed staff and QMA's will be in-serviced by 7/19/13 on Medication Administration, cart inspection and Medication Label to MAR to Chart matching. Medication pass audit on all licensed staff and QMA's will be completed to ensure the 3 check system is being used during medication administration. Completion date: 7/19/13. Complete audit on all residents for matching Labels to MAR to Chart was completed by Director of Assisted Living and/or designee. Completion date: 7/2/13. No residents have been affected by the alleged deficiency. Measures that will be put in place to or systemic changes that will be made to ensure the deficient practice does not recur: Revised policy and procedure for medication delivery and proper labeling wrote 6/20/13 with in-service given 6/25/13. Copy of pharmacy manifest to be given to each charge nurse or QMA upon delivery of medication. Charge nurse to check each medication received with Label to MAR to Chart before</p>	

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	<p>puts them away. She indicated that the nurse checks the container against the doctor's order on the MARs [medication administration record].</p> <p>During an interview with LPN#4 on 6-19-13 at 9:30a.m., she indicated if there is an issue when cross checking the container of medications with the MAR's, they [the nurse] immediately call the pharmacy to verify the order and what was sent or call and verify the order with the doctor. When shown the container for the Mucinex and the Detrol, LPN#4 retrieved the resident's medical chart and verified that the order is written for both medications to be given every other day and she verified that the containers for both medications read daily. She indicated she would call the doctor right away and clarify the medications.</p> <p>On 6-19-13 at 9:50a.m., LPN#4 indicated she spoke to Resident #10's doctor and the order was clarified for the Detrol and placed a new sticker on the container and a new order to discontinue the Mucinex was received.</p> <p>Review of the policy and procedure for 'Ordering and Receiving</p>		<p>placing mediation in Med Cart. Copy of manifest with licensed staff or QMA signature declaring medication label has been checked and correct is to be given to the Director of Assisted Living/Designee.4. Corrective actions will be monitored to ensure the deficient practice will not recur.Audit will be completed by the Director of Assisted Living/designee on three medications delivered each day, Monday through Friday, except Holidays to ensure Label to MAR to Chart checks are being completed correctly.Audit will be completed quarterly by the Director of Assisted Living/designee on all resident's medication by using the Label to MAR to Chart.All audits will be combined into a monthly report. The findings will be reported at the Quality Assurance Committee Meeting.5. Date the systemic changes will be completed: 7/19/13.6. Westminster Assisted Living would like to request paper compliance to be considered for this tag. 7/19/13.</p>		

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	<p>Non-Controlled Medications' on 6-19-13 at 10:30a.m., indicate when receiving medication from pharmacy that the facility 'verifies medications received with the prescribers orders, promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor'. The Mucinex was received on 5-10-13 and the label was incorrect and was not verified or corrected. The Detrol was received on 6-3-13 and the label was incorrect and was not verified or corrected.</p>			