STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE MANOR NURSING HOME	1109 E NATIONAL HWY WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Recertification and State Licensure survey. Survey dates: April 15, 16, 17, 18, and 19, 2013. Facility number: 000303 Provider number: 155708 Aim number: 100287530 Survey team: Carole McDaniel RN TC Martha Saull RN Dorothy Watts Terri Walters RN 4/18/13 and 4/19/13 Census bed type: SNF: 3 SNF/NF: 37 Total: 40 Cenus payor type: Medicare: 2 Medicaid: 32 Other: 6 Total: 40 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 1, 2013, by Jodi Meyer RN	F000000	Please accept the following as our credible allegation of substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation, interview, and record review, the facility failed to ensure past federal survey reports were readily available for resident viewing for 5 of 5 survey days. Findings include: On initial tour of the facility on 4/15/13 at 6:45 P.M., the annual State Board of Health surveys dated for the years 2012, 2011, and a complaint survey report dated for the year 2013 were observed in the front hall of the facility on a bulletin board. The reports had been connected to the bulletin board by push pin tacks and were hanging off the bulletin board at approximately a 45 degree angle. Each report had a cover sheet page indicating the year of the survey	F000167	Hillside Manor Nursing Home shall continue to make the results of past surveys accessible to residents. Hillside Manor will attempt to satisfy the experienced surveyor by hanging the past survey reports in a "labeled" binder and hanging them directly above the corridor handrail and directly below the information corkboard, located directly across from the residents activity calender. The survey reports were moved before the survey team left the building on 4-19-13.This deficient practice does not apparetnly effect any residents, guests, or previous surveyors and no one has ever complained or suggested they were not accessible or readable. The survey reports would/will have to be removed from the pin or hook holding them onto the board and thus, it doesn't seem that it would make any difference if it was hanging at a 45 degree angle or straight. The reports will be available in the same format	05/15/2013

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	report in large hand written printing. The 1/2 top portion of the 2012 survey report had been partially covered by a facility staffing documentation obstructing the viewing of the the report. The reports were a small typed print on a 8 1/2 x 11 inch paper with the pages stapled together on the upper the left hand corner. The survey reports were positioned approximately 4 feet off the ground. The reports remained on the bulletin board all survey days (4/15, 16, 17, 18, 19/13). On 4/19/13 at 9:10 A.M., the Administrator was made aware of the survey reports not being easily accessible for residents in wheelchairs to remove from the tacks to read and/ or to read the report hanging from the bulletin board at an angle. The Administrator indicated at that time she would remove the survey reports from hanging off the bulletin board for astethetic purposes. 3.1-3(b)(1)		sent to the facility from the ISDH and the only changes will include the applicable plan of correction listed for each deficient practice. The changes made to the survey report binders and accessibility will be discussed in the next 3 months of resident council meetings.This procedure shall be monitored by the Administrator for the next 12 months who also shall be responsible for proper compliance.	

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F000225	Hillside Manor Nursing Home	05/15/2013

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	Based on interview and record review, the facility failed to ensure prompt reporting of allegations of abuse to the State Survey Agency for 3 of 3 allegations of abuse investigations reviewed. Resident #5, Anonymous Resident, Resident #100 Findings include: 1. On 4/17/13 at 11:09 A.M., the Health Care Administrator (HCA) provided a copy of the facility's incident report form from an incident that occurred on 4/25/12 alleging a CNA had been verbally abusive with a resident in the dining room. The incident reporting form was lacking documentation of the time the incident was reported to the Indiana State Department of Health (ISDH). The incident was reported to the ISDH on 4/26/12. 2. On 4/18/13 at 9:52 A.M., the HCA provided a copy of an incident report form outlining the facitility's investigation concerning an allegation of verbal abuse by a CNA towards Resident #5 in the dining room. The allegation was reported to the survey team by Resident #5's roommate. The abuse allegation was reported to the HCA		shall report any allegations of abuse to the ISDH "immediately", not to exceed 24 hours. Hillside Manor will not and does not employ any employee with a police or court record of abuse. A police background and state nurse aide registry is consulted before employment. No residents have been adversely effected by the alleged deficient practice of not "immediately" reporting any allegations. A new Abuse policy was implemented that reads, "Upon notification of an allegation of abuse/neglect, the administrator or designee shall "immediately" meaning as soon as possible, but ought not to exceed 24 hours after discovery of the incident, notify the ISDH via fax/email/telephone of the allegation". The three allegations brought forward by the ISDH surveyor were all investigated and found to NOT be substantiated allegations of abuse. Two reports that were faxed on the morning of 4-18-13 were reported as not being located in the "ISDH system" by Jodi Myer, RN as of 4-26-13, were re-sent via email on 4-10-13 by Julie Chapman, HFA. The same two reports were faxed to the area Ombudsman on 4-18-13 at approximately 9:05 am and the Administrator recieved a phone call from the Ombudsman approximatley 15 minutes later to discuss the allegations, thus proving that the faxes were attempted and recieved by one	

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	on 4/17/13 at 6:30 P.M. The time the incident was reported to ISDH was not documented. 3. On 4/18/13 at 9:52 A.M., the HCA provided a copy of an incident report form from an incident that had been reported to the HCA by the survey team on 4/17/13. The allegation of abuse was made by a resident who wished to remain anonymous. The resident indicated that a staff member at the facility had yelled at the resident. The resident indicated that the staff member no longer worked at the facility. The anonymous allegation of abuse was reported to the HCA on 4/17/13 at 6:30 P.M. The time the incident was reported to the ISDH was not documented. During an interview with the HCA on 4/18/13 at 9:52 A.M., the HCA indicated that she had faxed 2 incident reports on 4/18/13 at 9:00 A.M. to the ISDH concerning Resident #5 and an Anonymous Resident. As of 4/26/13, no reports had been received at the Indiana State Department of Health. On 4/18/13 at 9:20 A.M., the facility's policy and procedure for abuse and neglect was reviewed. The policy and		party. A third report was faxed later that evening when a surveyor made another allegation of abuse and that report was recieved by the ISDH. When possible, the Administrator will attempt to send reports via email as to maintain a time and date stamp of information sent to ISDH. An in-service was conducted to all employees on 4-25-13 and 5-9-13 regarding the immediate reporting of any allegation ofabuse to the administrator or designee. The proper compliance of this procedure shall be the resonsibility of the Administrator who will over-see its compliance indefinatley. All reportable incidents will be reviewed by the Quality Assurance Committee.	

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	procedure for abuse and neglect was as follows: "...Allegation of abuse/neglect are to be reported to the Indiana State Department of Health and the area Ombudsman." There were no time frames outlined in the facility's policy and procedures for reporting to the ISDH or the Ombsuman. During an interview with the Health Care Administrator (HCA) on 4/18/13 at 9:52 A.M., the HCA indicated she routinely faxed all abuse allegations to the state within 24 hours of those reports being reported to her. The HCA indicated she was under the impression a facility had up to 24 hours to report an allegation. The HCA was made aware that the regulations for reporting allegations of abuse, according to the Centers for Medicare and Medicaid, were as follows: "Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident...". The HCA indicated she would update the facility's Policy and Procedure to reflect that requirement. 3.1-28(c)			

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F000226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to develop policies and procedures to report allegations of abuse in a prompt and timely manner to the Indiana State Department of Health. Findings include: 1. On 4/17/13 at 11:09 A.M., the Health Care Administrator (HCA) provided a copy of the facility's incident report form from an incident that occurred on 4/25/12 alleging a CNA had been verbally abusive with a resident in the dining room. The incident reporting form was lacking documentation of the time the incident was reported to the Indiana State Department of Health (ISDH). The incident was reported to the ISDH on 4/26/12. 2. On 4/18/13 at 9:52 A.M., the HCA provided a copy of an incident report form outlining the facitility's	F000226	Hillside Manor Nursing Home shall develop and implement an abuse policy and procedure that prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident property.Hillside Manor Nursing Home has re-written the Policy and Procedure regarding abuse and "reporting" abuse to the ISDH to include the following language, "Upon notificiation of an allegation of ause/neglect, the administrator or designee shall "immediately" meaning as soon as possible, but ought not to exceed 24 hours after discovery of the incident, notifiy the ISDH via fax/email/telephone of the allegation" and also include the TIME the incident was reported to the facility and the TIME it was reported to the ISDH. Hillside Manor will not and does not employ any employee with a police or court record of abuse. A police background check and state nurse aide registry is consulted before employment. No residents have been adversely effected by the deficient practice. The three allegations brought forward by the ISDH surveyor were all investigated and found to	05/15/2013

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	investigation concerning an allegation of verbal abuse by a CNA towards Resident #5 in the dining room. This allegation was reported to the survey team by Resident #5's roommate. The abuse allegation was reported to the HCA on 4/17/13 at 6:30 P.M. The form was lacking documentation of the time the incident was reported to ISDH. 3. On 4/18/13 at 9:52 A.M., the HCA provided a copy of an incident report form from an incident that had been reported to the HCA by the survey team on 4/17/13. The allegation of abuse was_ made by a resident that wished to remain anonymous. The resident indicated one staff member at the facility had yelled at the resident and that staff member no longer works at the facility. The anonymous allegation of abuse was reported to the HCA, on 4/17/13 at 6:30 P.M. The incident form was lacking documentation of the time the incident was reported to the ISDH. During an interview with the HCA on 4/18/13 at 9:52 A.M., the HCA indicated that she had faxed the 2 incident reports on 4/18/13 at 9:00 A.M. to the ISDH concerning Resident #5 and an Anonymous		NOT be substantiated allegations of abuse. Two reports that were faxed on the morning of 4-18-13 were reported as not being located in the "ISDH system" by Jodi Myer, RN as of 4-26-13, were re-sent via email on 4-10-13 by Julie Chapman, HFA. The same two reports were faxed to the area Ombudsman on 4-18-13 at approximately 9:05am and the Administrator recieved a phone call from the Ombudsman approximately 15 minutes later to discuss the allegations, thus proving that the faxes were attempted and recieved by one party. A third report was faxed later that evening when a surveyor made another allegation of abuse and that report was recieved by the ISDH. When possible, the Administrator will attempt to send reports via email as to maintain a time and date stamp of information sent to ISDH. An in-service was conducted to all employees on 4-25-13 and 5-9-13 regarding the immediate reporting of any allegation of abuse to the administrator or designee. The proper compliance of this procedure shall be the responsibility of the Administrator who will over-see its compliance indefinately. All reportable incidents will be reviewed by the Quality Assurance Committee.	

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	Resident. As of 4/26/13, no reports had been received at the ISDH office. On 4/18/13 at 9:20 A.M., the facility's policy and procedure for abuse and neglect was reviewed. The policy and procedure for abuse and neglect was as follows: "...Allegation of abuse/neglect are to be reported to the Indiana State Department of Health and the area Ombudsman." There were no time frames outlined in the facility's policy and procedures for reporting to the ISDH or the Ombudsman. During an interview with the Health Care Administrator (HCA) on 4/18/13 at 9:52 A.M., the HCA indicated she routinely faxed all abuse allegations to the state within 24 hours of those reports being reported to her. The HCA indicated she was under the impression a facility had up to 24 hours to report an allegation. The HCA was made aware that the regulations for reporting allegations of abuse, according to the Center for Medicare and Medicaid, were as follows: "Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident...". The HCA indicated she would update the facility's Policy and			

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	Procedure to reflect that requirement. 3.1-28(a) 3.1-28(c)			

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F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a resident's dignity was maintained during toileting in 2 of 3 common bathroom/shower rooms for 2 of 19 residents, residing on the front hall unit and the back hall unit who utilized the shower room. Resident #14, Resident #33 Findings include: 1. During initial tour of the facility on 4/15/13 at 6:45 P.M., the north hall shower/bathroom was observed. There were resident rooms located on either side of the bathroom/shower room; residents, staff and/or visitors could be observed passing by the room in the hallway. The shower room was a communial shower/bathroom and had recently been remodeled. The door was observed to open from right to left. The toilet was observed to the right of	F000241	Hillside Manor Nursing Home will promote the care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Hillside Manor's public shower/bathrooms were constructed in such a manner that a residents privacy and dignity may be breached if the door was opened during use. This deficient practice was corrected when three of three bathrooms/shower rooms had cubicle/privacy curtains were to shield each resident. 1. The South shower/bathroom unit has had a North/South cubicle curtain installed in front of the toilet and shower area to provide privacy during toileting and dressing/undressing to get into/out of the shower. 2. The Middle Hall shower/bathroom unit has had a north/south cubicle curtain installed in front of the toilet and shower area to provide priacy during toileting and dressing/undressing to get into/out of the shower.3. The north shower/bathroom unit has had a west/east cubicle curtain installed in front of the shower opening to shield residents during	05/15/2013

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	the entrance. The shower area was observed directly straight from the location of the door. Privacy curtains were lacking in the bathroom. On 4/17/13 at 10:25 A.M., in the north hall shower/bathroom, CNA #34 was observed opening the door to the bathroom. The door opens from the right side to the left. The toilet in the bathroom was observed to be on the right side of the room. At that time, a resident was easily viewed sitting on the toilet with her pants down. CNA #35 was observed standing beside the resident. At 10:30 A.M., CNA #35 pushed the resident out of the bathroom and back to the north dining room. At that time, the resident was identified by CNA #35 as Resident #14. 2. On 4/17/13 at 8:55 A.M, CNA # 23 entered the shower room located on the back hall. The CNA opened the door where Resident #33 was clearly observed through the doorway, from the hall, being assisted by 2 other CNAs with toileting. No privacy curtains were located at the entrance to the shower room to provide privacy for residents who were toileting or dressing after a		the shower process or while getting dressed/undressed. In addition, another cubicle curtain was installed around the toilet to shield the resident, and it runs from the entry door to the east wall of the bathroom.An inservice was held on 4-25-13 and 5-9-13 with all personnel to discuss residents privacy and dignity. The staff was provided examples of how a resident privacy may be breached if the door was opened or cracked, without having pulled the cubicle curtain. Staff was instructed about three of three bathrooms/shower rooms.The A.D.O.N. shall observe for proper use of the privacy curtains 5 days per week over the next 6 months.	

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	shower. When the door to the shower room was opened, there was no curtain to shield the view of the shower entry or the commode. On 4/19/13 at 4 P.M., the Administrator was made aware of the concern of residents being visible on the toilet from the hall by passerbys. She indicated they would fix this issue. 3.1-3(t)			

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F000279 SS=E	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. 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. 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).			
	A. Based on record review, and interview, the facility failed to develop comprehensive care plans to address symptoms and/or behaviors (for which psychotropic's were given) with measurable goals, time frames and interventions specific to individual resident needs for 4 of 10 residents reviewed for unnecessary drugs. Resident #17 Resident #5 Resident #40 Resident #42 B. Based on observation, interview	F000279	The corrective action taken for those residents found to be affected by the deficient practice is that Resident identified as # 17,#5,#40and #42 care plans and monthly behavior tracking were updated as 5-1-13 to address specific symptoms and/or behaviors for which psychotropic medications are given Resident #23's care plan was updated on 4-23-13 to include interventions with a desired goal to maintain a comfortable status. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* any	05/17/2013

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	and record review, the facility failed to ensure the plan of care for a Hospice resident experiencing pain included interventions to reflect the desired outcome for the resident to maintain a comfortable pain status for 1 of 1 residents reviewed for Hospice care. Resident #23 Findings include: A .1. The clinical record of Resident #17 was reviewed on 4/18/13 at 10:00 A.M. The resident had diagnoses which included, but were not limited to, dementia and anxiety disorder. The resident had been receiving an antidepressant drug, Lexapro 10 mg po (by mouth) daily since 6/15/12. The clinical record contained tracking of the targeted behavior of crying,the data was to be recorded for each shift. On 4/18/13 at 11:55 A.M., the SSD(Social Service Director) was interviewed regarding the residents depression. She indicated the resident did not present as depressed, but she missed her family. She indicated the resident forgot their visits and therefore, thought they had not visited.		resident that receives Psychotropic medications and or experiences pain has the potential to be affected by the same deficient practice. A house wide reassessment will be completed by DON, ADON and Social Services to ensure that all Care plans and Monthly Behavior Tracking logs are specific to the resident's behaviors for the medication use. All residents experience pain, care plans will be updated to include interventions and a desired outcome. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that A Monthly Behavior / Psychotropic Medication Review will be conducted with consult Pharmacists, DON, Social Services and ADON. The team will review the residents Specific Behaviors being monitored and medications due for GDR. Care plan will be updated accordingly. All residents pain assessments will update and care plan updated according to the finding of assessment. An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing residents with behaviors and tracking methods and pain interventions according to the plan of care. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality	

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	The resident also was receiving Lorazepam (for anxiety) 1 mg po QD since 12/14/10. The clinical record contained tracking of the target behavior "anxiety" on a shift by shift basis. The tracking for January 2013, February 2013, and March 2013, indicated that no anxiety was noted. On 1/11/13, a physicians order was received for the Lexapro dose, it was doubled in strength. The 1/10/13, Minimum Data Set Assessment(MDS) for significant change and the 3/25/13, Quarterly MDS, both noted there had been no physical or verbal behaviors. The care plan, since 2/28/13,did not directly address the depression or the anxiety with specific interventions i.e. alternatives to drugs. It was a standardized general care plan, used whenever any resident was given any psychotropic. The names of the drugs given to the resident were filled in. The care plan included, "Resident currently on psychotropic medications for antianxiety and antidepressant. Lexapro for depression and Lorazepam for anxiety." The goal was " Resident will be on		Assurance tool has been developed and implemented to monitor the tracking of the resident with behavior symptoms and pain to ensure a care plan is in place and specific to the resident for a desirable outcome. This tool will be completed by the DON/designee daily for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 17, 2013**Quality Assurance Tool F – 279 Care plan development of Specific behaviors and pain care plans DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR PATIENTS COMMENTS** **1 2 3 4 5 6 7 8** 1. The resident with Psychotropic medications have specific behaviors on tracking log and care plan	

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	the lowest dose possible of medication as ordered by the physician through next review." The interventions related to the goal were: " Work with physician on reduction to assure symptoms are controlled on the lowest dose possible.", "Utilize alternative interventions to assist with symptoms the resident may exhibit prior to the use of any prn (as needed rather than routinely administered) medications" and " Notify physician of any negative reactions related to the medication usage." The care plan lacked specific intervention to address either anxious or depressed behaviors or the resident's inability to recall visits. A. 2. The clinical record of Resident #5 was reviewed on 4/18/13 at 1:00 P.M. The resident had been receiving Lexapro 10 mg po QD since 9/7/10. On 3/7/13, a pharmacy recommendation for reduction was faxed to the physician. On 3/13/13, the physician ordered double the dose, Lexapro 20 mg daily. The behavior tracking log listed "crying" as a targeted indicator on a		2. The residents experiencing pain receives pain medication and a follow for effectiveness is documented 3. There is a care plan in place to address the appropriate interventions to prevent/ manage pain	

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	shift by shift basis, although the behavior was not addressed on the corresponding care plan. Resident #5 was also receiving Ambien 5 mg po every night for insomnia since 6/20/12. The behavior tracking logs specified incidents of insomnia for assessment data on a shift by shift basis. Documentation in the clinical record was lacking to support any non drug interventions had been attempted prior to the onset of hypnotic drug use. Resident # 5 was also receiving Lorazepam 0.25 mg po TID (3 times per day) for anxiety since 6/15/12. The clinical record Behavioral tracking ,specified to be for incidents of anxiety, was documented every shift. The 3/15/13, quarterly MDS did not note behavioral symptoms related to moods or sleeplessness. The 2/28/13 Care plan for Resident #5 did not address anxiety or depression directly. It addressed psychotropic drugs as a concern or problem and named all three drugs			

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	above, Lexapro for depression, Ambien for insomnia and Lorazepam for anxiety. There were two goals set for the resident. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review." Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage." The care plan was standardized for any psychotropic medication and were non specific for the particular drug side effect or usage complications.			

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	The care plan did not specify interventions for the individual resident either as alternatives to drugs or as supportive interdisciplinary efforts to diminish doses and/or eliminate drug use. On 4/18/13 at 11:55 A.M., the SSD had been interviewed. She had indicated the tracking was being completed on specific behaviors every shift and she did review it for her progress notes. She indicated she was a contributing discipline to the care planning sessions but had only recently accepted her position. She indicated she could see how knowledge from assessing behavior incidents could be could be used, in consort with other disciplines, to develop specific interventions as adjuncts to drug use or means to decrease or eliminate drugs. . A. 3. The clinical record of Resident #40 was reviewed on 4/18/13 at 11:00 A.M. The resident was receiving Restoril for a year since an original order on 3/23/12 for Restoril 15 mg po for insomnia. The nurses notes from 3/1/12 to 3/23/12 were reviewed for incidents of insomnia. Documentation was lacking to identify why the hypnotic was started. Documentation was lacking to identify			

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	any non drug alternatives attempted to facilitate sleep. Behavior logs targeted sleeplessness for monitoring each shift after the hypnotic medication was started without sleeplessness recorded. The current care plan of 2/28/13, still did not address the problem of insomnia specifically. It did address use of three psychotropic medications, one being Restoril for insomnia, however, the goals and interventions were standardized and non specific to drug or resident. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review." Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to			

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	assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage." The care plan interventions were not developed for specific drugs or the individual resident. A. 4. The clinical record of Resident #42 was reviewed on 4/19/13 at 10:00 A.M. The resident had been receiving Xanax (drug for anxiety) 2 mg po at bedtime QD since 3/22/12. He was also receiving Seroquel (antipsychotic) 300 mg po QD since 3/6/12. The 2/28/13 Care plan for Resident #42 addressed psychotropic drugs as a concern or problem and named both drugs above, Seroquel and Xanax. There were two goals set for the resident. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review."			

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	Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage." The care plan was non specific to individual resident symptoms or particular to drug rather than drug category. A. 5. On 4/19/13 at 3:00 P.M., the Director of Nursing was informed of the care plan problems related to lack of non drug interventions or any specific interventions related to behaviors. She indicated she had been in her position less than a week at onset of survey but care plan development was an area she would be working on. B. On 4/18/13 9:07 A.M., CNA #30			

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	and #31 entered Resident #23's room to reposition her. As they turned the resident to her side, she stated "my ankle hurts." Both CNAs continued to turn the resident. On 4/18/13 at 12 P.M., LPN #20 was observed changing the resident's dressings. As LPN #20 was removing the resident's dressings to the right outer ankle, the resident was yelling "it hurts, it hurts." LPN #20 continued with the dressing changes. After applying skin prep to the two scabbed areas on the arch of the right foot, she replaced the heel bows as the resident was yelling "it hurts, it hurts." On 4/18/13 at 12:30 P.M., Resident #23 was observed receiving medications from LPN #20. During the medication administration, Resident #23 moaned out, "My ankle hurts." LPN #20 continued with the medication administration through the G (Gastrostomy) tube. On 4/18/13 at 12:50 P.M., during a g-tube feeding, Resident #23 cried out "my elbow hurts." The resident was observed lying on her right side at the time. LPN #20 did not stop to reposition or ask resident about the pain. A few minutes later the resident			

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	said "oh, my ankle still hurts." LPN #20 replied, " Well it should be getting better soon. That is why we put the medication on it everyday." On 4/19/13 at 8:09 A.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated the resident was able to relay pain by facial grimaces and "she will tell you." On 4/19/13 at 10:14 A.M., the ADON and DON (Director of Nursing) were interviewed. At that time, the DON reviewed the current MAR (medication administration record) and indicated the resident was not on anything routinely for pain. PRN (as needed) pain medication included the following: Morphine 15 mg, q (every) 3 hours as needed for pain and Tylenol 650 mg every 4 hours as needed for pain. At that time, the prn (as needed) medication record was reviewed. The resident had not been medicated for pain on 4/17/13 or 4/18/13. At that time, the DON indicated the Pain assessment recorded no pain. She indicated that was done in February and Hospice does the pain assessment weekly. A Hospice nurse note dated 4/17/13, indicated the following: "Full			

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	assessment complete with collaboration of FS (facility staff)...alert with confusion, c/o (complained of) right ankle pain. FS nurse notified..." A Hospice plan of care, dated 2/26/13 addressed the following problem: "Alteration in physical comfort, r/t (related to) disease process and pain." The plan of care had the following interventions dated 2/26/13: "Assess pain type, location, duration, non-verbal cues of pain, relief measures and responses to tx q visit and prn; educate caregiver to contact hospice for changes in level of comfort." On 4/19/13 at 11 A.M. a copy of the Hospice nurses note from 4/17/13 was reviewed. The note documented the following information: for pain scale indicated the resident had an occasional moan or groan, low level of speech with a negative or disapproving quality, location Right ankle. The form also indicated that current pain control medications were adequate and the prn medication is needed less than daily. Intervention was "unrelieved pain - call." The form also noted the caregiver (facility staff) were educated			

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	on pain medications and also on alternate pain management techniques. Documentation was lacking in the plan of care of specific alternate pain management techniques. On 4/19/13 at 2:15 P.M., the DON and the ADON were interviewed. She indicated the facility didn't have a pain care plan and the hospice care plan didn't really include alternative interventions to try prior to medicating and the care plan didn't specify to evaluate the pain medication for effectiveness. etc. The ADON indicated the order had been changed to have the Hospice nurse visits decreased to 1 -2 times a week. She indicated that was changed on 3/16/13, from a visit of 2-3 times a week. The Hospice care plan was not updated to reflect the change. 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a plan of care was followed in regards to psychoactive medication management and/or reductions for 2 of 10 residents reviewed for psychoactive medications (Resident #10 & Resident #23), and/or management of weight loss in a resident with a gastrostomy tube feeding for 1 of 1 resident reviewed for weight loss with a gastrostomy tube feeding (Resident #23). Resident #10, Resident #23 Findings include: 1. On 4/17/13 at 2 P.M., the clinical record of Resident #10 was reviewed. Diagnoses included, but were not limited to, depressive disorder, psychosis and insomnia. A plan of care which addressed the usage of Psychoactive medications was dated 2/28/13. The plan of care included, but was not limited to, the	F000282	The corrective action taken for those residents found to be affected by the deficient practice is that Resident identified as # 10 and #23 care plans and monthly behavior tracking were updated as of May 1, 2013 to address specific symptoms and/or behaviors for which psychotropic medications are given. There physicians were notified of deficient practices and new orders were recieved regarding justification for medication use.Resident #23's care plan was updated on 4-23-13 and placed on weekly weights. . 5/1/13 MD was notified of resident weight fluctuating new order was received to increase feeding. Residents weight on 4/30/13 =109.7# and 5/7/13 =114.8. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* any resident that receives Psychotropic medications and or experiences pain has the potential to be affected by the same deficient practice. A house wide reassessment will be completed by DON, ADON and Social Services to ensure that all Care plans and Monthly Behavior	05/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2013
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	following medications: Lorazepam (Ativan) to address anxiety Interventions included but were not limited to, the following: "monitor side effects and behaviors; work with physician on reduction to assure signs and symptoms are controlled on lowest dose." The current Consultant Pharmacist Drug Regimen Review, had monthly documentation for the year 2012 to the current month. The form indicated on 2/15/12 an "Ativan GDR." That was the only documentation regarding the drug regimen review related to the Ativan. On 4/19/13 at 2:20 P.M., the DON (Director of Nursing) was interviewed regarding medication GDR (gradual dose reduction) of the medication Ativan. She indicated she didn't see any evidence of reduction and/or GDR or justification to continue the Ativan. The current "Psychoactive and Sedative/hypnotic Utilization by Resident" form was provided by the DON at that time. The form indicated the resident was currently taking Ativan 1 mg po every day for anxiety. The form indicated the order date for the medication was 8/2/11.		Tracking logs are specific to the resident's behaviors for the medication use. All monthly weights will be obtained and reviewed by ADON any description will be reweighed and documented on the weight record as a reweigh. Any weights Up or down 3 or more will be reported to MD and placed on weekly weights to manage weight loss closely. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that A Monthly Behavior / Psychotropic Medication Review will be conducted with consult Pharmacists, DON, Social Services and ADON (IDT Team). The team will review the residents Specific Behaviors being monitored and medications due for GDR. Physician will be notified of all GDR due by DON/ADON. Care plans will be updated accordingly. . ADON/Designee will complete a Quality Assurance tool weekly to monitor tracking of weight losses and Physician responses to GDR An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing residents Specific behaviors, Gradual Reduction of medication and weight management according to the plan of care. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality	

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	2. The clinical record of Resident #23 was reviewed on 4/17/13 at 5 P.M. Diagnoses included but were not limited to the following: Alzheimer's dementia with psychotic features, vascular dementia with Lewy body dementia, poor cognition, depression and anxiety. A plan of care, dated 2/28/13, addressed the following concern: "Resident currently on psychotropic medications including: antianxiety, antipsychotic and antidepressant. " Interventions included but were not limited to the following: "work with physician on reduction to assure symptoms controlled on lowest possible dose." On 4/19/13 at 10 A.M., the DON and ADON were interviewed. The resident did have a feeding tube inserted on 2/22/13. The DON indicated the resident's medication included but were not limited to the following: Zoloft for depression; Risperdol for dementia and psychotic features; Remeron for an appetite stimulant and vascular dementia The DON indicated the pharmacy recommendations don't document any attempted GDR for Seroquel, Risperdal or Remeron. The DON		Assurance tool has been developed and implemented to monitor the tracking of the resident with weight loss and GDR are addressed by their physician to ensure a care plan is in place and specific to the resident for a desirable outcome. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The IDT team will met Second Monday of every month to review Psychotropic medications and behaviors. All care plan will be updated of any changes or recommendations documented The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 17 ,2013 **Quality Assurance Tool F – 282 Weight loss management/ Care plan of Behavior/ GDRDIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR PATIENTS**	

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	indicated the physician wasn't responding to the pharmacy recommendation of Zoloft and Remeron GDRs. At that time, the DON provided a copy of the "(name of facility) Behavior charting. The dates of the form ranged from 2/6/13 - 3/23/13. All three entries indicated the resident had not had any behaviors. At that time, the ADON and DON provided a current copy of the "Psychoactive and Sedative/Hypnotic utilization by resident" form. The form included but was not limited to the following: "resident was started on Remeron (antidepressant) on 8/10/12 at 30 mg q hs for weight loss and vascular dementia; Zoloft (antidepressant) started on 8/10/12 at 150 mg qd for vascular dementia with psychotic features; Risperdone (antipsychotic) 0.5 mg at noon and hs and 0.25 mg q 7 a.m. " Documentation was lacking in the clinical record of the care plan being followed in regards to a GDR and/or having ensured the lowest possible dose was administered to the resident. 3. On 4/17/13 at 5 P.M., the clinical		**COMMENTS** **1 2 3 4 5 6 7 8** 1. The resident with Psychotropic medications have specific behaviors on tracking log and care plan 2. If the resident due for a reduction, has it been reduced and or is there documented justification for reduction Does the care plan indicate changes? 3. There is a care plan in place to address the appropriate interventions to prevent/ manage Weight loss 4. Monthly weights completed and any resident Up or Down 3 # reported to physician/Family and charted in NN 5. Resident losing 3 or more # placed on weekly weights and intervention put in placed to prevent further weight loss Intervention placed on Care plan and C.N.A. assignment sheets	

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	record of Resident #23 was reviewed. Diagnoses included, but was not limited to, Alzheimer's dementia, status post cerebravoscular accident, vascular dementia with Lewy body dementia and gastrostomy tube (G-tube) placement on 2/22/13 and 3/9/13. The most recent MDS (minimum data set assessment) dated 2/21/13, indicated the following for the resident: severely impaired cognition, extensive assistance required for bed mobility and at risk for pressure ulcers. A Nutrition risk Data Collection and assessment form, dated 12/20/12, indicated the resident's usual body weight range was 122 lb - 129 lbs. (pounds). A facility care plan, dated 2/22/13, addressed the problem of "At risk for Altered Nutritional Status with G tube placement. Approaches included the following: "continue feedings per MD order, dietician to see et (and) evaluate; monitor placement q (every) shift and prn (as needed); notify MD of any significant changes; monitor G tube site q shift , check patency q use prn."			

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	A facility care plan, dated 2/22/13, addressed the problem of "Res (resident) at risk for wt (weight) loss r/t (related to) dementia/weakness and G tube placement." Interventions included the following: "weight monthly and weekly if needed prn; notify MD, dietary mgr (manager) and dietician of potential wt loss problems; jevity 1.2 - 1 can 4 x (times) day..." On 4/18/13 at 5 P.M., the current MAR (medication administration record) was reviewed. The MAR had the following tube feeding order printed "Jevity 1/2 can 4 x day with 90 ml (milliliters) water before and after meds/60 ml before and after meds." The word "Jevity" had a line drawn through it with the word "Fibersource HN (high nutrition) 1.2 cal" written above the Jevity. Also the words "meds" had been scratched out and meals written beside the second words "meds." Neither of these revisions were initialed, dated or timed. On 4/18/13 at 6 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated she had been employed at the facility since the fall of 2012. She indicated the resident had surgery on 2/22/13, the			

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	G tube was placed. At that time, the ADON indicated the facility was taking weekly weights on the resident, which began on 1/29/13. The weekly weights were documented as follows for the year 2013: 1/29=130 lb; 2/5=125 lbs; 2/12=120 lbs; 2/19=115 lbs; [G tube placed on 2/22/13]; 2/26=115 lbs; 3/5=101 lbs; G tube replaced on 3/9/13; 3/12= 104 lbs; 3/19=116 lbs.; 3/26=116 lbs and 4/2= 116.8 lbs. At that time, the ADON was interviewed as to the reason for the 14 lb weight loss from 2/26 until 3/5. The ADON indicated the following: "on 3/5/13 the physician was notified of excessive drainage to the G tube dressing" Documentation in the nurses notes (NN) on 3/5/13 at 9 P.M. indicated the following: "G tube drsg (dressing) changed d/t (due to) excessive drainage. Physician notified of drainage, new order received..." A physician order, dated 3/5/13 at 5			

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	P.M. indicated the following: "Hold feeding x (time) 1 (one), hold free water till A.M." NN dated 3/6/13 at 10 A.M. indicated the following: "...yellow drainage pouring from g-tube site...checked for residual et noted to have approximately 60 cc residual...meds (medications) flushes et feedings being held until (physician name) returns page." NN 3/6/13 at 1 P.M. indicated the following: "Hold feedings until 5 P.M., only give meds with water, updated MD after 5 P.M. today..." NN dated 3/6/13 at 6 P.M. indicated to "decrease free water...cut feeding to 1/2 can qid (four times a day)..." At that time, the ADON indicated on 3/9/13, the resident returned to the hospital to have a new feeding tube put into place. She indicated at that time, the flange portion of the G tube was not functioning properly. She explained the flange was a circular disc portion of the G tube, which was located below the level of the skin. She indicated the defective portion of the G tube had allowed tube feeding solution, which was instilled into the resident via the G tube, to "run back out" of the resident. The ADON indicated she doesn't know exactly the date the problem started with the			

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	tube feeding running out from the resident. The ADON indicated the malfunctioning flange on the G tube and the tube feeding running out of the resident was the reason for the 14 lb weight loss from 2/26 to 3/5. At that time, documentation was reviewed in the nurses notes for February and March 2013. The ADON indicted the first documented NN of the problem with the G tube leaking was on 3/5/13 at 9 P.M. At that time, the MAR (medication administration records) were also reviewed for March 2013. The ADON indicated documentation was lacking on the March MARS of a problem with the tube feedings leaking, until the feeding was held on 3/5/13. On 4/19/13 at 8 A.M., the DON provided copies of the Nutritional Progress notes. The Registered Dietician (RD) note dated 2/8/13 included but was not limited to, the following: "...will continue to monitor po (per os) intake, wt (weight)..." The next RD note was dated 3/1/13 and included, but was not limited to the following: "Res is now on Jevity 1.2 - 4 cans dly (daily)...Res with 60 cc water before et after meds (medications) et 300 cc water 8 x day			

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	to provide 2640 cc water flush daily, plus 768 cc water from feeding. Total 3408 cc dly (daily)...Res is tolerating feedings at this time to monitor TF (tube feeding) tolerance, wt (weight)..." The next documented Nutritional Progress note is dated 4/8/13 and included but was not limited to, the following: "RD Review: Orders reflect 1/2 can Jevity 4 x's daily, pureed diet, shakes bid, magic cups bid and protein powder bid. Current wt 99.4 lbs. Nursing reports good tolerance to feedings and flushes. Hospice status." On 4/19/13 at 9:30 A.M., the ADON and the DON were interviewed. They indicated the first documentation of the nurses notes indicating the tube feedings were running back out of the residents abdomen was on 3/6/13. The ADON indicated at that time, she doesn't know how long that was occurring. She indicated documentation was lacking in the medical record to indicate exactly how long that was occurring. She indicated the physician came to the facility and saw the resident on 3/8/13, but did not document progress notes. She also indicated the physician spoke to the dietician but			

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	did not document progress notes. She indicated at that time, she was unable to find documentation the physician was notified on 3/5/13 of the significant weight loss. On 4/19/13 at 10:40 A.M., the ADON and the DON (Director of Nursing) were interviewed. The ADON indicated the weights documented on the Weight record for the year 2013 were accurate. She indicated the weights for the month had been rechecked and the scale recalibrated but the rechecked weights had not been documented. At that time, the current policy and procedure titled "Nutrition Risk/Weight Loss" was received from the ADON and DON. The undated policy indicated the following: "It is the policy of (name of facility) to avoid all unplanned significant weight loss...Each resident will have a Nutritional Risk Assessment completed be the Dietician upon...with any significant change...Weights will be reviewed by Nursing Administration and the Dietician to identify any significant weight loss. Significant weight loss will be identified if the resident has a weight loss...of 5% in one month...Residents who have been			

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	identified with a significant weight loss/gain will have that information reported to their physician for additional interventions warranted..." At that time, the ADON provided nursing progress notes in monitoring the resident. The ADON's notes indicated the following: 2/26/13: still declining in overall health; 3/5/13: "Resident is currently on G tube feedings. Will continue with monitoring. Residents family is aware of significant weight loss et Hospice is also aware. MD is currently monitoring." Progress note from 3/12/13: "Resident this week having trouble with G tube had to have it replaced...Feedings have resumed et are doing better..." Progress note 3/19/13: "...weight is improving." The care plan was not followed in that documentation was lacking in the clinical record that the G Tube was monitored for placement q (every) shift and prn (as needed); and/or that the physician was notified of any significant changes, and/or the dietician had been notified of the leaking gastrostomy tube, prior to the 14 lb weight loss was noted on 3/5/13.			

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F000309 SS=G	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. A. Based on observation, interview and record review, the facility failed to ensure a Hospice resident had pain assessments completed, and/or interventions implemented to attempt pain reduction in response to repeated complaints of pain for 1 of 1 residents reviewed for Hospice care. Resident #23 B. Based on observation, interview and record review, the facility failed to ensure a resident's extreme leaning position in her recliner was assessed for 1 of 2 resident's assessed for positioning in a recliner. The facility failed to follow their policy and procedure for administering oral medication with at least 4 ounces of water and failed to follow the manufacturers ' guideline for administering potassium chloride with a glass of water or juice for a resident who received crushed medications during the medication pass observation.	F000309	The corrective action taken for those residents found to be affected by the deficient practice is that Resident identified as Resident #23's care plan was updated on 4-23-13 to include interventions with a desired goal to maintain a comfortable status. Nurse #32 was reeducated on assessing residents for pain and interventions to address pain management. Resident #10's Physician was notified on 4-19-13 of extreme leaning in chair new order was received to receive OT evaluation to address positioning in recliner. Nurse #32 was educated on the proper techniques to administer medications. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* Any resident that experiences pain has the potential to be affected by the same deficient practice. A house wide reassessment of pain & Positioning will be completed by DON/ ADON to ensure that all Care plans and interventions are specific to the residents to obtain	05/17/2013

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	Resident #10 Findings include: A.. On 4/17/13 at 10 A.M. the clinical record of Resident #23 was reviewed. Diagnosis included, but was not limited to, Alzheimer's dementia, status post cerebravoscular accident and vascular dementia with Lewy body dementia. The most recent MDS (minimum data set assessment) dated 2/21/13 indicated the following for the resident: severely impaired cognition; extensive assistance required for bed mobility. A facility plan of care, dated 2/27/13 addressed the problem of: "Resident on Hospice: Failure to Thrive." Approaches included: "Staff will provide total care for resident." A Hospice nurse note dated 4/17/13, indicated the following: "Full assessment complete with collaboration of FS (facility staff)...alert with confusion, c/o (complained of) right ankle pain. FS nurse notified..." On 4/18/13 at 9:07 A.M., CNA #30		optimal comfort status. Physician will be notified of finding. All nurses and QMA will be checked off on a medication pass review to ensure deficient practice doesn't occur in the future. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Pain assessments will be completed quarterly and significant changes and specific interventions will be up dated on care plans Quarterly screens will be completed by the Therapy Department on all residents for proper positioning. ADON/Designee will complete a Quality Assurance tool weekly to monitor pain management and positioning. All Nurses and QMA's will have medications pass review. An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing positioning, medication administration technique and pain management. ,. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Quality Assurance tool has been developed and implemented to monitor the tracking of the resident with Pain and Positioning to ensure a care plan is in place and specific to the resident for a desirable outcome. A Medication Pass audit has been developed to ensure that proper technique is being following while	

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	and #31 entered Resident #23's room to reposition her. As they turned the resident to her side, she stated "my ankle hurts." Both CNAs continued to turn the resident. On 4/18/13 at 12 P.M., LPN #32 was observed changing the resident's dressings. As LPN #32 was removing the resident's dressings to the right outer ankle, the resident was yelling "it hurts, it hurts." LPN #32 continued with her dressing changes. After applying skin prep to two scabbed areas on the arch of the right foot, she replaced the heel bows as the resident was yelling "it hurts, it hurts." On 4/18/13 at 12:30 P.M., Resident #23 was observed receiving medications from LPN #20. During the medication administration, Resident #23 moaned out, "My ankle hurts." LPN #20 continued with the medication administration through the G (Gastrostomy) tube. On 4/18/13 at 12:50 P.M., during a g-tube feeding, Resident #23 cried out "my elbow hurts." The resident was observed lying on her right side at the time. LPN #20 did not stop to reposition or		administering medication. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 17 ,2013 **Quality Assurance Tool F – 309 Medication Pass (See audit), Pain Assessment, Positioning DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR PATIENTS COMMENTS** **1 2 3 4 5 6 7 8** Is the resident experiencing pain? Is there a pain assessment? Has the assessment been updated? Has an intervention been documented? Is the pain Care planed? 2. If the resident is Hospice has the information been communicated to them and	

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	ask resident about the pain. A few minutes later the resident said "oh my ankle still hurts." LPN #20 replied, " Well it should be getting better soon. That is why we put the medication on it everyday." On 4/19/13 at 8:09 A.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated the resident was able to relay pain by facial grimaces and "she will tell you." On 4/19/13 at 10:14 A.M., the ADON and DON (Director of Nursing) were interviewed. At that time, the DON reviewed the current MAR (medication administration record) and indicated the resident was not on anything routinely for pain. At that time, the prn (as needed) medication record was reviewed. The resident had not been medicated for pain on 4/17/13 or 4/18/13. At that time, the DON indicated the Pain assessment stated no pain. She indicated that was done in February and Hospice does the pain assessment weekly. At that time, the ADON and the DON were made aware of the resident having been observed voicing multiple complaints of pain and those complaints were voiced to multiple staff. Pain assessments and/or pain		addressed in their notes/care plan? 3. Is the resident positioned properly in the chair? 4. Does the resident need a evaluation for therapy? 5. Has the positioning been documented on the care plan- are invention in place?	

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	control attempts were not completed for the resident. B. On 4/16/13 at 10:10 A.M., Resident #10 was observed in her recliner at her bedside. The recliner was observed with the foot rest in the up position. The resident was observed leaning to her left side, with her left axilla area resting over the left arm rest. The level of the resident's head was below the level of the bedside standing sitting beside the resident. Her right shoulder was observed in the horizontal center, of the back of the recliner chair. The resident was eating potato chips, without difficulty. On 4/16/13 at 12:30 P.M., the resident was observed in her recliner at her bedside, again leaning to the left side. At that time, the resident was eating her lunch and the level of her head was above the level of the beside table. Her right shoulder was towards the horizontal center of the chair. The resident was eating independently, without difficulty. On 4/16/13 at 4:30 P.M., the resident continued to be observed positioned in her recliner, leaning to the left side with the resident's eye level at the top			

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	of the cabinet beside her. On 4/17/13 at 8:45 A.M., the resident was observed in her recliner as noted at 10:10 A.M. on 4/16/13. CNA #30 was observed entering the resident's room at that time. When CNA #30 left the room, the resident remained in the same position. On 4/17/13 at 12:30 P.M., the resident was again observed in the same position as noted above, eating lunch without difficulty. On 4/18/13 at 9 A.M., the resident was again observed in her recliner as noted above at 10:10 A.M. on 4/16/13. At that time, the resident was interviewed. She indicated she felt "OK" in her recliner. The resident demonstrated she was able to readjust her right shoulder over somewhat to her right horizontal center, approximately 1/3 of the way over from the back of the recliner. Within a few seconds of repositioning, the resident returned to the previous position of her left axilla resting on the left arm rest of the recliner. On 4/19/13 8 A.M., the DON (Director of Nursing) was interviewed. She indicated she was aware the resident leaned to the left in her			

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	recliner. She indicated the resident hasn't been evaluated for the leaning in her recliner. She indicate they would have the Occupational Therapy Department evaluate her. On 4/19/13 at 2:23 P.M., the DON was again interviewed. She indicated was unaware if the resident has ever been evaluated for her leaning to the left severely in her recliner. At that time, the DON reviewed the resident's current medical record. She indicated she didn't see an evaluation on the chart. The same resident was observed during the medication pass observation as follows: During an observation 4/18/13 at 9:20 A.M., LPN #32 prepared Resident #10's medication for administration. LPN #32 crushed seven medications and poured the crushed medications onto 15 cc of applesauce. The crushed medications were as follows: Ativan 1 mg, Metformin 500 mg, Clorpegogel 75 mg, Vitamin C, Spirolactone 25 mg, Lasix 40 meq, Zinc 20 mg, Multivitamin. LPN #32 opened three Potassium Chloride 10 meq capsules and poured the medication onto the 15 cc of applesauce and the other eight crushed medications.			

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	Using a spoon, LPN #32 blended the mixture of applesauce and the eleven crushed tablets/capsules of medications together. LPN #32 took the prepared medications mixture into Resident #10's room and administered the medications to Resident #10 in two spoonfuls. After the second spoonful of medication was administered, Resident #10 made a grimacing face. Resident #10, opened and closed her mouth repeatedly as she tried to swallow the applesauce laden with the medications. As Resident #10, opened and closed her mouth, remnants of the crushed pills were observed on her lips and tongue. LPN #32 said, "OK." LPN #32 then turned and walked away without offering or encouraging Resident #10, to drink any fluids. On 4/18/13 at 9:35 A.M., LPN #32 indicated she mixed Resident #10's medications in applesauce because it was easier for the resident to swallow. The Clinical record was reviewed on 4/18/13 at 12:30 P.M. Diagnoses included, but were not limited to, cerebrovascular accident, Parkinson's disease, depression, COPD [chronic			

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	obstructive pulmonary disease], hypertension, diabetes mellitus, anemia, coronary artery disease. Minimum Data Set (MDS) indicated Resident # 10 had no signs or symptoms of swallowing disorders. On 2/19/13 at 4:40 P.M., a review of the 2012 Nursing Spectrum Drug Handbook procedure for administering potassium chloride under the section titled "Patient Teaching" read as follows: "...instruct patient to take the oral form with or just after a meal, with a glass of water or fruit juice." On 2/19/13 at 4:40 P.M., the facility's policy and procedure " Preparation and General Guidelines for Medication Administration" was reviewed. Section 9 of the Administration section read as follows: "At least 4 ounces of water or other acceptable liquid are given with oral medications." On 4/19/13 at 6:15 P.M., the DON was made aware no water was offered to Resident #10's medication administration. The DON was also made aware nine (9) medications crushed and mixed with 15 cc of applesauce were not palatable to the			

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	resident. 3.1-37(a)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure a worsening in a pressure sore was assessed and/or an abrasied and/or reddened area was assessed and monitored for 1 of 2 residents reviewed for pressure sores. Resident #23 Findings include: On 4/17/13 at 10 A.M., the clinical record of Resident #23 was reviewed. Diagnosis included, but was not limited to, Alzheimer's dementia, status post cerebravoscular accident and vascular dementia with Lewy body dementia. A Braden Scale Pressure Ulcer Risk assessment was dated 2/13/13 and	F000314	The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident's Left hip, Bilateral elbows and left knee wounds were measured on 4-19-13 by ADON. The physician was notified of the updated assessment of wounds. New Orders were received. The Weekly Pressure Ulcer Progress report and Care plan was updated to include current treatment, intervention and nutritional status. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* Any resident that has any skin alterations has the potential to be affected by the same deficient practice. A house wide reassessment will be completed by Charge Nurses to ensure that all skin alterations are measured accurately and appropriate interventions are in place. Physicians and families will be notified of any changes found. All care plans and Weekly Pressure Ulcer Reports will be updated accordingly.	05/15/2013

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	indicated the following: "Sensory perception is very limited (responds to painful stimuli); moisture-(resident) is often moist (linen changed at least once per shift); chair-fast; very limited mobility (makes occasional changes in position, unable to make frequent position changes); nutrition is probably inadequate; friction and shear is a problem (moderate/max assist in turning)." The form indicated a total score of 11, which indicated the resident was at high risk for developing pressure sores. The most recent MDS (minimum data set assessment) dated 2/21/13 indicated the following for the resident: severely impaired cognition; extensive assistance required for bed mobility; at risk for pressure ulcers; 1 or more unhealed pressure ulcers at stage 1 or higher; highest stage is unstageable. A plan of care, addressed the following problem: "Potential for Skin Breakdown" was dated 2/26/13. The form included but was not limited to, the following interventions: "Assess skin per facility policy;		The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that A Weekly Complete Body Assessment will be completed on all residents to ensure all abraded and /or redden areas are assessed and monitored. The Wound Nurse and or designee will assess and record measurements on all skin conditions weekly. The Results will be reviewed with the DON and Charge Nurse to assure that healing is progressing and all appropriate intervention is in place. If after two weeks the skin condition is not improving the charge Nurse or DON will notify the physician for possible change in treatment and or intervention to enhance healing. Care plan will be updated accordingly. DON will update the pressure Wound Log with current measurements each week and submit the report to the IDT team weekly stand up meeting. An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing residents with skin alteration as well as how to develop a plan of care for skin alterations. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* A Quality Assurance tool has been developed and implemented to monitor the care of the resident with skin alterations and inventions to prevent development of skin alterations. This tool will be completed by the DON/designee daily for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 15 ,2013	

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	maintain adequate nutrition and hydration." On 4/18/13 9:07 A.M., CNA #30 and #31 entered the room to reposition the resident. They removed the covers from the resident and turn the resident on her side. The resident stated her "ankle hurts." Both CNAs continued to turn the resident and clean her peri area. A dressing was observed to the residents left, lower hip area. The dressing over that area was dated 4/18/13. CNA #31 indicated they turn resident every hour. At that time, a scabbed area was observed to the resident's left knee, approximately the size of a pencil eraser. On 4/18/13 at 10:03 A.M., CNA #30 and #31 repositioned the resident in her bed. Again, the scabbed area to the resident's left knee was observed. On 4/18/13 at 11:13 A. M,. CNA #30 and #31 again repositioned the resident. The scabbed area to her left knee, was again visible. At that time, LPN #32, removed the dressing to the left hip area that was dated 4/18/13. The area appeared to be oval in shape, less than 1/2 inch at the widest part. It appeared as a linear type break in the skin. LPN		**Quality Assurance Tool** **F - 314** **DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR PATIENTS COMMENTS** **1** **2** **3** **4** **5** **6** **7** **8** 1. The resident with skin alterations, Weekly Skin Progress report completed (Measurements)	

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	#32 applied the Hydrogel [topical treatment] to the area and them applied the border dressing. She then removed the left boot, applied skin prep and during that time, the resident was again yelling "it hurts, It hurts." LPN #32 stated "I know, we are almost done." The resident's right elbow was observed to be reddened but was not opened. On 4/18/13 at 12:50 P.M., during a g-tube feeding, Resident #23 cried out "my elbow hurts." The resident was observed lying on her right side at the time. LPN #32 did not stop to reposition or ask resident about the pain. A few minutes later the resident said "oh my ankle still hurts." LPN #32 replied, " Well it should be getting better soon. That is why we put the medication on it everyday." On 4/18/13 at 4:34 P.M., the ADON (Assistant Director of Nursing) and DON (Director of Nursing) were interviewed. They indicated the resident currently had the following skin impairments: area to her lateral, right ankle; areas along the arches of the lateral and medial areas of her right foot; a protective dressing to the left hip. The DON indicated the resident had to sit down quickly and		2. There is documentation to support that weekly skin assessments are being conducted and that any changes in skin integrity has been reported to the physician for treatment instructions. 3. There is a care plan in place to address the appropriate interventions to prevent skin breakdown and/or if a skin condition does exist a care plan is in place with appropriate interventions for the care of the skin condition.	

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	barely hit the wheelchair with her hip and that area wasn't opened. Documentation was lacking of the a scabbed area to the resident's left knee and/or the right elbow being reddened. On 4/18/13 at 6 P.M., the ADON (Assistant Director of Nursing) and DON (Director of Nursing) were interviewed. She indicated the resident became a Hospice patient on 2/26/13 with the diagnosis of failure to thrive, and indicated the resident received the special, low air loss bed. The DON indicated on 3/1/13, the area to the left hip started with the order of Hydrogel and Optifoam dressing. She indicated the left hip area wasn't open, the dressing was just for protection. On 4/19/13 at 10:30 A.M., the ADON was interviewed. Upon request, she viewed the resident's left knee and the left hip. At that time, she was made aware of the pencil sized scabbed area to the resident's left knee. She indicated at that time, she was not aware of the area. At that time, the ADON removed the dressing to the left hip. The area appeared to have changed in appearance from 4/18/13. The area to the left hip was currently 1/2 inch,			

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	an irregular shape with a yellowish exudate around the edges. The ADON stated they have a wound nurse who comes in and makes recommendations every 4 - 5 weeks. The ADON indicated she does the weekly measurements. She indicated if the CNAs (certified nursing assistants) find a new skin area, they document it on a form. She indicated she picks up the skin sheets daily and and the CNAs would find a new area, they tell the ADON and if she's not here they call whoever is on call. The ADON stated she does a head to toe weekly on each resident. At that time, the resident's bilateral elbows were reddened in a 1 inch circular area. At that time, the current MAR (medication administration record) was reviewed. The form indicated the left hip dressing had been changed on 4/18/13 on the 11-7 shift and on 4/19/13 on the 7-3 shift. Documentation was lacking on the MAR of the dressing being changed to the left hip on the 3-11 shift. At that time, the ADON indicated documentation was lacking on the resident's continued reddened right elbow and the change in the left hip area. On 4/19/13 at 10:40 A.M., the DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2013
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	provided a current copy of the facility policy and procedure for "...Pressure Ulcer Program." The policy and procedure was undated. The policy and procedure included but was not limited to, the following: "It is the policy of (name of facility) that all residents will be evaluated for the risk of developing skin problems. Procedure:...An individual care plan will be developed and implemented to address those residents at risk for pressure ulcers and those with ongoing conditions. Each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care...Each week the wound nurse (ADON) will assess and record measurements on all skin conditions..." On 4/18/13 at 12 P.M. LPN #32 was observed changing the resident's dressings. As LPN #32 is removing the resident's dressings to the right outer ankle, the resident was yelling "it hurts, it hurts." LPN #32 continued with her dressing changes. After applying skin prep to two scabbed areas on the arch of the right foot, she replaced the heel bows as the resident is yelling "it hurts, it hurts." The left knee scabbed area was again visible and no treatment was performed on the area.			

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	On 4/19/13 at 12:05 P.M., the ADON was interviewed. The ADON indicated that someone should have report the change in the left hip area as were observed from yesterday to today to her. She also agreed that the staff should have informed her know of the bilateral elbows being reddened and also the scabbed area to the resident's left knee. On 4/19/13 at 2 P.M., the ADON stated she made the physician aware of both reddened elbows, the change in the left hip area and the scabbed are to the left knee. 3.1-40(a)(2)			

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F000322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on interview and record review, the facility failed to ensure a resident with an NPO status (nothing by mouth), whose sole nutritional intake was dependent on a gastrostomy tube (g tube) did not experience unavoidable, significant weight loss (12%) in a 1 week period for 1 of 1 residents reviewed with a gastrostomy tube. Resident #23 Findings include: On 4/17/13 at 10 A.M. the clinical record of Resident #23 was reviewed. Diagnoses included, but was not limited to, Alzheimer's dementia,	F000322	The corrective action taken for those residents found to be affected by the deficient practice is that Resident identified as #23 Current weight = 114.8, (5/7/13) Physician was notified on 4/19/13 of concerns regarding weight loss and diet. New order received for ST evaluation. New order received for resident to receive pleasure meals per her request. 5/1/13 Physician increased feedings to 1 can 4xday. 5/7/13 Registered Dietician calculated feeding for caloric intake, MD aware and chooses to not to change feeding at this time d/t gastric retention. Continue to monitor weights weekly and monitor gastric retention. *The corrective action taken for the other residents having the potential to be affected by the*	05/15/2013

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	status post cerebravoscular accident and vascular dementia with Lewy body dementia. A hydration risk assessment dated 2/13/13 included, but was not limited to the following: swallowing difficulty; diagnosis of urinary tract infection; use of 9 or more medications; included a total hydration risk assessment score of 21, which indicated the resident was at risk for hydration issues; and resident did not have presence of edema. The most recent MDS (minimum data set assessment) dated 2/21/13 indicated the following for the resident: severely impaired cognition and extensive assistance required for bed mobility, at risk for pressure ulcers, had one or more pressure ulcers... A facility care plan, dated 2/22/13, addressed the problem of "At risk for Altered Nutritional Status with G tube placement. Approaches included the following: "continue feedings per MD order, dietician to see et (and) evaluate; monitor placement q (every) shift and prn (as needed); notify MD of any significant changes; monitor G tube site q shift , check patency q use prn."		*same deficient practice is that* Any resident that has a G-tube has the potential to be affected by the same deficient practice. All residents receiving g-tube feedings were reassessed by Registered Dietician to ensure adequate amount of calorie intake was prescribed and Physicians were notified of recommendation. All Residents with g-tube feedings orders were clarified to include checking for placement and residual feeding and to Notify MD of > 60 residual feeding. . The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that All monthly weights will be obtained and reviewed by ADON any description will be reweighed and documented on the weight record as a reweigh. Any weights Up or down 3 or more will be reported to MD and placed on weekly weights to manage weight loss closely. An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing weight loss and care of residents with g-tube. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Quality Assurance tool has been developed and implemented to monitor the tracking of the resident with g-tubes and any resident with weight loss to ensure interventions and/or	

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	A facility care plan, dated 2/22/13, addressed the problem of "Res (resident) at risk for wt (weight) loss r/t (related to) dementia/weakness and G tube placement." Interventions included the following: " weight monthly and weekly if needed prn; notify MD, dietary mgr (manager) and dietician of potential wt loss problems;..." A facility care plan, dated 2/22/13, addressed the problem of "Res at risk for dehydration r/t g tube placement." Approaches included, but were not limited to, the following: "Administer feedings and fluid per tube as MD ordered..." A facility plan of care, dated 2/27/13 addressed the problem of: "Resident on Hospice: Failure to Thrive." Approaches included: "Staff will provide total care for resident." A physician order dated 3/6/13 indicated the resident was to have received 90 mls (milliliters) water before and after the tube feedings and 60 mls before and after the medications through the G tube. A Hospice plan of care dated 4/10/13, indicated the resident was		physician notification has been addressed and care plan is in place and with specific interventions to address the weight loss and care of the g-tube to obtain the desirable outcome. An Enteral Nutritional Therapy skills audit has been developed to ensure that proper technique is being following while caring for a resident with a g-tube. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 15 ,2013 **Quality Assurance Tool** **F – 322** **G-tube / Weight loss** **DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.**	

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	NPO (nothing by mouth) and received Fibersource 1/2 can four times a day. On 4/16/13 at 2 p.m. the DON (Director of Nursing) provided a copy of the monthly weights for the current year. Weights for the resident were documented as followed: January 127 lbs. (pounds); February 125 lbs.; March 115 lbs. and April 116.8 lbs. On 4/18/13 at 6 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated she had been employed at the facility since the fall of 2012. She indicated the following for the resident: Speech therapy began for the resident on 1/29/13 due to resident refusing to eat and was discontinued on 2/19/13 due to a lack of cooperation with the resident. On 2/20/13, a surgical consult was obtained for G tube (gastrostomy tube) placement. On 2/22/13, the G tube was placed. On 2/26/13, the resident became a Hospice patient, with the diagnosis of failure to thrive. At that time, the ADON indicated the facility was taking weekly weights on the resident, which began on 1/29/13. The weekly weights were		**INDICATOR PATIENTS COMMENTS** 1 2 3 4 5 6 7 8 1. If the resident is G-tube, is there an order to monitor for check for placement and checking for residual and is it being documented. 2. Has the resident experienced weight loss, are they on weekly weights and has the family and physician been notified and	

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	documented as follows for the year 2013: 1/29=130 lb; 2/5=125 lbs; 2/12=120 lbs; 2/19=115 lbs; 2/22 G tube placed; 2/26=115 lbs; 3/5=101 lbs; 3/9 = G tube replaced; 3/12= 104 lbs; 3/19=116 lbs.; 3/26=116 lbs and 4/2= 116.8 lbs. At that time, the ADON was interviewed as to the reason for the 14 lb weight loss from 2/26 until 3/5. The ADON indicated the following: "on 3/5/13 the physician was notified of excessive drainage to the G tube dressing." Documentation in the nurses notes (NN) on 3/5/13 at 9 P.M. indicated the following: "G tube drsg (dressing) changed d/t (due to) excessive drainage. Physician notified of drainage, new order received..." A physician order, dated 3/5/13 at 5 P.M. indicated the following: "Hold feeding x (time) 1 (one), hold free water till A.M." NN dated 3/6/13 at 10 A.M., indicated the following: "...yellow drainage pouring from g-tube site...checked for residual et noted to have approximately 60 cc residual...meds (medications) flushes		documented? 3. Does the resident have a registered dietician calculation for calorie intake completed? Has Physician been notified? 4. Has the care plan been updated to include specific interventions to address the weight loss?	

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	et feedings being held until (physician name) returns page." NN 3/6/13 at 1 P.M., indicated the following: "Hold feedings until 5 P.M., only give meds with water, updated MD after 5 P.M...." NN dated 3/6/13 at 6 P.M., indicated to "decrease free water...cut feeding to 1/2 can qid (four times a day)..." At that time, the ADON indicated on 3/9/13, the resident returned to the hospital to have a new feeding tube put into place. She indicated at that time, the flange portion of the G tube was not functioning properly. She explained the flange was a circular disc portion of the G tube, which was located below the level of the skin. She indicated the defective portion of the G tube had allowed tube feeding, which was instilled into the resident via the G tube, to "run back out" from the resident. The ADON indicated she doesn't know exactly the dated the problem started with the tube feeding running out from the resident. The ADON indicated the malfunctioning flange on the G tube and the tube feeding running out of the resident is the reason for the 14 lb weight loss from 2/26 to 3/5. At that time, documentation was reviewed in the nurses notes for			

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	February and March 2013. The ADON indicted the first documented NN of the problem with the G tube leaking was on 3/5/13 at 9 P.M. At that time, the MAR (medication administration records) were also reviewed for March 2013. The ADON indicated documentation was lacking on the March MARS of a problem with the tube feedings leaking, until the feeding was held on 3/5/13. On 4/19/13 at 8 A.M., the DON provided copies of the Nutritional Progress notes. The Registered Dietician (RD) note dated 2/8/13 included but was not limited to, the following: "...will continue to monitor po (per os) intake, wt (weight)..." The next RD note was dated 3/1/13 and included, but was not limited to the following: "Res is now on Jevity 1.2 - 4 cans dly (daily)...Res with 60 cc water before et after meds (medications) et 300 cc water 8 x day to provide 2640 cc water flush daily, plus 768 cc water from feeding. Total 3408 cc dly (daily)...Res is tolerating feedings at this time to monitor TF (tube feeding) tolerance, wt (weight)..." The next documented Nutritional Progress note is dated 4/8/13 and included but was not limited to, the following: "RD Review: Orders			

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	reflect 1/2 can Jevity 4 x's daily, pureed diet, shakes bid, magic cups bid and protein powder bid. Current wt 99.4 lbs. (sic) Nursing reports good tolerance to feedings and flushes. Hospice status." At that time, the ADON was interviewed as to the RD documentation of the resident's note above indicating the resident is consuming oral fluids. The ADON indicated at that time, the resident was NPO (Nothing by mouth) and only being administered the tube feedings via the G tube (for all nutrition). She indicated she didn't know why the RD documented the note she did on 4/8/13 and could not provide an explanation for the contents of the progress note but did indicate they were inaccurate (regarding the pureed diet, magic cups, protein powder and shakes). On 4/19/13 at 9:30 A.M., the ADON and the DON were interviewed. They indicated the first documentation of the nurses notes indicating the tube feedings were running back out of the residents abdomen was on 3/6/13. The ADON indicated at that time, she doesn't know how long that was occurring. She indicated documentation was lacking in the			

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NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HWY WASHINGTON, IN 47501	

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	medical record to indicate exactly how long that was occurring. She indicated the physician came to the facility and saw the resident on 3/8/13 but did not document progress notes. She also indicated the physician spoke to the dietician but did not document progress notes. She indicated at that time, she was unable to find documentation the physician was notified on 3/5/13 of the significant weight loss. On 4/19/13 at 10:40 A.M., the ADON and the DON (Director of Nursing) were interviewed. The ADON indicated the weights documented on the Weight record for the year 2013 were accurate. She indicated the weights for the month had been rechecked and the scale recalibrated but the rechecked weights had not been documented. At that time, the current policy and procedure titled "Nutrition Risk/Weight Loss" was received from the ADON and DON. The undated policy indicated the following: "It is the policy of (name of facility) to avoid all unplanned significant weight loss...Each resident will have a Nutritional Risk Assessment completed be the Dietician upon...with any significant change...Weights will be reviewed by			

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	Nursing Administration and the Dietician to identify any significant weight loss. Significant weight loss will be identified if the resident has a weight loss...of 5% in one month...Residents who have been identified with a significant weight loss/gain will have that information reported to their physician for additional interventions warranted..." At that time, the ADON and DON also provided a copy of the current "Enteral Nutrition Therapy Bolus Feeding" policy and procedure. The policy and procedure is undated. At that time, the ADON provided nursing progress notes in monitoring the resident. The ADON's notes indicated the following: 2/26/13: still declining in overall health; 3/5/13: "Resident is currently on G tube feedings. Will continue with monitoring. Residents family is aware of significant weight loss et Hospice is also aware. MD is currently monitoring." Progress note from 3/12/13: "Resident this week having trouble with G tube had to have it replaced...Feedings have resumed et are doing better..." Progress note 3/19/13: "...weight is improving."			

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	3.1-44(a)(1)			

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F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. During observation, interview and record review, the facility failed to ensure effective administration of a nebulizer medication for 1 of 1 residents receiving nebulizer treatments. Resident #49 Findings include: During an observation on 4/18/13 at 11:00 AM., Resident # 49 was lying on his back. The head of Resident #49's bed was elevated 30 degrees, his eyes were closed and his mouth was gaping open. LPN #33 listened to Resident #49's lung sounds and took his pulse and oxygen saturation level. LPN #33 washed her hands and poured the medication (Dueoneb 2.5-0.5 mg/ml) into the medication reservoir cup. LPN #33 turned the nebulizer machine on and proceeded	F000328	The corrective action taken for those residents found to be affected by the deficient practice is that Resident identified as #49 Nebulizer treatment order has been updated to include via HHN mask for effective administration on 5/10/13. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* Any resident that receives Nebulizer treatments have the potential to be affected. All Residents with orders to receive Nebulizer treatments were evaluated during administration of treatment for effectiveness. All orders were clarified by physician for the appropriate technique to administer nebulizers. . The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that All Licensed nurses were checked of on nebulizer treatments to ensure effective administration of nebulizer medication. An in-service was conducted on April 25 th and May 9 th for all nursing staff	05/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2013
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	to place the mouthpiece in Resident #49's mouth. LPN #33 instructed Resident #49 to close his lips around the mouthpiece and take a deep breath. Resident #49 opened his eyes periodically but never became alert enough to grasp the nebulizer tube with his lips and/or form a seal. The Dueoneb aerosol medication was flowing continuously from the opposite end of the mouth piece. Without success, LPN #33 continued to cue Resident #49 throughout the treatment to close his lips around the mouthpiece and breathe deeply. LPN #33 said, "He keeps falling asleep for me." During an observation of Resident #49's second nebulizer treatment on 4/19/12 at 12:35 P.M., Resident #49 was sitting up in his Geri-chair with his eyes open. LPN #33 washed her hands and then poured the medication into the nebulizer cup. LPN #33 listened to Resident #49's lung sounds and took his pulse and oxygen saturation level. LPN #13 started administering the Dueoneb aerosol treatment with the hand held nebulizer. LPN #13 held the neb treatment tube in Resident # 49's mouth and encouraged Resident #49 to take deep breaths. Resident #49 made a seal with his lips and followed		addressing nebulizer treatments. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Quality Assurance tool has been developed and implemented to monitor the effective administration nebulizer treatments and ensuring all orders for treatments address specific technique to administer. A Nebulizer skills audit has been developed to ensure that proper technique is being following while caring for a resident with a g-tube. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 15 ,2013 **Quality Assurance Tool** **F – 328** **HHN Tx** **DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.**	

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	direction to breathe deeply. During an interview with LPN #33, on 4/19/13 at 1:55 P.M., LPN # 33 indicated Resident #49 was more alert today and able to follow commands. LPN #33 indicated she noticed during Resident #49's treatment on 4/18/13 he was not very awake and his mouth was open during the treatment. LPN #33 indicated she did the treatment yesterday before lunch and today she did the treatment after lunch. LPN #33 indicated that, in order to administer Resident #49's medication when Resident #49 was alert ,she would have to frequently call the physician to change the medication administration time because LPN #33 never knew when Resident #49 was alert enough for successful medication administration. During an interview with the DON on 04/19/13 at 6:15 P.M., the DON indicated that the nursing staff should use a mask to administer medication if a nebulizer treatment was ordered and the resident was not alert enough to close his/her lips around the mouthpiece. The clinical record for Resident #49 was reviewed on 4/19/13 at 11:00		**INDICATOR PATIENTS COMMENTS** 1 2 3 4 5 6 7 8 1. If the resident has order for HHN Tx, Is there an order addressing the technique to administer the Treatment? 2. Does the MAR address tech to administer the Treatment	

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	A.M. Diagnoses included, but were not limited to the following: anxiety, depression, diabetes mellitus, hyperlipidemia, dementia, heart failure, history of cerebrovascular accident. Physicians' orders for 4/1/13 though 4/30/13 read as follows: Dueoneb 2.5-0.5 mg/3 ml, inhale content of 1 vial 3 times a day. The facility's policy and procedure on "Administering Medication through a small volume Nebulizer" was reviewed on 4/19/13 at 5:00 P.M. Section 14 read as follows: " Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask)." 3.1-47(a)(6)		3. Has the care plan been up dated? 4. Was the treatment administered according to the proper technique?	

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F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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. Based on record review, interview, and observation, the facility failed to ensure residents were free from drug use which was unnecessary and/or of excessive duration and/or without adequate indication for use for 7 of 10 residents reviewed for unnecessary drugs. Resident #17 Resident #5 Resident #40 Resident #42 Resident #10 Resident #23 Resident #22	F000329	The corrective action taken for those residents found to be affected by the deficient practice is that Residents identified as #17, #5, #40, #42#10, #23and #22 Physicians have been notified of the deficit practice and documentation was obtained or indication and or medications were reduced. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* A Facility over all review of all residents receiving Psychotropic medication was conducted on 5-6-13 with DON, Social	05/15/2013

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	Findings include: 1. The clinical record of Resident #17 was reviewed on 4/18/13 at 10:00 A.M. The resident had diagnoses which included, but were not limited to, dementia and anxiety disorder. The resident had been receiving an antidepressant drug, Lexapro 10 mg po (by mouth) daily since 6/15/12. The monthly pharmacy review noted that and generated a recommendation on 12/12/12. The recommendation included " ...has been taking Lexapro 10 mg po daily for depression for 6 months now. Please consider a trial reduction to Lexapro 5 mg po QD (daily) for depression if appropriate. Antidepressant evaluations recommended every 6 months for the first year and then yearly thereafter. Thanks for your time and consideration." The physician responded on 1/11/13 to disagree and increased the Lexapro to double the dose at 20 mg po QD, without clinical rationale. The clinical record contained tracking of target behavior occurrences on a shift by shift basis. The tracking for January 2013, February 2013, and March 2013 all indicated the resident		Services ADON and consulted Pharmacists reviewing any resident due for reductions and or clinical rational for medication use. All Care plans and Monthly Behavior Tracking logs were updated to the resident's specific behaviors for the medication use. Each residents physician will be notified of updating residents plan of care to include clinical rational for medication use. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that A Monthly Behavior / Psychotropic Medication Review will be conducted with consult Pharmacists, DON, Social Services and ADON. The team will review the residents Specific Behaviors being monitored and medications due for GDR. Care plan will be updated accordingly. An in-service was conducted on April 25 th and May 9 th for all nursing staff addressing unnecessary drug use and clinical rational for us according to the plan of care. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that The Monthly Pharmacist consult report on reductions and outcomes as well as minutes from Monthly Behavior/ Psychotropic Medication review meeting will be forward to the Quality Assurance Committee to review at monthly meetings. A Quality Assurance tool has been developed and implemented to monitor the resident receiving Psychotropic medications to ensure a clinical rational for medication has been addressed to prevent unnecessary and or excessive	

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	had no exhibited target behavior of crying. Social Service Director (SSD) progress notes of 3/25/13 included "...resident states she feels good and if she is down she just visits with one of her friends here." On 4/18 at 11:55 A.M., the SSD was interviewed regarding the residents depression. She indicated the resident did not present as depressed but she missed her family in that the resident forgot their faithful visits and therefore thought they had not visited. The SSD was informed of observations of the resident on all survey days, some in daytime and some evening when the resident was consistently initiating conversation, parked in her wheel chair in high traffic areas where she was engaged in observing and interacting with outgoing interest in others, and was quick to smile. The SSD indicated "That's pretty much her." The resident also was receiving Lorazepam (for anxiety) 1 mg po QD since 12/14/10. Pharmacist notations recommending gradual dose reduction (GDR) were being made periodically and/or lack of responses were also being noted. The notations were dated 9/28/11, 11/22/11, 3/21/12, 4/18/12, 9/19/12, and 4/1/13.		duration of these medications. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 15 ,2013 **Quality Assurance Tool** **F – 329** **Unnecessary Drugs** **DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR** **PATIENTS** **COMMENTS** **1** **2** **3** **4** **5** **6** **7** **8**	

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	The recommendation being repeated was "...receiving Lorazepam 1 mg po QD and Lorazepam 1 mg po prn anxiety. These doses have been in place greater than 6 months. CMS(Center for Medicare Services) guidelines for therapy recommended that long term care facility residents on benzodiazepine drug therapy category of drugs to which Lorazepam belongs) undergo periodic drug reductions to help determine that the resident is on the lowest effective dose of the medication. Chronic benzodiazepine use puts patients at risk for depression, delirium and falls." The recommendation did not get a response from the physician until 4/11/13. It was as follows: "Benefit of therapy is currently greater than risk of adverse drug reactions. The current dose is felt to be the lowest clinically effective dose. Continue therapy as ordered." The clinical record contained tracking of the target behavior "anxiety" on a shift by shift basis. The tracking for January 2013, February 2013, and March 2013, directly before the physician 's decision indicated that no anxiety was occurring. Documentation was lacking to		1. The resident with Psychotropic medications have specific behaviors on tracking log and care plan 2. Has there been an attempt to reduce or alter any the resident's medication use. 3. Is there a documented clinical rational for the use of the medication if the medication has not been reduced or attempted to be reduced	

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	demonstrate clinical contraindication to GDR for either Lexapro or Lorazepam. The care plan since 2/28/13 set unmeasurable goals and directed nonspecific interventions for the problems of depression and anxiety. The care plan included, "Resident currently on psychotropic medications for antianxiety and antidepressant. Lexapro for depression and Lorazepam for anxiety.' One goal was " Resident will be on the lowest dose possible of medication as ordered by the physician through next review." The interventions related to the goal were first " Work with physician on reduction to assure symptoms are controlled on the lowest dose possible.", "Utilize alternative interventions to assist with symptoms the resident may exhibit prior to the use of any prn (as needed rather than routinely administered) medications." and last directive " Notify physician of any negative reactions related to the medication usage." The care plan lacked specific intervention to address either anxious or depressed behaviors.		4. Have all pharmacy recommendations been addressed by the physician?	

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	2. The clinical record of Resident #5 was reviewed on 4/18/13 at 1:00 P.M. The resident had been receiving Lexapro 10 mg po QD since 9/7/10. On 3/7/13 a pharmacy recommendation was faxed to the physician. It noted the drug had been given at that dose for greater than 6 months. it recommended consideration of a trial dosage reduction or discontinuation if appropriate. The physician responded on 3/13/13 by doubling the dose to " Lexapro 20 mg daily." Clinical documentation did not provide rationale of contraindication to a decrease moreover support an increase. On the 4/1/13 pharmacy review, the pharmacist noted " Lexapro actually increased." The behavior log tracking "crying" as a targeted indicator on a shift by shift basis for 1/13, 2/13, and 3/13 indicated no behaviors occurred. Resident #5 was also receiving Ambien 5 mg po every night for insomnia since 6/20/12. Pharmacy recommendations requested attempt at GDR on 6/20/12 without response by 7/18/12, another request for GDR on 9/19/12 and 10/17/12 and 12/12/12. There was a response on			

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	12/12/12 when the physician directed to continue the drug since previous attempts at an order change and/or reduction have been unsuccessful. Documentation was lacking of any prior unsuccessful reduction attempts. On 4/19/13 at 10:20 A.M., the DON (Director of Nursing) indicated the clinical record research done by the facility was unable to verify a prior reduction attempt. The behavior tracking logs for insomnia during 1/13, 2/13, and 3/13, all indicated insomnia had not occurred. The reference drug book title 2010 Nursing Spectrum Drug Handbook page 1251 contained an Ambien reference. It included but was not limited to: " Stress that drug is meant only for short-term use (7 to 10 days)." and "...rebound insomnia may occur for 1-2 nights after he discontinues the drug." Documentation in the clinical record was lacking to support any non drug interventions had been attempted prior to the onset of hypnotic drug use. Resident # 5 was also receiving Lorazepam 0.25 mg po TID (3 times			

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	per day) since 6/15/12. A pharmacy recommendation on 12/12/12 noted the drug in use for 6 months and included "CMS (Center for Medicare Services) guidelines for therapy recommended that long term care facility residents on benzodiazepine drug therapy category of drugs to which Lorazepam belongs) undergo periodic drug reductions to help determine that the resident is on the lowest effective dose of the medication. Chronic benzodiazepine use puts patients at risk for depression, delirium and falls." The physician response was "Previous failures have been noted with attempts to reduce the current dose. Benefit of therapy is currently greater than the risk of adverse drug reactions. The current dose is felt to be the lowest clinically effective dose. Continue therapy as ordered." The clinical record Behavioral tracking every shift in January 2013, February 2013, and March 2013, for anxiety showed no incidence except on 3/24/13 when there were 12 anxiety manifestation on that one day. The 2/28/13 Care plan for Resident #5 addressed psychotropic drugs as a concern or problem and named all three drugs above, Lexapro for			

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	depression, Ambien for insomnia and Lorazepam for anxiety. There were 2 goals set. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review." Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage." The care plan was not standardized for any Psychotropic medication and were non specific to resident or particular to drug rather than drug category. . 3. The clinical record of Resident #40			

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	was reviewed on 4/18/13 at 11:00 A.M. The resident had an order on 3/23/12 for Restoril 15 mg po for insomnia. The nurses notes from 3/1/12 to 3/23/12 were reviewed for incidents of insomnia. Documentation was lacking to identify why the hypnotic was started. Documentation was lacking of an assessment of sleep pattern, type of insomnia i.e. trouble getting to sleep, staying asleep and/or returning to sleep and possible etiology of insomnia. Documentation was lacking to identify any non drug alternatives attempted to facilitate sleep. On 1/16/13 a pharmacy recommendation requested an attempt at GDR. On 2/10/13 the physician declined, responding that previous attempts had been unsuccessful. Documentation was lacking to identify any prior attempts had occurred. On 4/6/13 the physician again declined a GDR on the same grounds. On 4/19/13 at 3:00 P.M.,the DON indicated, after researching the clinical record, there had been no previous attempts. Behavior logs for sleeplessness in			

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	January 2013, February 2013, and March 2013 recorded no incidence of sleeplessness. The care plan of 2/28/13 did not address insomnia. It did address use of three psychotropic medications, one being Restoril for insomnia however the goals and interventions were standardized and non specific to drug or resident. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review." Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage."			

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	The care plan was not standardized for any Psychotropic medication and were non specific to resident or particular to drug rather than drug category. 4. The clinical record of Resident #42 was reviewed on 4/19/13 at 10:00 A.M. The resident had been receiving Xanax (drug for anxiety) 2 mg po at bedtime QD since 3/22/12. He was also receiving Seroquel (antipsychotic) 300 mg po QD since 3/6/12. The pharmacy recommendation of 4/1/13 indicated Seroquel had been given for a year. "CMS guidelines recommend that long term care facility residents on antipsychotic drug therapy undergo periodic dose reductions to help determine that the resident is on the lowest effective dose of medication. Would a reduction be appropriate for this resident? The physician responded to the pharmacist "I changed this before get your records straight!!!!" The pharmacist also indicated the Xanax had been given for greater than a year and requested the physician consider a dose reduction. The physician responded "Same!!!!" indicating he believed the pharmacist records were in error.			

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	On 4/18/13 at 6:00 P.M., the DON and Administrator were asked to research the clinical record and their tracking records to determine if the pharmacist had been in error. They responded that they already had done so and the pharmacist was correct that both drugs were due to be considered for reduction. The 2/28/13 Care plan for Resident #42 addressed psychotropic drugs as a concern or problem and named both drugs above, Seroquel and Xanax. There were two goals set. The first goal was "The resident will have no negative effects related to the use of psychotropic medications thru the next review." The second was "Resident will be on lowest dose possible of medication as ordered by the physician through next review." Interventions and approaches included: "Monitor for side effects related to medication usage. Monitor for any behaviors that the medication may be utilized for. Work with physician on reduction to assure symptoms controlled on lowest dose possible. Utilize alternative interventions to			

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	assist with symptoms the resident may exhibit prior to use of any prn medications. Notify physician of any negative reactions related to the medication usage." The care plan was not standardized for any Psychotropic medication and were non specific to resident symptoms or particular to drug rather than drug category. 5. On 4/17/13 at 2 P.M. the clinical record of Resident #10 was reviewed. Diagnoses included, but were not limited to, the following: depressive disorder, psychosis and insomnia. A plan of care which addressed the usage of Psychoactive medications was dated 2/28/13. The plan of care included, but was not limited to, the following medications: Lorazepam (Ativan) to address anxiety. Interventions included but were not limited to, the following: " monitor side effects and behaviors; work with physician on reduction to assure signs and symptoms are controlled on lowest dose. " The current Consultant Pharmacist Drug Regimen Review, had monthly documentation for the year 2012 to			

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	the current month. The form indicated on 2/15/12 an "Ativan GDR." That was the only documentation on the drug regimen review related to the Ativan. On 4/19/13 at 2:20 P.M., the DON (Director of Nursing) was interviewed regarding medication GDR (gradual dose reduction) of the medication Ativan. She indicated she didn't see any evidence of reduction and or GDR or justification to continue the Ativan. The Behavior logs which were used to monitor for crying, anxiety and insomnia were all blank for the current month of April 2013 with no behaviors documented. The current "Psychoactive and Sedative/hypnotic Utilization by Resident" form was provided by the DON at that time. The form indicated the resident was currently taking Ativan 1 mg po every day for anxiety. The form indicated the order date for this medication was 8/2/11. 6. On 4/17/13 at 4 P.M., the clinical record of Resident #22 was reviewed. Diagnoses included but were not limited to dementia, weakness and frequent falls.			

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	A plan of care dated 2/28/12, addressed the following problem: "Resident is currently on psychotropic medications including antidepressant, Remeron with diagnosis Dementia." Interventions included but were not limited to the following: "monitor for any behaviors that the medication may be utilized for; work with physician on reduction to assure symptoms controlled on lowest possible dose. " The current Medication Administration record indicated the medication Remeron had been started on 2/29/12 at a dose of 15 mg q hs. On 4/19/13 at 2:55 P.M., the DON and ADON (Assistant Director of Nursing) were interviewed. She indicated there has been no attempted reduction of the medication Remeron since it was started on 2/29/12. The ADON indicated the resident doesn't see the psychiatrists. She indicated the medication was for appetite and the resident's weight was stable. At the time, the current weights for 2013 were reviewed. They are as follows: 1/13= 140 lbs (pounds); 2/13=140 lbs; 3/13 = 139.6 lbs; 4/13 =			

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	142.6 lbs. The residents weights last year ranged from 123 lbs - 139 lbs. The current Psychoactive and sedative/hypnotic utilization by resident form was received from the DON and ADON on 4/19/13 at 3 P.M. The form indicated the resident was on Remeron 15 mg po, q hs and the medication class was antidepressant. The form indicated the order date was 2/29/12 and there was no date indicated for the next evaluation date. The monthly Pharmacist review log was reviewed from 3/21/12 to the current month. Documentation was lacking as to a GDR being addressed for the medication Remeron. 7. The clinical record of Resident #23 was reviewed on 4/17/13 at 5 P.M. Diagnoses included but were not limited to the following: Alzheimer's dementia with psychotic features, vascular dementia with Lewy body dementia, poor cognition, depression and anxiety. A plan of care, dated 2/28/13, address the following concern: "Resident currently on psychotropic medications including: antianxiety, antipsychotic and antidepressant. " Interventions included but were not			

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	limited to the following: "work with physician on reduction to assure symptoms controlled on lowest possible dose. " On 4/19/13 at 10 A.M., the DON and ADON were interviewed. The DON indicated the resident did have a history of refusing to eat last year. The resident did have an inpatient psychiatric admission in August 2012 with diagnosis of general anxiety disorder, major depression, vascular dementia with Lewy body dementia features, obsessive compulsive disorder, behavioral disturbances and psychotic features. The resident did have a feeding tube inserted on 2/22/13. The DON indicated the pharmacy recommendations don't document any attempted GDR for Seroquel, Risperdal or Remeron. The DON indicated the physician isn't responding to the pharmacy recommendation of Zoloft and Remeron GDRs. The DON indicated the resident's medication included but were not limited to the following: Zoloft for depression; Risperdol for dementia and psychotic features; Remeron for an appetite stimulant and vascular dementia. At that time, the DON provided a copy of the "(name of facility) Behavior charting. The dates of the form ranged from			

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	2/6/13 - 3/23/13. All three entries indicated the resident had not had any behaviors. At that time, the ADON and DON provided a current copy of the "Psychoactive and Sedative/Hypnotic utilization by resident" form. The form included but was not limited to the following: resident was started on Remeron (antidepressant) on 8/10/12 at 30 mg q hs for weight loss and vascular dementia; Zoloft (antidepressant) started on 8/10/12 at 150 mg qd for vascular dementia with psychotic features; Risperdone (antipsychotic) 0.5 mg at noon and hs and 0.25 mg q 7 a.m. 8. The undated Policy and Procedure for "Consultant Pharmacist Reports: Documentation and communication of consultant Pharmacist recommendations" included the following excerpts: "...B. Comments and recommendation concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review....C... If the prescriber does not respond to the recommendation directed to him/her within a reasonable time			

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	frame, the Director of Nursing and or the consultant pharmacist may contact the Medical Director..." 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(6)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to utilize safe food cool down methods for food storage and/or carry out proper sanitation procedures on 2 of 2 kitchen tours with potential to impact 36 residents being served food from the kitchen. Findings include: 1. On 4/15/13 at 7:00 P.M., the first tour of the kitchen began. Dietary aid (DA) #1 was working in the kitchen and indicated there were no leftovers saved from the supper meal. She indicated the facility did save leftovers for re-service to residents sometimes. In the refrigerator there was a plastic container holding 18 hard boiled and peeled eggs which were positioned in a double layer. The lid was tightly fitted on the container which felt very warm to the touch. The DA indicated she had prepared the eggs for egg salad for the following day. She	F000371	Hillside Manor Nursing Home shall maintain a clean and sterile kitchen and follow established safe serve food guidelines for both heating and cooling foods properly. Improper sanitization procedures and improper cool down procedures for stored foods could effect several or all residents. Upon notification of the improper cool down procedure noted on 4-15-13 an immediate inservice of all kitchen staff was held that night on 4-15-13 at 8pm. A new cool down policy was written and a cool down temperature log was established and is maintained in the dietary department. The food service director instructed cleaning of the microwave on the night of 4-15-13. The food service director had to wait until the next am (4-16-13) to make an immediate purchase of food service utensils (spatulas) and as such, the old, distorted handled utensils were disposed of that day. The staff was inserviced on 4-18-13 and 5-9-13 regarding proper sanitization and the aide in question was also able to provide the food service director with	05/15/2013

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	indicated she put them in the refrigerator 1 and 1/2 hours earlier. She had not taken the temperature of the eggs before placing them in the refrigerator and indicated the eggs would not be checked for temperature again. When asked about the process of cooling down food, she indicated it was done as fast as possible so she had put them in the refrigerator right away but indicated the food temperatures were never checked after being placed in the refrigerator. The eggs tested at 140 degrees of Fahrenheit scale (F). She was not familiar with a system of ensuring temperature cooling within specific time frames. The Food Service Supervisor (FSS) indicated "We try to get the temps down in 6 hours, it has to get down to 70 F in 2 hours and then to 40 F within the total 6 hrs." When asked if there was a system of ensuring the cooling, by taking temperatures, she indicated there was not. Cool down temperature requirements were not posted but the FSS indicated she had a copy. She referred to her copy of the requirement and reported correctly. In the first 2 hours the cooked food has to be cooled from 135 F down to 70 F within 2 hours and from 70 F to 41 F or less within 4 hours but the entire process must be		return demonstration of proper sanitization of food tables. The dietary staff was then inserviced on 5-9-13 on proper cool down procedures, cleanliness of work area and sanitization, and distorted, or soiled handled utensils. The Registered Dietician shall inspect atleast 2 times per month that the proper cool down techniques are in place and the log is adequate and up to date, that the kitchen including but not limited to microwave and cooking utensils are clean and in proper working condition, and that the dietary staff performs proper sanitization techniques during cleaning. This report of finding from the RD shall be given to the Director of Nursing and Administrator over the next 6 months. Any concerns/finding shall be discussed in the Quality Assurance Committee for review.	

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	done in 6 continuous hours. She indicated she would develop a system to take and log temperatures to ensure food made it to the lower temperature quickly and inservice staff on how to get the temperature lower before putting food into the refrigerator in the fist place. During the tour there were 3 of 4 spatulas noted in use with distorted melted handles with dark brown matter trapped in the contortions when melted and/or broken, jagged handles. The microwave door and operation surfaces were tacky to the touch with a brownish build up and visible dried food matter adhered. The interior had a sour odor and the surfaces were covered with brown film and had dried food matter and splatters and oil build up discoloring the interior cabinet color. On 4/15/13 at 9:30 P.M. the FSS provided an inservice handout dated 2010, in lieu of a Policy and Procedure for Quick chilling foods. It directed "First 2 hours/ 135 F - 70 F and within 6 hours from 135 F to 41 F or less. USE SHALLOW PANS."			

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	2. On 4/18/13 at 9:30 A. M. Cook #1 was observed to be performing food preparation of different components of the noon meal on two (2) separate food contact surfaces. She had a damp wash rag and two (2) brown paper towels which she carried back and forth from one surface to another to wipe up spills. The items were soiled with food matter. She indicated the the damp rag had been dipped in the bucket solution to get it wet originally but was not stored in the bucket. She indicated the bucket contained detergent but not the sanitizer. She indicated the sanitizing of surfaces was completed after the cooking was done and the surface was cleared. For the sanitizing she was observed to use the the same rag and the detergent solution to wipe the surface. Then she applied the sanitizing solution to the wet surface (diluting it's strength). She wiped the surface thoroughly dry with paper towels in a period of 35 seconds from the application of the spray. She stated "And that's how we do it." The white sanitation spray bottle had brown matter accumulated in the hand grip grooves, was overall tacky and had dried food matter on the nozzle attachment. The manufacturer direction on the Cerva bottle directed			

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	the sanitizing solution was to be sprayed on, left to contact the surface for 60 seconds and air dried. The FSS was interviewed following being informed of the observation. She indicated the Policy and Procedure for the process was to follow the directions on the bottle from the manufacturer and had not realized the cook did not understand when or how to do it but would inservice accordingly. 3.1-21(i)(2) 3.1-21(i)(3)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. A. Based on observation, interview, and record review, the facility failed to store and monitor medications within	F000431	The corrective action taken for those residents found to be affected by the deficient practice is that The refrigerator on front was replaced on 5/8/13. A	05/15/2013

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	manufacturers' recommended temperature ranges in 1 of 2 medication refrigerators. B. Based on observation, interview and record review, the facility failed to return medications to the pharmacy and/or destroy medications in a timely manner for 9 residents whose medications were observed stored in the facility on 2 of 2 medication carts and/or in 2 of 2 medication rooms. Resident #48, Resident #6, Resident #19, Resident #5, Resident #28, Resident #41, Resident #46, Resident #32 and Resident #40 Finding included: A. On 4/19/13 at 10:30 A.M., in the medication storage room located behind the nurse's station, on the front hall, LPN #33 read the temperature of the medication storage refrigerator at 22 degrees Fahrenheit (F) from the thermometer located on the first shelf of the refrigerator. The temperature was observed to be read correctly by LPN #33. At that time, the medications stored in the refrigerator included, but were not limited to, an Emergency Drug Kit, which contained eleven (11) 2 ml vials		complete Med Storage review was conducted on 4/24/13 of Medication carts, Medication rooms including the refrigerators by the Facilities pharmacy. Nurse #35 was explained the proper procedure for destruction of medications. . *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* The Facility policy was updated to include daily refrigerator temp checks and destruction / return of medication to pharmacy in a timely manner. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that Daily temperatures will be obtained of all medication storage refrigerators by DON/designee. The results will be logged on a monthly log record to ensure medications are being stored at manufactures recommended guidelines. Nurse receiving orders will be responsible for removing any medication from carts and /or storage areas, immediately upon receiving an order to change medication. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that A Medication storage audit is to take place on 5-29-13 and then a Quarterly Medication Storage Audit will be conducted by the facility's Pharmacy, the report will be	

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	of Ativan, and one (1) 10 ml multidose vial of Tuberculin Purified Protein (TB Test). The medication producers' recommendation for the proper storage temperature of Ativan and Tuberculin Purified Protein was "Do not freeze. Store unopened containers in the refrigerator at 36-46 degrees F." During an interview with the Assistant Director of Nursing (ADON) on 4/19/3 at 11:10 A.M., the ADON indicated that the maintenance man would replace the thermometer and then check the temperature again . During an interview with LPN #33 on 4/19/13 at 10:30 A.M., LPN #33 indicated that the refrigerator temperatures were checked and documented on the medication temperature log posted on the door of the refrigerator the first thing in the morning by someone in administration. On 4/19/13 at 4:08 P.M., LPN #34 read the temperature of the medication storage refrigerator at 26 degrees (F) from the thermometer located on the first shelf of the refrigerator. The temperature was		forward to the Quality Assurance Committee to review at monthly meetings. A Quality Assurance tool has been developed and implemented to monitor that storage of medication, and timely return and or destruction of medication are being completed timely. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted. Completion date: May 15 ,2013 **Quality Assurance Tool** **F – 431** **Medication Storage** **DIRECTIONS: Through observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" for not applicable. Review the outcomes to determine the need for additional interventions or action plan.** **INDICATOR** **PATIENTS**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HWY WASHINGTON, IN 47501	

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	observed to be read correctly by LPN #34. LPN #33, who was standing there at the same time, indicated that the maintenance man had replaced the thermometer earlier that morning following the first observed temperature reading of 22 degrees Fahrenheit. Section K of the facility's policy and procedure for "Medication Storage" was reviewed on 4/19/13 at 5:00 P.M., and it read as follows: "... medications requiring refrigeration of temperatures between 36 degrees F and 46 degrees F . are kept in a refrigerator with a thermometer to allow monitoring..." B. 1. On 4/19/13 at 11:30 A.M., during an inspection of the medication cart located on the back hall, seven (7) tablets were observed in a medication cup in the 3rd drawer of the medication cart. No identification as to whom the medication belonged or the type of medications was observed on the cup. On 4/19/13 at 11:30 A.M., LPN #35 indicated the pills belonged to Resident #32. LPN #35 indicated Resident #32 had been sent to the hospital on 4/13/13 and had not		**COMMENTS** 1 2 3 4 5 6 7 8 1. Are temperature logs completed on medication room refrigerators? Are Temperatures with in Manufactures recommended range (35-45)? 2. Are new orders for medications changed removed from storage area upon receiving order to change orders?	

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	returned to the facility. LPN #35 indicated the pills should not have been left in the drawer. The pills should have been destroyed. Review of the physician's order dated 4/13/13 for Resident #32 read as follows: "4/13/13, Admit to the behavior heath unit." Section 14 of the Policy and Procedure for "Medication Administration" was reviewed on 4/19/13 at 5:00 P.M., and it read as follows: "... For residents not in their rooms or otherwise unavailable to receive medication pass, the medication administration record (MAR) is flagged with tags, colored plastic strips, drinking straws, or paper clips. After completing the medication pass, the nurse returns to the missed resident to administer the medication." B. 2. Based upon clinical record review on 4/19/13 at 3:05 P.M., the residents listed below did not have a current physician's order for the listed medications which were located on the medication cart. Resident #41 - one (1) 15 ml bottle of Natural Tears Balance.		3. Are medications returned/destroyed according to facility policy	

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	Resident #46 - one (1) vial of insulin Novolin R u-100. The vial had been opened, but documentation on the vial did not document the date it was first used. Resident # 6 - one (1) tube of Erythromycin Ophthalmic ointment and one(1) 15 ml bottle of Sulfamide 10% eye drops. Resident #48 - one (1) tube of Bactroban 2%, one (1) bottle of Milk of Magnesia 150 cc, forty-two (42) tablets of Compazine 10 mg, fifty-two (52) Juven packets. Resident #5 - six (6) tablets Coumadin 1 mg, forty-two (42) Sentry Senior tablets, twenty-nine (29) Ferro-Sequels tablets. Resident #40 - Seven (7) Coumadin 3 mg tablets, forty-one (41) Coumadin 1 mg tablets. Resident #19 - Eleven (11) vials of Proventil. Resident #28 - One (1) tube of Neosporin Antibiotic ointment, one (1) tube of Bactroban ointment. B. 3. Located in the medication storage room in the front hall was one, half used, 250 ml bottle of 0.9%			

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	normal saline. The date the container of Normal saline was opened was not documented. Located in the medication storage room in the back hall was one half used, 250 ml bottle of 0.9% normal saline. The date the normal saline was opened was not documented. Section M of the Policy and Procedure for "Medication Storage" was reviewed on 4/19/13 at 5:00 P.M., and it read as follows: "...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of accordingly to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." On 4/19/13 at 10:15 A.M., LPN #33 indicated that a person from the pharmacy came once a month and reviewed the medication carts and the medication storage rooms for expired medications. LPN #33 indicated that when a bottle of insulin or solution was opened, the date on the container should be documented on the container. 3.1-25(o)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE MANOR NURSING HOME	1109 E NATIONAL HWY WASHINGTON, IN 47501

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	3.1-25(m)			

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F000441 SS=E	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F000441	Hillside Manor shall maintain an infection control program that	05/17/2013

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	A. Based on observation, interview and record review, the facility failed to ensure good hand washing technique was used during medication administration during 1 of 2 observed medication passes; 1 of 1 G-tube (Gastrostomy tube) feedings and 1 of 1 dressing changes. Resident # 23 B. Based on interview and record review, the facility failed to ensure facility policies were in place to address procedures for isolation in regard to pathogens Clostridium Difficile (C.diff) and Methicillin Resistant Staphylococcus Aureus (MRSA). The facility also failed to ensure an effective disinfectant detergent had been utilized to clean isolation rooms which had residents who had resided with the diagnosis of C. diff. Findings include: A. 1. The clinical record for Resident #23 was reviewed on 4/19/13 at 3:15 P.M. Diagnoses included, but were not limited to, the following: Alzheimer ' s, hypertension, dementia, depression, bipolar disease. The physician's orders read as follows: Fibersource HN 1.2 cal 1/2		helps prevent the development or transmission of infections in a safe and sanitary environment. Hillside Manor shall provide services to our residents (such as dressing changes, tube feedings, etc.) using proper, safe, and sterile techniques including hand-washing protocols that prevent cross contamination or the spread of pathogens. Improper sterile techniques and hand-washing procedures could have a potential negative impact on those residents. All personnel were in-serviced on 4-25-13 and 5-9-13 regarding the new infection control policy and procedures for C-Diff and MRSA. Also, during this time, the equipment, policy location, and protocols were discussed. Proper hand-washing techniques were reviewed by all. Proper hand-washing techniques were reviewed by all staff with emphasis on glove usage and hand washing in between and after. The LPN noted in the 2567 was given 1-on-1 education and provided return demonstration. Additionally, all nurses were signed off on hand washing by the the D.O.N.Infection control policies and proper handwashing/glove usage will be added to our regular and routine in-service schedule.The D.O.N. and A.D.O.N. shall weekly monitor the nursing staff providing sterile services to our residents for the next 3 months.	

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	can 4 times a day. Risperdone 0.5 mg 1 tablet per g-tube at noon. Use 60 cc of water before and after medication administration and use 90 cc of water before and after bolus feeding. On 4/18/13 at 12:30 P.M., LPN #32 sanitized her hands. LPN #32 then proceeded to open the resident's medication drawer. LPN #32 touched several of the boxes of medication located in the drawer looking for Resident #23's Risperdone. After finding Resident #23's Risperdone, LPN #32 then touched the MAR and the surface of the medication cart. LPN #32 reached for a plastic medication cup and placed her 2 fingers inside the cup in order to move it closer to her on the medication cart. LPN #32 crushed the Risperdone 0.5 mg and poured the crushed medication into the same medication cup into which she had just put her 2 fingers. LPN #32 poured 15 cc of water into the crushed medication and mixed it together. Upon entering Resident #23's room, LPN #32 went into the Resident #23's bathroom and washed her hands for 9 seconds. After LPN #32 dried her hands, LPN 32 put gloves on, and, after checking the placement of the gtube, LPN 32 proceeded with administering the		They shall monitor proper and acceptable sterile service techniques including handwashing, dressing changes, and glove usage. Hillside Manor shall maintain an infection control program that helps prevent the development or tansmission of infections in a safe and sanitary environment. Hillside Manor has revised and improved the existing infection control policy to include policies and procedures with detailed instructions on contact precautions regarding C-Diff and MRSA. (Policies Included) This procedure change also included the implementation of our new "Dispatch Bleach Germicidal Spray" which is a multipurpose, borad spectrum cleaner disinfectant for use in healthcare and other areas where control of cross contamination is required, especially during outbreaks of Clostridium difficile and other healthcare associated infections. Kills C-diff spores in 5 minutes, kills 99.99% bacteria, viruses, and fungi in 1 minute on hard, non-porus surfaces, kills mycobacterium bovis-BCG(TB) in 30 seconds, kills MRSA in 1 minute, and VRE in 1 minute as well as others. Additionally, three red totes were purchased, labeled "isolation materials" that include in them both policy and procedures for C-Diff and MRSA, gloves, gowns, masks, and red bags. Two of the red totes will always be kept in the clean linen	

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	resident's medication. During the administration of Resident #23's medication, Resident # 23 cried out, "My ankle still hurts." LPN #32 proceeded to pour the 60 cc of water into the gtube after the medication had flowed through the gtube. LPN #32 removed her gloves and returned to her medication cart where she prepared Resident #23's 125 ml Fibersource H2,1.2 calorie feeding. Upon returning to Resident #23's room with the Fibersource feeding in a cup, LPN #32 entered Resident #23's bathroom and filled each of 2 Styrofoam cups with 90 cc of water. LPN #32 did not wash her hands, but LPN #32 did don gloves and started aspirating Resident #32's gtube to check for residual. A 15 cc residual was aspirated from Resident #23's gtube. LPN #32 stopped and said she needed to call the physician before she could proceed with the feeding because the facility's policy and procedure required staff to call the physician whenever 15 cc or more residual was aspirated from a gtube. LPN #32 removed her gloves and left the room without washing her hands. A. 2. On 4/18/13 at 12 P.M. , Resident #23 was observed in her bed. LPN #32 was preparing to		closet and 1 will be kept in the south utility room. These are accessible 24/7. The dispatch bleach germicide will be kept in the south utility room, as it is under lock and key. The D.O.N. or designee shall assume responsibility for the availability of the new policies, implementation of such, isolation equipment, and proper documentation of discovery and protocols established. This responsibility is on-going. The D.O.N. or designee shall keep administration informed of any infectious residents requiring contact isolation or any resident infected. All new hires will recieve orientation by the D.O.N. or her designee regarding infection control policies and procedures, hand washing, and proper glove usage. Completion Date: May 17, 2013 HILLSIDE MANOR POLICY & PROCEDURE PREVENTION & CONTROL OF C-DIFF (CLOSTRIDIUM) POLICY: It is the policy of this facility to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. PREVENTION & CONTROL: 1. A resident who has >3 loose stools in a 24 hour period should be considered possible infected and placed on precautions immediately (If a private room is	

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	change the resident's dressings. With gloved hands, LPN #32 removed the old dressing to the resident's right outer ankle. Without changing gloves, LPN #32 then picked up the bottle of Hydrogel, which was sitting on the bedside table and squirt the solution on the opened, inside wrapper of the dressing. She then applied the Hydrogel to the right outer ankle. LPN #32 did not change gloves and/or handwash between removing the old dressing to applying the new dressing. With the soiled, gloved hands, she picked up the black marker, which was sitting on the bedside table, she was working from and dated the newly applied dressing to the right ankle. LPN #32 then removed her gloves and without washing her hands, applied new gloves. She then applied skin prep (pre-moistened prepackaged treatment wipes) to the outer areas of the lateral foot and the heel. With gloved hands, she then replaced the antipressure boot to the resident's right foot. LPN #32 them removed her soiled gloves and without handwashing, put on a new pair of gloves. She removed the dressing off the left hip. Without changing gloves, LPN #32, took the same bottle of Hydrogel,		unavailable, cohort residents with CDI) Get order to test stool for CDI 2. Isolation materials (gowns, gloves, masks, red bags & "Dispatch Bleach") will be placed in the "south utility closet" in the cabinet with red sign on door labeled "Isolation Materials". In addition, a mobile tote labeled "isolation materials" may be placed in the resident room. 3. A red tag shall be placed on the outside of the resident door stating, "Report to the Nurses' Station before entering". 4. A red barrel is located in the south utility room with a red trash bag inside it. All linens must be bagged inside the resident room in a red bag and placed directly into the red barrel. All trash from the resident room shall be placed into a red bag and placed inside the red barrel. 5. The resident shall use a bedside commode. Spray with "Dispatch bleach" after use. 6. Continue with contact precautions until diarrhea has resolved for two days 7. Staff shall use gowns and gloves and remove them before exiting room. 8. Staff should use handwashing before and after care given. 9. The resident room shall be cleaned daily with "dispatch bleach" (pay close attention to bedrails, light switches, call lights, bedside table, remotes, bedside	

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	squirt it on the opened interior dressing packaging and applied it to the area on the left hip. Without changing gloves and/or handwashing, LPN #32 applied the clean border dressing. She then took the unclean gloved hands and used the pen lying on the table to date the drsg. Again, without changing gloves or handwashing, LPN #32 removed the left boot and the resident was observed to have two reddened/scabbed type areas along the outside of the left foot. LPN #32 applied skin prep to these area. She then reapplied the boot to the left foot. LPN #32 took her gloves off and picked the black marker from the bedside table and put it in her pocket without handwashing and/or cleansing the pen. She left the room without handwashing and returned to the nurses station without handwashing. On 4/18/13 at 6 P.M., the DON provided a current copy of the policy and procedure for "Dressing Change Policy". The policy was undated. The purpose of the policy is to provide dressing change guidelines for nursing staff. The procedure included, but was not limited to the following: "The following steps will be used to perform dressing changes:		commodes, door knobs) 10. When possible, residents should have their own supplies left in the room (blood pressure cuff, stethoscopes, thermometers, etc) but if they cannot be left in the room, they must be properly disinfected before leaving the room with "dispatch bleach". 11. Residents shall eat in their room during this time and receive any requested activity material that may be performed in room (books, movies, crosswords, music, etc) Note: Additional isolation material kits are located in each clean linen closet throughout the facility. HILLSIDE MANOR POLICY & PROCEDURE PREVENTION & CONTROL OF MULTIDRUG-RESISTANT ORGANISMS (INCLUDING MRSA & VRE) POLICY: It is the policy of this facility to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. PREVENTION & CONTROL: 1. A resident with a multidrug-resistant organisms (MDROs) including MRSA (methicillin oxacillin-resistant staphylococcus aureus) and VRE (vancomycin-resistant enterococci) are bacteria and other microorganism that have	

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	Wash hands, assemble supplies, DON clean gloves, remove old dressing, discard dressing and used gloves in appropriate receptacle, wash hands, perform wound treatment as ordered and wash hands..." At that time, the DON was interviewed. She indicated the policy should stated after removing the old dressing and washing hands, to apply clean gloves, perform the treatment and remove the soiled gloves before washing hands again. At that time, the DON also provided a current copy of the facility policy and procedure for "handwashing." The policy was undated. The policy included but was not limited to the following: "...The use of gloves does not replace handwashing...wash hands after handling used dressings...after removing gloves..." B.1. On 4/18/13 at 10:28 A.M., the housekeeping supervisor was interviewed regarding cleaning of a resident room which had housed a resident with C. diff. She indicated the housekeeping staff would enter the resident room with gloves and clean the resident room using the detergent PH 7 Q to mop floors,		developed resistance to one or more classes of antimicrobial drugs. 2. Staff will use standard universal precautions as the primary approach to preventing transmission of MDROs. 3. Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the facility. 4. Masks and gowns are NOT recommended for routine use in caring for residents with MRSA or VRE, unless they are performing splash-generating procedures (wound irrigations) or large amounts of drainage present. 5. If the staff and physician believe that the resident is at risk of spreading the infection, the physician may want to initate contact precautions. Contact precautions are suggested when the resident has a respiratory MDRO, large amount of drainage that can't be covered by a dressing, poor hygiene techniques, and poor cognition. 6. If placed on Contact precautions: a. Place the red tote labeled "isolation materials" in the residents room b. Place the red sign "Stop, Please report to the Nurses station before entering" on the resident door c. Place the resident in a private room when available d. Caregivers shall place all	

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	bedside table, the bathroom, etc. On 4/18/13 at 10:40 A.M., the Housekeeping Supervisor provided information on the disinfectant/germicidal detergent PH 7 Q. The information included PH 7 Q virucidal against: " HIV-1 (AIDS virus), Influenza A/Hong Kong, Herpes Simplex Type 1, Herpes Simplex Type 2, Vaccinia, Rubella, Adenovirus Type 4, HBV (Hepatitis B Virus)..." "...This disinfectant is also efficacious against Pseudomonas aeruginosa, Salmonella choleraesuis, MRSA (Methicillin Resistant Staphylococcus aureus), VRE (Vancomycin Resistant Enterococcus faecalis) and Trichopyton mentagrophytes." The documentation was lacking to indicate PH 7 Q would be effective against C. diff. .2. On 4/18/13 at 3:58 P.M., the acting Infection Control Nurse was interviewed regarding facility policy isolation procedures in regard to Clostridium Difficile (C. diff) and Methicillin Resistant Staphyloccus Aureus (MRSA). The acting Infection Control nurse indicated if a resident was admitted to the facility and had diagnoses for example of MRSA or C.diff, she would call the physician to		items from the resident in red bags before leaving the room; including linens, clothing, and trash. The red bags shall go directly to the south soiled utility room and placed in the red barrel. e. Caregivers shall put on a gown, mask, and gloves before entering and remove them (place into red bag) before exiting door. f. Residents with a MDRO may participate in group dining, group activities, and socialize outside of room if they have drainage wounds that may be covered, body fluids are contained, and he/she observes good hygiene practices g. Residents placed onto contact precautions shall remain so until a clear culture report has been obtained in the facility. Isolation Materials located in red totes in clean linen closets & south utility room	

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	find out if physician wants gown, mask, etc. If she the acting Infection Control Nurse was not at the facility the Director of Nursing (DON) would call the physician. She indicated isolation policy and procedure was determined by the physician. Information from the physician included but was not limited to: if the resident needed a private room or if a bedside commode would be used. She indicated the facility did not have a facility policy for C. Diff but used inservice information to address isolation procedures. On 4/18/13 at 5:00 P.M., the facility inservice information entitled, " FAOs (frequently asked questions) about 'Clostridium Difficile' was received and reviewed. The inservice information had a fax date of 1/23/08. This information included but was not limited to questions: "...What are some of the things that hospitals are doing to prevent C. diff infection?..." "... Clean their hands with soap and water or an/alcohol-based hand rub before and after caring for every patient...Use Contact Precautions to prevent C. diff from spreading to other patients. Contact Precautions mean: Whenever possible, patients with C. diff will have a single room or share a room only with someone else who			

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	also has C. diff. Health care providers will put on gloves and wear a gown over their clothing while taking care of patients with C. diff... Patients on Contact Precautions are asked to stay in their hospital rooms as much as possible. They should not go to common areas, such as the gift shop or cafeteria. They can go to other areas of the hospital for treatment and tests..." The inservice information included, " How can Clostridium difficile infection be prevented in hospitals and other health care settings?: ...Continue these precautions until diarrhea ceases. Because Clostridium difficile-infected patients continue to shed organism for a number of days following cessation of diarrhea, some institutions routinely continue to isolation for either several days beyond symptom resolution or until discharge, depending upon the type of setting and average length of stay..." The inservice information also included but was not limited to: "... Consider using an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental service disinfection			

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	after cleaning in accordance with label instructions; generic sources of hypochlorite (e.g., household chlorine bleach) also may be appropriately diluted and used..." "...Note: EPA-registered disinfectants are recommended for use in patient-care areas. When choosing a disinfectant, check product labels for inactivation claims, for use and instructions..." On 4/18/13 at 4:14 P.M., the acting Infection Control nurse was made aware of handout information regarding PH 7 Q, that had been provided by the Housekeeping Supervisor. She was made aware PH 7 Q was not effective against C. diff. She was also made aware of problem of documentation lacking of specific isolation policies and procedures in regard to MRSA and C. diff. The acting Infection Control nurse indicated at that time the facility did use the disinfectant detergent PH 7 Q to clean in regard to pathogens MRSA and C.diff. On 4/18/13 at 5:00 P.M., the acting Infection Control Nurse also provided inservice information entitled, "Questions & Answers: STAPH/MRSA skin infections (dated 01/14/04). The documentation			

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	included but was not limited to: definition of MRSA, how MRSA infections spread, and what I should do to keep others from getting a skin infection. The inservice lacked documentation in regard to specific facility procedures for staff to implement in regard to resident MRSA infections. 3.1-18(L) 3.1-18(b)(1)			

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F000463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview and record review, the facility failed to ensure functional call lights were available for use at the nurses station on the North unit and in a central unisex bathroom for 1 of 3 units in the facility on the front unit, for 2 of 7 survey days with potential to impact 9 residents on the North unit who used call lights. Findings include: 1. On 4/16/13 at 8:00 A. M. the call system panel at the nurses station was noted to light up one red light at the top of the panel when a resident or more than one resident had a call light turned on. Staff were observed to have to look in the halls to see what rooms had lights on, to identify which resident needed assistance. The call lights over the residents' doors were not visible from the nurses station, for the North unit residents. LPN #3 indicated that was what they had done "for some time since the remodeling." She indicated	F000463	Hillside Manor Nursing Home shall maintain in proper working order all call-light systems used to notify and summons assistance and help from our staff to our residents. The annunciator panel diode that illuminates the light in the north nurses station panel had failed. As the alerting panel buzzer was still operational along with the room identifying hall light, no safety or service to the residents was compromised. This small unit serviced about 9-10 rooms and the call for assistance can only be silenced in the residents room. The annunciator switch in the communal bathroom was intermittent and therefore faulty. This had the potential to effect all residents who would use the communal bathroom. The annunciator panel diode was repaired as soon as possible (4-19-13) by Vanguard of Evansville, Indiana along with the replacement of the intermittent bathroom switch. An inservice was held with all personnel on 4-25-13 and 5-9-13 to notify maintenance or the administrator 24/7 of any faulty or failed items potentially affecting resident safety or service. The example of the corresponding light failure in	05/15/2013

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	the panel at the nurse's station had red lights signifying each room for visual identification at the desk however they were lost in the remodeling. At 10:00 A.M. the Maintenance engineer was observed checking the panel. He indicated he had to have it replaced by Vanguard earlier in the day and was making sure it was working. He indicated he had known it was not working until the staff identified the problem. At that time he was interviewed regarding ongoing preventive maintenance. He indicated he generally did not do anything with call lights unless staff notified him of a problem. He indicated the call light system was not on any ongoing preventive maintenance and was not routinely checked or logged. 2. On 4/19/13 at 2:55 P.M., the communal bathroom (across from resident room 1) call light was checked. The call light, when activated in the bathroom, did not sound or light up the light bulb outside the bathroom door. On 4/19/13 at 3:02 P.M., LPN #3 was notified of the call light in the communal bathroom not working. She indicated at that time she would notify the		the call-light panel was cited. The maintenance supervisor has placed the call light system on his preventative maintenance program. A monthly check of all call-lights (including panels) in the facility is verified for proper working condition, logged, and turned into the administrator for safe keeping. All un-correctable failures will be immediatly turned over to the administrator. This mechanical maintenance shall be the responsibility of the 10 year veteran maintenance supervisor who shall report directly to the administrator of any replacement or repairs. The D.O.N. shall assist by monitoring the staff nurses in regards to immediate notification of any faulty or failed items. The administrator shall assume reponsibility of over-seeing the notification and maintenance of any needed repair--no time limit shall be assigned to this responsibility--it will be ongoing. Date completed: 5-15-13	

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	maintenance man of the call light not working. On 4/19/13 at 3:10 P.M., the maintenance man indicated the communal call light of the bathroom was not working and he was working on it. 3.1-19(u)(1) 3.1-19(u)(2)			

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F000464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observations, the facility failed to ensure that one (1) dining room had enough room to accommodate residents seated in wheelchairs and broda chairs. The facility failed to ensure that there was enough room for staff to reach residents without turning sideways to walk between residents or interrupting other residents during meal service in 1 of 2 dining rooms, during 3 dining observations for 4 of 4 residents observed during the meal observations. Resident # 18, Resident # 6, Resident # 49, Resident # 5 Findings include: During an observation of the meal service on 4/16/13 at 12:15 P.M., seated at the assisted feeding table in the front dining room were three residents and CNA #22.	F000464	Hillside Manor shall provide our residents with dining rooms with adequate space to accomodate all activities. The deficient practice of not ensuring that there was adequate space between tables and chairs had the potential to effect all residents using the dining room area. The north dining room, (dining room in question) was evaluated and observed on 4-22-13 at 730am. Upon completion of the meal service a new seating chart was developed for the entire facility. In the north dining room far west side of the room, two large straight back chairs were removed from the dining room. 4 small 24"x24" square tables were removed from the north dining room and 8 extra chairs not in use were removed. The table in question, our feed table was located on the far west wall and those residents were moved to the far north east side, of which has the most room to accomodate the use of wheelchairs and large broda style chairs. The tables were positioned towards the north wall,	05/15/2013

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	Resident #18 was sitting in a wheelchair at the back of the table, against the wall. Resident #49 was sitting in a broda chair with CNA #22 seated in a chair to his right. Resident #6 was seated on the left side of the table. The distance between the wall and the back of the Resident #49's broda chair was approximately width 1-1/2 of a 12 inch floor tile. The distance between the wall and Resident #6's broda chair was the wideth of 2 of the 12 inch floor tiles. Two chairs were observed also against the wall, one in each corner. In order for staff to reach Resident #18, Resident #49 or Resident # 6 they would need to be moved. During an observation of the meal service on 4/18/13 at 12:20 P.M., Resident # 18 and Resident #6 were seated between the table and the back wall. Resident #49 was between the table and the side wall and Resident #5 was seated between the opposite side wall and the table. The distance between the wall and both Resident #49 and Resident # 5 were 2 of the 12 inch floor tiles. During an interview with CNA # 22 on 4/18/13 at 12:25 P.M., CNA #22 indicated that the table where		allowing ample room for residents to sit on the north side of table and the south side of the table and allow staff or other residents to exit the area without having to move someone else.All personnel was inserviced on 4-25-13 and 5-9-13 regarding the Revised seating arrangement in the north dining room. A copy of seating chart is located in both C.N.A. assignent books and shall not be altered without consent from the D.O.N. Staff was educated on the importance and safety of easy access to all residents, using caution not to block anyone in, and the importance of utilizing the space provided efficiently by not cluttering the area with additional chairs, carts, etc. The Administrator and D.O.N. shall be responsible for maintaining an adequate seating chart that will allow ample room for residents. There is no time table on this monitoring effort, it shall be ongoing. Completion date: 5-15-13	

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	Residents #18, #6, #49, and #5 were sitting was the assisted feeding table and that these same residents were almost always seated at that table. 3.1-19(v)			

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F000518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on interview and record review, the facility failed to ensure 2 of 5 employees interviewed regarding disaster planning were prepared to respond to a tornado warning and/ or a chemical spill incident. LPN # 34, ADON Findings included: 1. On 4/18/13 at 4:50 P.M., LPN #34 was interviewed regarding what to do in a tornado warning. She indicated she worked evening and night shifts at the facility. She indicated if the facility had received notice of a tornado warning the residents would be kept away from the doors and windows. She indicated she was not sure if residents should be kept in their rooms or moved to the hall. She indicated it would be the same for residents on evenings and night shifts.	F000518	Hillside Manor Nursing Home shall, and does, include fire and disaster in-service to all employees on a regular basis. Such is also included in the orientation of any new employee. The deficient practice noted could have the potential to effect all residents.An all personnel inservice was conducted on 4-25-13 and 5-9-13 to discuss disaster policy and procedures including fire,earthquake,chemical spills, and tornados.The facility policy and procedures for the above mentioned shall remain the same BUT an additional copy of each policy shall be maintained in the communication book at each nurses station for additional review if needed.Additionally, the monthly fire drills shall be augmented with a quarterly un-announced disaster drill (other than fire) initiated by the D.O.N. or the A.D.O.N. or Administrator. This drill shall be documented in regards to the scope, the staff involved, and proper response from staff. A tornado warning drill was completed on 5-13-13 at 1:30pm. The D.O.N or	05/15/2013

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	2. On 4/18/13 at 5:18 P.M., the Assistant Director of Nursing (ADON) was interviewed regarding facility procedure in a tornado warning and a chemical spill. She indicated if a tornado warning had been issued residents would be removed from their rooms into the hall area. She indicated all residents during all shifts would be moved to the hall area for a tornado warning. She also indicated at that time she did not know the facility's policy and procedure for a chemical spill. 3. On 4/18/13 at 5:45 P.M., the facility administrator provided the facility policy entitled, " Severe Thunderstorm & Tornado Policy" and "Chemical Spills Policy/Procedure." The facility's tornado policy included but was not limited to: "1. If the Warning on the radio or local sirens sound, this means to seek cover. 2. During day time hours, All residents will be directed to the Middle Hall Way. Ambulatory residents will be directed to Middle Hall First, followed by wheelchair bound residents. Bedfast residents will remain in their rooms with the following implemented: Blinds closed, curtains drawn, and door shut." "... 6. During night time hours, beds will be moved		Administrator shall monitor the staff's knowledge of the fire and disaster policy and procedure through the facility un-announced drills and shall be responsible for the frequency of re-education and in-service training. This responsibility shall have no time limit and shall continue indefinately.	

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	away from all windows, blinds closed, drapes/curtains drawn, and room doors shut..." The facility's chemical spills policy included but was not limited to: "... Procedure: Charge nurse will notify Administrator/Executive Director, Maintenance and Director of Nursing in the event of chemical spill. Shut down outside intake ventilation. Close all doors to the outside and close and lock all windows..." 3.1-51(b)			