

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2015
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 2, 3, 4, 5, & 6, 2015</p> <p>Facility number: 000399 Provider number: 155750 AIM number: 100289100</p> <p>Survey team: Cheryl Mabry, RN-TC Brooke Harrison, RN Susan Worsham, RN (3/04, 2015) Angela Patterson, RN (3/02, 3/03, 2015) Patty Allen, RN (3/06, 2015) Marsha Smith, RN (3/05, 3/06, 2015) Dorothy Plummer, RN (3/06, 2015)</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicaid: 34 Other: 2</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 225 SS=D Bldg. 00	<p>Total: 36</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 16, 2015; by Kimberly Perigo, RN.</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>				

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	<p>progress.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of resident mistreatment was immediately reported to the Administrator, as indicated by the facility's abuse policy for 1 of 1 resident reviewed for an allegation of mistreatment. (Resident #16) (LPN #1, LPN #2)</p> <p>Findings include:</p> <p>Resident #16's clinical record was reviewed, on 3/4/15 at 2:54 p.m. Diagnosis included, but were not limited to: cerebral palsy and spastic hemiplegia.</p> <p>The current Minimum Data Set (MDS) assessment, dated 1/20/15, indicated Resident #16 was interviewable and was totally dependent of two or more staff members for bed mobility, transfer, and toilet use.</p> <p>On 3/2/15 at 11:45 a.m., Resident #16 indicated the following:</p>	F 225	F-225 1. Abuse Policy and Procedure reviewed with all staff and internal investigations were completed with no substantial findings. Diagnosis for Resident #16 includes a personality disorder. Behaviors with this disorder includes falsely accusing, fabricating issues, and pitting one person against another per resident's Psychiatrist. These behaviors are part of Resident #16 medical record for behavior management and the care plan. 2. Any resident has the potential to be affected. 3. HFA in-serviced and re-educated all staff regarding reporting any allegations of abuse immediately to their supervisor and/or the DON and HFA. The facility has re-educated each staff member, supervisors and interdisciplinary team regarding promptly reporting any allegation of abuse to the Facility Administrator. Included in re-education was the importance of completing in writing on a daily basis any allegation of abuse. This will be included in the 24	03/30/2015	

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	<p>1). There are 3 aides that are very rude for no reason. I always need my hips repositioned. One day CNA #4 would not do it [indicating reposition hips]. She told me to wiggle myself to where I need to be. She knows I don't have the strength in my lower extremities. She just left out of the room. I told License Practical Nurse #2 (LPN) and she repositioned me. CNA #4 took care of me later that day.</p> <p>2). Resident #16 indicated, on a different day I put my light on and CNA #2 answered the light. I told her I need to use the bathroom. She went to get another aide to help. When CNA #2 and CNA #3 came into the room, CNA #2 said we need you to help stand like we know you can. I signed to her If I do it, I would not ask for help. CNA #3 said, If you are not going to help we are not going to help you. I shrugged my shoulders. CNA #2 walked out and left the room. CNA #3 threw my legs back in the bed. I was left kind of crooked in the bed and she left the bed rail down. I cried so hard. I called my mom and told her what was going on. My mom called LPN #2. LPN #2 came in and said, these girls (indicating CNA #2 and CNA #3) don't realize that the patients have their good and bad days, but in your case you</p>		<p>hour nursing report and the written allegation given to the facility administrator daily. 4. HFA, DON, SSD will monitor daily. The QA Committee will review quarterly for 6 months. The facility will follow the recommendations of the committee. 5. Date Completed: 03/30/15</p>	

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	<p>are unable to use your lower half. LPN #2 put me on the commode. I just want them to be nice. Those 2 together (indicating CNA #2 and CNA #3) have major attitudes when working together.</p> <p>On 3/4/15 at 2:59 p.m., CNA #2 indicated, Resident #16 has told me I was rude to her roommate. I have never had problems with Resident #16. She was mad at me, because I wouldn't go get her a pop from the store. The DON (Director of Nursing) has not questioned me about problems with Resident #16. We are always suppose to enter Resident #16's room in two's. I have never observed CNA #3 being rude to Resident #16. I was not made aware of any problems.</p> <p>On 3/4/15 at 3:20 p.m., CNA #3 indicated, Resident #16 was difficult when providing care. We will put her on the commode and she gets agitated if we can't understand what she is trying to tell us. I usually go get another CNA to help me, who understands her. The only problem she had with me is when I don't understand her signing. She has never said I was rough or forceful when putting her to bed. The Administration staff had not spoken to me about concerns with Resident #16.</p> <p>On 3/5/15 at 11:16 a.m., CNA #1</p>			

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	<p>indicated Resident #16 told me one of the CNA's put her legs in the bed "rough." It was about a month ago. I told LPN#1. I am not sure what LPN #1 did. It should have been reported.</p> <p>On 3/5/15 at 11:48 a.m., LPN #1 indicated, Resident #16 has told me some of the girls on 2nd shift are mean to her. She had typed out CNA #3 and CNA #4 have been mean to her. I think she said CNA #3 slung her legs in the bed and was pretty rough. I reported it to the DON.</p> <p>On 3/5/15 at 1:29 p.m., LPN #2 indicated, Resident #16 has never told me anyone has mistreated or been mean to her. Well one time she told me that staff wanted her to use her upper body strength to help get on the bedside commode. I was in the hall at the medication cart. She started screaming at the CNA's and fingering them. I went in and assisted her on the commode. She was really upset and I explained to her we just want her not to lose upper body strength. She can be a challenging resident. She has never told me that any CNA had been mean or rough to her.</p> <p>On 3/5/15 at 1:47 p.m., the Director of Nursing indicated, "I was not aware of the allegation until you mentioned it to</p>			

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	<p>me this morning. If LPN #1 told me I don't remember."</p> <p>On 3/3/15 at 9:45 a.m., the Administrator and the Director of Nursing (DON) both indicated those allegations of mistreatments were not reported to them. This was the first they had heard about those allegations and they had not been reported to the state.</p> <p>On 3/2/15 at 12:59 p.m., the Administrator provided policy "INCIDENTS OR ALLEGED ABUSE" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. ...PROCEDURE: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: ...2. ...the staff member must then export the incident to the supervisor in charge ... at the time of the incident. 3. A thorough investigation will be initiated of the allegations, ...4. There must be appropriate steps taken to prevent further [potential] abuse while the investigation is in progress. 5. The supervisor will then give written documentation detailing the incident to the Administrator , Director of Nursing, or Social Service Director. 6. If the</p>			

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F 226 SS=D Bldg. 00	<p>suspected abusive individual is an employee, it is the responsibility of the supervisor at the time of the incident ... to suspend the ... employee until the incident can be fully investigated. 9. If the incident is not witnessed the staff member receiving the report ... shall immediately inform the supervisor or the Administrator, Director of Nursing. ...10. All incidents of resident abuse will be reported to the Indiana State Department of health, ..."</p> <p>On 3/2/15 at 12:59 p.m., the Administrator provided policy "ABUSE PROHIBITION" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... NOTE: In addition any individual who has been alleged as exhibiting abusive behavior should not be permitted to continue to care for residents until and investigation has been completed and the allegation found to be unsubstantiated."</p> <p>3.1-28(c)</p> <p>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</p>			

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	<p>property.</p> <p>Based on interview and record review, the facility failed to ensure their abuse policy was implemented and immediately reporting allegation of mistreatment to the Administrator for 1 of 1 resident reviewed for an allegation of mistreatment. (Resident #16) (CNA #3, LPN #1, LPN #2)</p> <p>Findings include:</p> <p>Resident #16's clinical record was reviewed, on 3/4/15 at 2:54 p.m. Diagnosis included, but were not limited to: cerebral palsy and spastic hemiplegia.</p> <p>The current Minimum Data Set (MDS) assessment, dated 1/20/15, indicated Resident #16 was interviewable and was totally dependent of two or more staff members for bed mobility, transfer, and toilet use.</p> <p>On 3/2/15 at 11:45 a.m., Resident #16 indicated the following:</p> <p>1). There are 3 aides that are very rude for no reason. I always need my hips repositioned. One day CNA #4 would not do it [indicating reposition hips]. She told me to wiggle myself to where I need to be. She knows I don't have the strength in my lower extremities. She</p>	F 226	<p>F-226 1. Abuse Policy and Procedure reviewed with all staff and internal investigations were completed with no substantial findings. Diagnosis for Resident #16 includes a personality disorder. Behaviors with this disorder includes falsely accusing, fabricating issues, and pitting one person against another per resident's Psychiatrist. These behaviors are part of Resident #16 medical record for behavior management and the care plan. 2. Any resident has the potential to be affected. 3. HFA in-serviced and re-educated all staff regarding reporting any allegations of abuse immediately to their supervisor and/or the DON and HFA. The facility has re-educated each staff member, supervisors and interdisciplinary team regarding promptly reporting any allegation of abuse to the Facility Administrator. Included in re-education was the importance of completing in writing on a daily basis any allegation of abuse. This will be included in the 24 hour nursing report and the written allegation given to the facility administrator daily. 4. HFA, DON, SSD will monitor daily. The QA Committee will review quarterly for 6 months. The facility will follow the recommendations of the QA committee. 5. Date completed: 3/30/15</p>	03/30/2015

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	<p>just left out of the room. I told License Practical Nurse #2 (LPN) and she repositioned me. CNA #4 took care of me later that day.</p> <p>2). Resident #16 indicated, on a different day I put my light on and CNA #2 answered the light. I told her I need to use the bathroom. She went to get another aide to help. When CNA #2 and CNA #3 came into the room, CNA #2 said we need you to help stand like we know you can. I signed to her If I do it, I would not ask for help. CNA #3 said, If you are not going to help we are not going to help you. I shrugged my shoulders. CNA #2 walked out and left the room. CNA #3 threw my legs back in the bed. I was left kind of crooked in the bed and she left the bed rail down. I cried so hard. I called my mom and told her what was going on. My mom called LPN #2. LPN #2 came in and said, these girls (indicating CNA #2 and CNA #3) don't realize that the patients have their good and bad days, but in your case you are unable to use your lower half. LPN #2 put me on the commode. I just want them to be nice. Those 2 together (indicating CNA #2 and CNA #3) have major attitudes when working together.</p> <p>On 3/4/15 at 2:59 p.m., CNA #2 indicated, Resident #16 has told me I was</p>			
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	<p>rude to her roommate. I have never had problems with Resident #16. She was mad at me, because I wouldn't go get her a pop from the store. The DON (Director of Nursing) has not questioned me about problems with Resident #16. We are always suppose to enter Resident #16's room in two's. I have never observed CNA #3 being rude to Resident #16. I was not made aware of any problems.</p> <p>On 3/4/15 at 3:20 p.m., CNA #3 indicated, Resident #16 was difficult when providing care. We will put her on the commode and she gets agitated if we can't understand what she is trying to tell us. I usually go get another CNA to help me, who understands her. The only problem she had with me is when I don't understand her signing. She has never said I was rough or forceful when putting her to bed. The Administration staff had not spoken to me about concerns with Resident #16.</p> <p>On 3/5/15 at 11:16 a.m., CNA #1 indicated Resident #16 told me one of the CNA's put her legs in the bed "rough." It was about a month ago. I told LPN#1. I am not sure what LPN #1 did. It should have been reported.</p> <p>On 3/5/15 at 11:48 a.m., LPN #1 indicated, Resident #16 has told me some</p>			
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	<p>of the girls on 2nd shift are mean to her. She had typed out CNA #3 and CNA #4 have been mean to her. I think she said CNA #3 slung her legs in the bed and was pretty rough. I reported it to the DON.</p> <p>On 3/5/15 at 1:29 p.m., LPN #2 indicated, Resident #16 has never told me anyone has mistreated or been mean to her. Well one time she told me that staff wanted her to use her upper body strength to help get on the bedside commode. I was in the hall at the medication cart. She started screaming at the CNA's and fingering them. I went in and assisted her on the commode. She was really upset and I explained to her we just want her not to lose upper body strength. She can be a challenging resident. She has never told me that any CNA had been mean or rough to her.</p> <p>On 3/5/15 at 1:47 p.m., the Director of Nursing indicated, "I was not aware of the allegation until you mentioned it to me this morning. If LPN #1 told me I don't remember."</p> <p>On 3/3/15 at 9:45 a.m., the Administrator and the Director of Nursing (DON) both indicated those allegations of mistreatments were not reported to them. This was the first they had heard about</p>			

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	<p>those allegations and they had not been reported to the state.</p> <p>On 3/2/15 at 12:59 p.m., the Administrator provided policy "INCIDENTS OR ALLEGED ABUSE" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. ...PROCEDURE: Should any type of abuse or alleged abuse occur, the following procedure is to be followed: ...2. ...the staff member must then export the incident to the supervisor in charge ... at the time of the incident. 3. A thorough investigation will be initiated of the allegations, ...4. There must be appropriate steps taken to prevent further [potential] abuse while the investigation is in progress. 5. The supervisor will then give written documentation detailing the incident to the Administrator , Director of Nursing, or Social Service Director. 6. If the suspected abusive individual is an employee, it is the responsibility of the supervisor at the time of the incident ... to suspend the ... employee until the incident can be fully investigated. 9. If the incident is not witnessed the staff member receiving the report ... shall immediately inform the supervisor or the</p>			

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F 282 SS=D Bldg. 00	<p>Administrator, Director of Nursing. ...10. All incidents of resident abuse will be reported to the Indiana State Department of health, ..."</p> <p>On 3/2/15 at 12:59 p.m., the Administrator provided policy "ABUSE PROHIBITION" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... NOTE: In addition any individual who has been alleged as exhibiting abusive behavior should not be permitted to continue to care for residents until and investigation has been completed and the allegation found to be unsubstantiated."</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure plans of care were followed for a resident needing an assessment for restraint elimination (Resident #32) and a resident needing laboratory blood tests for medication and blood count monitoring (Resident #17), and physician's orders were followed for</p>	F 282	F-282 Resident #32-DON completed the restraint assessment immediately on 3/5/15. No changes indicated. Resident #17-DON contacted contract Lab service immediately. The physician orders had been sent to the Lab timely. However, the Lab missed the order. The facility nursing staff requested	03/30/2015

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	<p>a resident with an order to wear an immobilizer for 3 weeks (Resident #4).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #32 was reviewed on 3/5/15 at 10:01 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, agitation, history of falls, and dementia with behavior disturbance.</p> <p>A recapitulated physician's order for March, 2015, with an original order date of 9/21/12, indicated Resident #32 could be in a [brand name] chair, especially designed for reclining and tilting, with straps, due to the resident's, "inability to maintain upright position, slides down & leans."</p> <p>A care plan for Resident #32, dated 9/20/12, indicated, "Restraint Use... [brand name] chair with straps d/t [due to] inability to maintain upright position, slides down & leans)...needed due to the following medical symptoms: paces to the point of exhaustion d/t [due to] Alzheimer..."</p> <p>On 3/5/15 at 10:21 a.m., the Administrator provided a policy, dated April, 2014, titled, "Use of Restraints," and indicated it was the policy currently</p>		<p>stat draw on 3/5/15 from Lab. Lab results were normal.</p> <p>Resident#4-DON immediately reviewed physician's orders for accuracy. Attending physician contacted and he ordered to discontinue the immobilizer to left arm. 2. Any resident has the potential to be affected. 3.The facility implemented a new auditing tool to be used to insure all MDS assessments are completed in a timely manner. This assessment was accidently missed. MDS coordinator and assistant were in-serviced regarding how to effectively use the tool and monitor for compliance on March 30,2015. B. DON in-serviced nursing staff on March 30,2015, regarding monitoring of Laboratory Policy and Procedure that now includes comparing the monthly laboratory list from medical records to resident lab orders. C. Included in the March 30,2015 in-service for licensed nursing staff was a review and transferring of physician's orders accurately and timely. DON will recheck physicians orders and when resident returns from any outside provider. The facility implemented a new system in the form of a new check off list for MDS assessment completion. The HFA will review weekly for timely MDS assessments for restraints and affix his initials on the check-off document. In addition RN consultant will review monthly</p>				

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	<p>used by the facility. The policy indicated, "Restraints shall only be used for the safety and well-being of the resident(s)...16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination..."</p> <p>Physical Restraint Elimination Assessments for Resident #32, indicated he had been assessed for restraint reduction/elimination on 6/17/14, 8/26/14, and 10/28/14. No assessments were found in the resident's record after 10/28/14.</p> <p>On 3/5/15 at 10:44 a.m., the Director of Nursing indicated no restrain reduction/elimination assessments had been done on Resident #32 since 10/28/14. She indicated she had missed the assessment due in January, 2015.</p> <p>2. The clinical record of Resident #17 was reviewed on 3/5/15 at 10:59 a.m. Diagnoses for the resident included, but were not limited to, dementia with behaviors, psychosis, and anemia.</p> <p>a. A recapitulated physician's order for March, 2015, with an original order date of 7/16/14, indicated Resident #17 was to</p>		<p>with routine regular visits. 4. All license staff, DON, HFA, SSD will monitor. The QA committee will review quarterly for 6 months. The facility will follow the recommendations of the QA committee. 5. Date Completed 3/30/2015.</p>				

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	<p>receive divalproex sodium 250 mg. (milligrams) sprinkles 2 times per day at 9:00 a.m. and 3:00 p.m., and 500 mg at bedtime. Divalproex sodium, also known as valproic acid, is classified as an anti-convulsant medication. It was ordered for Resident #17 as a mood stabilizer to treat psychosis.</p> <p>A recapitulated physician's order for March, 2015, with an original order date of 1/19/12, indicated Resident #17 was to have a laboratory blood test drawn monthly to measure the level of valproic acid in his blood.</p> <p>A current care plan for Resident #17, dated 7/1/09, indicated a problem of, "Res [resident] requires use of Depakote [divalproex sodium] d/t [due to] Alzheimer's, dementia." Interventions included, "Monitor Valproic acid levels as ordered and notify MD [medical doctor] of any abnormal values."</p> <p>The Nursing 2014 Drug Handbook, 34th edition, copyright 2014, "valproic acid," indicated this medication can cause life threatening damage to the liver or pancreas, and, "Monitor drug level. Therapeutic level is commonly considered to be 50 to 100 mcg/mL [micrograms per milliliter]."</p>			

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	<p>No laboratory results for valproic acid levels were found in the resident's clinical record.</p> <p>b. A recapitulated physician's order for March, 2015, indicated Resident #17 was to have a complete blood count (CBC) drawn every month to measure the amount of red cells in his blood, related to his diagnosis of anemia. Anemia is a decrease in the amount of red blood cells or hemoglobin in the blood.</p> <p>A current care plan, dated 11/30/12, indicated Resident #17 had a potential for abnormal labs and fatigue related to anemia. Interventions included, "Monitor labs as ordered: CBC q [every] month."</p> <p>No laboratory results for CBC levels were found in the resident's clinical record for January or February, 2015.</p> <p>On 3/5/15 at 3:14 p.m., the Director of Nursing (DON) indicated she had spoken with the lab and the resident's orders for monthly valproic acid and CBC levels did not get put into the lab's computer. No valproic acid levels or CBC's were drawn for January nor February, 2015. The DON indicated the day nurse usually checked on Wednesdays to make sure all labs were drawn as ordered, but somehow it didn't get done in January nor</p>			

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	<p>February, 2015.</p> <p>On 3/5/15 at 3:30 p.m., the Administrator provided an undated policy, titled, "Lab Work/XRays - Ordering of," and indicated it was the policy currently used by the facility. The policy indicated, "Residents who need laboratory or radiological services will receive services on-site...in a timely manner."</p> <p>3). Resident #4's clinical record was reviewed on 3/4/15 at 12:33 p.m. Diagnosis include but were not limited to: osteoarthritis, osteoporosis, and compression fracture lower spine.</p> <p>On 3/3/15 at 10:11 a.m., interview with LPN #1 indicated Resident #4 fell on 2/13/15 and dislocated her left shoulder.</p> <p>Physician's order dated 2/14/15, indicated "immobilizer to L [left] arm at all times.</p> <p>Nursing notes dated 2/14/15, indicated "...Call from the hospital ... Res [Resident] to have immobilize to L (left) shoulder x 3 weeks. ..."</p> <p>On 3/2/15 at 1:00 p.m., Resident #4 was observed in her bed without the immobilizer in place for the left arm.</p> <p>On 3/2/15 at 4:15 p.m., Resident #4 was observed ambulating in the hall without</p>			

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	<p>the left arm immobilizer in place.</p> <p>On 3/3/15 at 1:00 p.m., Resident #4 was observed not to be wearing her left arm immobilizer while ambulating in the hall.</p> <p>On 3/4/15 at 2:00 p.m., Resident #4 was observed ambulating from her room to the nurses station without wearing her left arm immobilizer.</p> <p>On 3/4/15 at 2:25 p.m., Resident #4 was observed to ambulate down the hall to her room and sit in the recliner in her room. Resident #4 was observed not to be wearing her left arm immobilizer. Resident #4 indicated, "They told me I don't have to wear the arm thing anymore."</p> <p>On 3/5/15 at 9:18 a.m., Resident #4 was observed not to be wearing her left arm immobilizer.</p> <p>On 3/5/15 at 10:00 a.m., the Director of Nursing (DON) indicated, "They said [indicating the hospital] for her to wear her immobilizer a few days. I didn't see anything that said 3 weeks. I will call the doctor right now and see what he wants to do."</p> <p>On 3/5/15 at 10:11 a.m., Resident #4 was observed in the hallway trying to open</p>			

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F 323 SS=D Bldg. 00	<p>the bathroom door and indicated, "My arm still hurts. Resident #4 was observed to be holding her left arm close to her body and then guarding it with her right hand.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure staff provided supervision to prevent a resident from wandering into other residents' rooms for 1 of 1 resident reviewed for supervision of wandering behavior. (Resident #20)</p> <p>Findings include:</p> <p>Resident #20's clinical record was reviewed on 03/04/2015 at 2:22 p.m. Diagnosis included, but were not limited to: schizophrenia, bipolar, and poor impulse control.</p> <p>Resident #20's current care plans, all dated 11/18/14, included, but were not limited to: "PROBLEM: Resident</p>	F 323	<p>F-323 1. Facility had attempted on Friday 27th of February 2015, to send Resident #20 out for in-house Psych Therapy, but all units refused admission. Nursing staff immediately assessed resident and contacted physician. New orders received/obtained on 3/4/15 that stated "May be in a Broda chair with straps x 2 hours d/t aggressive behaviors and safety. Resident is on 15 minute watches with corresponding documentation. 2. Any resident has the potential to be affected. 3. The facility reviewed and updated policy and procedure for Resident Behaviors. In-serviced conducted on 3/30/15 including re-educating all staff the importance of following protocol with each resident. Resident care plan updated to reflect changes. The facility will monitor with 15</p>	03/30/2015

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	<p>wanders aimlessly without regard to needs or safety as follows: ... wanders in and out of others rooms. GOAL: Resident will not wander... injure self or others while wandering... APPROACH: 1. Monitor the resident's wandering... verify location of the resident frequently..."; "PROBLEM: Resident is verbally abusive to staff and/or other residents as follows: yells and curses in slurred hard to understand speech. Becomes angry easily. GOAL: Resident will be redirected when abusive episodes occur..."; "PROBLEM: Resident is physically abuse as follows: Resists care freq [frequently] hitting staff with his fist."; "PROBLEM: Resident makes sexual comments and gestures to staff. Risks: Frequently makes vulgar comments to staff. GOALS: Resident will decrease episodes of sexual comments and gestures to no more than 1 time per shift...."</p> <p>The North American Nursing Diagnosis Association defines wandering as: meandering, aimless, or repetitive locomotion (walking) that exposes the individual to harm; it is frequently incongruent with boundaries, limits or obstacles.</p> <p>On 3/4/15 at 3:19, CNA #2 indicated, a few nights ago she heard Resident #10</p>		<p>minute checks and do one on one with resident, when necessary, and/or when wandering behavior is exhibited. 4. All staff, DON, HFA, SSD will monitor daily. QA committee will review quarterly for 6 months. The facility will follow the recommendations of the committee at that time. 5. Date Completed: 03/30/15</p>	

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	<p>scream really loud, so she ran into her room and saw Resident #20 hit Resident #40, 2 or 3 times in the head with his open fist. CNA #2 indicated RN #1 immediately came into the room and redirected Resident #20 out.</p> <p>During an interview, 3/5/15 at 9:14 a.m., RN #1 indicated, I think Resident #20 does scares a lot of the residents, because he does wander into peoples' rooms. I was working last Friday night and I know that he went into Resident #10's room. I went to the room right away and assessed the residents, but I didn't witness any injuries. I immediately called the psychiatric doctor. I told him there was increased agitation with the resident and that it took 3 people to get him out of their room. I've never seen him actually hit another resident, but I've seen him hit staff.</p> <p>Resident #20's clinical records and/or care plans did not indicated any other interventions were implemented for his wandering behavior into other resident's rooms.</p> <p>On 3/2/15 at 2:25 p.m., Resident #20 was observed to wander in the hallway by himself and walk into Resident #10, Resident #40, and Resident #42's shared room. Resident #20 was redirected out of</p>				

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	<p>the room by CNA #5.</p> <p>Resident #20's care plans did not indicated any updates were made, or new interventions were implemented after he wandered into the rooms, and the resident was not observed to be engaged in any activities.</p> <p>During an interview with Resident #10, on 3/3/15 at 2:33 p.m., Resident #20 was observed to open a closed door to the ADM's office and shut the door behind him. No staff was present. Resident #20 walked over to the conference table and grabbed the surveyor's right arm with both of his hands. The surveyor exited the room, walked down the hall, and obtained assistance from CNA #5. CNA #5 removed Resident #20 from the surveyor's arm and indicated, "If I told you what he wanted it would bother you." Resident #20 was then observed to ambulate down the hallway by himself.</p> <p>On 3/4/15 at 3:21 p.m., Resident #20 was observed to enter the Administrator's (ADM) office and sit down in a chair. The resident required extensive redirection by the ADM and the Social Service Director to remove him from the office.</p> <p>On 3/6/15 at 11:19 a.m., the</p>			

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F 329 SS=D Bldg. 00	<p>Administrator provided the policy "Resident Safety," undated, and indicated the policy was the one currently used by the facility. The policy did not indicate any procedure for resident supervision in the facility.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview,</p>	F 329	1. Lab was immediately	03/30/2015

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	<p>the facility failed to ensure a resident who was receiving a medication to treat psychosis, received physician ordered laboratory blood tests to monitor whether the dose he was receiving was safe and therapeutic. (Resident #17)</p> <p>Findings include:</p> <p>The clinical record of Resident #17 was reviewed on 3/5/15 at 10:59 a.m. Diagnoses for the resident included, but were not limited to, dementia with behaviors and psychosis.</p> <p>A recapitulated physician's order for March, 2015, with an original order date of 7/16/14, indicated Resident #17 was to receive divalproex sodium 250 mg. (milligrams) sprinkles 2 times per day at 9:00 a.m. and 3:00 p.m., and 500 mg at bedtime. Divalproex sodium, also known as valproic acid, is classified as a mood stabilizer. It was ordered for Resident #17 as a mood stabilizer to treat his psychosis.</p> <p>A recapitulated physician's order for March, 2015, with an original order date of 1/19/12, indicated Resident #17 was to have a laboratory blood test drawn monthly to measure the level of valproic acid in his blood.</p>		<p>contacted, blood drawn, and results were within normal limits.2. Any resident has the potential to be affected. 3.To monitor therapeutic blood levels: The facility DON or designee will compare all lab orders for each resident with labs being drawn by contract laboratory weekly to ensure all labs are drawn and completed as ordered on a timely basis. Any identified concerns will be immediately addressed with laboratory supervisor and corrections implemented. 4. All license staff, DON, HFA, SSD will monitor. The QA committee will review quarterly for 6 months. The facility will follow the recommendations of the QA committee. 5. Date Completed 3/30/2015.</p>	

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	<p>A current care plan for Resident #17, dated 7/1/09, indicated a problem of, "Res [resident] requires use of Depakote [divalproex sodium] d/t [due to] Alzheimer's, dementia." Interventions included, "Monitor Valproic acid levels as ordered and notify MD [medical doctor] of any abnormal values."</p> <p>The Nursing 2014 Drug Handbook, 34th edition, copyright 2014, "valproic acid," indicated this medication can cause life threatening damage to the liver or pancreas, and, "Monitor drug level. Therapeutic level is commonly considered to be 50 to 100 mcg/mL [micrograms per milliliter]."</p> <p>No laboratory results for valproic acid levels were found in the resident's clinical record.</p> <p>On 3/5/15 at 3:14 p.m., the Director of Nursing (DON) indicated she had spoken with the lab and the resident's orders for monthly valproic acid levels did not get put into the lab's computer. No valproic acid levels were drawn for January nor February, 2015. The DON indicated the day nurse usually checked on Wednesdays to make sure all labs were drawn as ordered, but somehow it didn't get done in January nor February, 2015.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/06/2015	
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160			
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F 371 SS=D Bldg. 00	<p>On 3/5/15 at 3:30 p.m., the Administrator provided an undated policy, titled, "Lab Work/XRays - Ordering of," and indicated it was the policy currently used by the facility. The policy indicated, "Residents who need laboratory or radiological services will receive services on-site...in a timely manner."</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff labeled thawed nutritional supplements, as the facility policy indicated. (Resident #20, Resident #32, and Resident #4)</p> <p>Findings include:</p> <p>On 3/2/15 at 9:25 a.m., a case of opened strawberry flavored Mighty Shakes (nutritional supplement) was observed in the kitchen refrigerator without an expiration or thawed date. There were 18 cartons in the case of 75, and all were</p>	F 371	<p>F-371 1. Dietary Manager immediately destroyed thawed nutritional supplements.2. Any resident has the potential to be affected.3. DN and RD in-serviced all dietary staff on 03/24/2015 to follow facility policy and procedure regarding labeling thawed nutritional supplements timely and as directed by policy.4. RD, DM, HFA will monitor daily. QA Committee will review quarterly for 6 months. The facility will follow the recommendations of the QA Committe at that time.5. Date Completed: 03/30/15</p>	03/30/2015			

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	<p>without an expiration date or a date thawed.</p> <p>The DM (Dietary Manager) indicated, "I think those are good for a few weeks, but I don't know for sure. I got that order on 1/28/15, and I didn't write on the box when they were thawed."</p> <p>During an interview, on 3/5/15 at 3:36 p.m., the Mighty Shake's product manufacturer representative indicated, "The Mighty Shakes are good for only 14 days after thawing."</p> <p>On 3/5/15 at 3:45 p.m., the DM was observed to pull out the case of Mighty Shakes from the refrigerator and throw away the box. She indicated, "I don't have the date on there, so there really is no way to know when they were thawed."</p> <p>On 3/6/14 at 2:47 p.m., the Administrator provided the "Food Production Labeling and Dating," policy, dated 9/2008, and indicated the policy was the one currently used by the facility. The policy indicated, "...2. Upon removal from freezer a. Mighty shakes shall be 'use by dated' 14 days from date removed from freezer..."</p> <p>3.1-21(h)(3)</p>			

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F 514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure a resident who received restorative range of motion had a complete and accurate documentation of range of motion was provided for 1 of 1 resident reviewed for range of motions. (Resident #15)</p> <p>Findings include:</p> <p>Resident #15's clinical record was reviewed, on 3//15 at 10:36 a.m. Diagnosis included, but were not limited to: plate in left foot, muscle spasm and chronic back pain.</p> <p>A Restorative nursing assessment, dated 12/9/14, indicated, "Res [resident] receives PROM [passive range of motion] ... ad [a day] ..."</p>	F 514	<p>1. Nursing staff immediately reminded to document resident care, even during survey. 2. Any resident has the potential to be affected. 3. The in-service on March 30,2015 included the importance of documenting when resident care is completed and/or administered. 4. Charge Nurse, DON, HFA will monitor daily. The QA committee will monitor quarterly for 6 months and then facility will follow the committee recommendations. 5. Date completed 3/30/2015.</p>	03/30/2015	

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	<p>Care plan "PROBLEM/STRENGTHS CONCERNS," dated 12/11/14, indicated, "The resident requires a restorative program for passive R.O.M. to restore or maintain their functional range of motion. ... GOAL: ... move ea [each] joint slowly, consistently, avoiding rapid ..abrupt movement through the full pain free range for 10 repetitions ... APPROACH: 1. Administer the program per schedule 15 min or more qd [every day]. ..."</p> <p>RESTORATIVE NURSING PROGRAM RANGE OF MOTION (ROM) dated January 27, provided no documentation ROM was completed. March 2015, ...RANGE OF MOTION ... had no documentation ROM was completed for March 2, 3, 4, 5, 6, 2015.</p> <p>3.1-50(a)(2)</p>			