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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155650 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/21/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LINCOLNSHIRE HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8380 VIRGINIA ST<br>MERRILLVILLE, IN46410 |
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| F0000              | <p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaints IN00096562 and IN00096566. This visit resulted in an extended survey-Immediate Jeopardy.</p> <p>Complaint number IN00096562 substantiated, Federal/State deficiencies related to the allegations are cited at F 253, F 314, and F 322.</p> <p>Complaint number IN00096566 substantiated, Federal/State deficiencies related to the allegations are cited at F 309, F 314, and F 514.</p> <p>Survey dates: September 12, 13, and 14, 2011<br/>Extended survey dates: September 15, 16, 19, and 21, 2011</p> <p>Facility number: 000577<br/>Provider number: 155650<br/>AIM number: 100266950</p> <p>Survey team:<br/>Marcia Mital, RN-TC<br/>(September 13, 14, 15, 16, 19 and 21, 2011)<br/>Regina Sanders, RN<br/>(September 13, 14, 15, 16, and 21, 2011)</p> | F0000         |   |                      |

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

TITLE

(X6) DATE

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

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|   | <p>Kelly Sizemore, RN<br/>Sheila Sizemore, RN<br/>(September 12, 13, 14, and 15, 2011)</p> <p>Census bed type:<br/>SNF/NF: 86<br/>Total: 86</p> <p>Census payor type:<br/>Medicare: 19<br/>Medicaid: 60<br/>Other: 7<br/>Total: 86</p> <p>Sample: 18<br/>Supplemental Sample: 13</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/26/11<br/>Cathy Emswiller RN</p> |   |   |                      |   |

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| F0157<br>SS=D      | <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> |               |   |                      |

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|   | <p>Based on record review and interview, the facility failed to ensure a resident's physician was notified in a timely manner related to a urine specimen not obtained and a medication not given as ordered, for 2 of 18 residents reviewed for physician notification in a total sample of 18. (Resident #41 and C)</p> <p>Findings include:</p> <p>1. Resident #41's record was reviewed on 9/15/11 at 9:45 a.m. Resident #41's diagnoses included, but were not limited to, diabetes type II, hemiplegia, and depressive disorder.</p> <p>A physician's order, dated 8/24/11 at 8 p.m., indicated "May straight cath to rule out confusion."</p> <p>A nurse's note, dated 8/24/11 at 8:21 p.m., indicated "Resident displayed signs of confusion. Writer attempted to straight cath resident, attempt unsuccessful, writer notified next shift."</p> <p>An physician's order, dated 8/25/11 (no time), indicated "Clarification: UA (urinalysis)/C + S (culture and sensitivity) et (and) you may straight cath if needed."</p> <p>The nurse's notes lacked documentation of any further attempts to obtain the urine</p> | F0157   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.</b> The facility does ensure the physician and family are notified when there is a change in condition. <b>F157 PLAN OF CORRECTION 1) Immediate action taken for those residents identified:</b> Regarding resident # 41, on 09-01-11 resident was sent to hospital for an evaluation related to confusion. Urinalysis was completed at the hospital and resident was treated for a UTI. Regarding resident C, a medication error was completed, physician was notified and there was no negative outcome. 2) <b>How the facility identified others:</b>An audit was completed on medication and treatment carts to ensure that all medications are available and any issues identified will be addressed. Review of the 24 hour report for any residents with a change of condition so that the physician will be updated with any change of condition. <b>3) System in place:</b>In-service will be presented for licensed staff regarding physician notification, change of condition and 24 hour</p> | 10/20/2011           |   |

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|   | <p>specimen and that the physician was ever notified the urine was not obtained.</p> <p>During an interview with the A Hall Unit Manager #6, on 9/15/11 at 1:43 p.m., she indicated the urine specimen was not obtained and the physician was not notified.</p> <p>2. Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, tracheostomy, aphasia, and diabetes mellitus.</p> <p>A. The physician's order recapitulation, dated 5/11, indicated an order on 8/4/11</p> |   | <p>report. All resident who experience a change in condition will be assessed by the nurse; the assessment will be documented in the progress notes; the physician will be contacted as applicable. The resident will be placed on the 24 report for follow up documentation assessment by the next shift. The 24 hour report will be utilized during shift to shift report as a communication tool for resident who require follow up.</p> <p><b>4) How the actions will be monitored and what quality assurance program will be in place:</b> The DON will review the 24 hour report sheet and physician orders with members of the interdisciplinary team during clinical meeting 5 days a week. Any issues identified, the physician will be notified. Issues identified with failure to report will be addressed with disciplinary action as appropriate. The results of the 24 hour review will be discussed during the monthly quality assurance meeting for 6 months.</p> |                      |   |

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|   | <p>for Lovenox (blood thinner) 30 milligrams in 0.3 milliliters inject subcutaneously every day.</p> <p>The resident's MAR, dated 8/11, indicated the Lovenox was not administered by the initials being circled on 8/4/11 through 8/8/11.</p> <p>During an interview on 9/14/11 at 2:05 p.m., LPN #11 indicated the circled initials on the MAR means the medication was not administered.</p> <p>During an interview on 9/15/11 at 1:05 p.m., the Corporate Nurse Consultant indicated she asked the nurses who had circled their initials and they indicated the medication was not available. She indicated the medication had been delivered from the pharmacy on 8/5/11.</p> <p>Review of the nurses' notes, dated 8/4/11 through 8/8/11, indicated a lack of documentation to indicate the physician had been notified of the Lovenox not being administered as ordered.</p> <p>During an interview on 9/14/11 at 2:45 p.m., the A Wing Unit Manager #6 indicated the physician should have been notified of the medication not being administered as ordered.</p> |   |   |                      |   |

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|   | <p>A facility policy, titled "PHYSICIAN NOTIFICATION FOR CHANGE IN CONDITION," dated 9/2005 and received as current from Nurse Consultant, indicated "...Purpose:...2. To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner...4. Other...medication error..."</p> <p>3.1-5(a)(2)<br/>3.1-5(a)(3)</p> |   |   |                      |   |

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| F0225<br>SS=D   | <p>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 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 record review and interview, the facility failed to thoroughly investigate and report to the Indiana State Department of Health, an unusual occurrence related</p> | F0225   | <b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's</b> | 10/20/2011           |   |

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|   | <p>to a resident exiting the building unattended for 1 of 3 residents who were elopement risks in a sample of 18. (Resident #31)</p> <p>Findings include:</p> <p>Resident #31's record was reviewed on 09/14/11 at 1:35 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident was admitted into the facility from another facility on 09/09/11.</p> <p>An Elopement Risk Assessment, dated 09/09/11, indicated the resident moved about independently (question #1), had a diagnosis of Alzheimer's Disease (question #2), had poor judgement/impaired safety awareness (question #3), and had a history of wandering (question #4). The assessment indicated the resident was at risk for elopement. The Elopement assessment indicated, "if the answer to #1 is YES, and either #4, #5, #6, #7, or #8 is YES, the nurse must proceed to care planning and initiate interventions." The Nursing Note on the assessment was left blank.</p> <p>A Nurses' Note, dated 09/09/11 at 9 p.m., indicated, "...Resident alert and orientated to self with confusion noted...has unsteady gait and wanders at times</p> |   | <p><b>desire to comply with the regulatory requirements and continue to provide quality care. The facility does complete a thorough investigation of unusual occurrences and report them to the Indiana State Department of Health.F225 Plan of Correction 1) Immediate action taken for those residents identified:</b> Wandergard was placed immediately on resident # 31 and physician was notified. <b>2) How the facility identified other residents:</b>An audit was completed on 09-14-11 and no other residents were identified. <b>3) System in place:</b>An in-service was presented regarding abuse prevention, investigation reporting, and resident assessment. All staff who suspects abuse will report to the Administrator/DON immediately. Measures will be taken to protect the resident. An investigation will be conducted to include resident, staff, and family interviews as appropriate. The occurrence will be reported to the appropriate state agencies as required. Routine elopement assessments will continue to be completed upon admission and change of condition as determined by the MDS. Those residents identified at risk will have appropriate measures taken. In-service training will be conducted for all</p> |                      |   |

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|   | <p>without assistance..."</p> <p>A Nurses' Note, dated 09/10/11 at 4:05 a.m., indicated, "...confusion noted...resident has unsteady gait and wanders at times without assistance..."</p> <p>A Nurses' Note, dated 09/10/11 at 11:35 a.m., indicated, "Resident attended church service at main lobby. Walked out of facility unattended. Assisted back to unit by daughter and staff. Wanderguard placed on right ankle..."</p> <p>During an interview on 09/14/11 at 2:05 p.m., the Administrator indicated he had came in the building right after church was over. He indicated the resident had followed the family outside and the daughter had brought him in and the facility then put a wanderguard bracelet on the resident. He indicated he did not see the resident go out the door but saw the daughter bring the resident back in. He indicated the resident had not been harmed and the facility should have already had something in place for the resident since he was an elopement risk.</p> <p>During a telephone interview with RN #5 (nurse on duty when the incident occurred) on 09/14/11 at 2:20 p.m., she indicated the resident was in church in the main lobby. She indicated the daughter</p> |   | <p>new employees and staff as needed on abuse reporting. <b>4) How the corrective actions will be monitored:</b>Will review all of the unusual occurrence report forms during the monthly quality assurance meeting for appropriate investigating and timely reporting. The Administrator will be responsible for monitoring.</p> |                      |   |

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|   | <p>had informed her she had found the resident in the parking lot. She indicated the daughter had said he had a history of wandering. She indicated she had reported this to the Administrator. She indicated the staff had not seen the resident leave the building.</p> <p>During a telephone interview with the resident's daughter on 09/14/11 at 5 p.m., she indicated she and her husband were in their car and getting ready to leave the parking when they saw her father in the parking lot. She indicated the resident was still under the carport. She indicated she assisted her father back into the building.</p> <p>During an interview on 09/15/11 at 11:35 a.m., the Administrator indicated he had spoke with the resident's daughter and she had told him the resident had followed her out. He indicated he thought the resident was close enough behind the daughter going out the door that the resident was supervised by the daughter, so he did not report or investigate the incident. He indicated he did not see the resident leave the building.</p> <p>3.1-28(d)</p> |   |   |                      |   |

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| F0226<br>SS=D      | <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's policy for investigating and reporting to the Indiana State Department of Health (ISDH) of an unusual occurrence related to an elopement for 1of 18 residents reviewed for unusual occurrences in a sample of 18 residents. (Resident #31)</p> <p>Findings include:</p> <p>Resident #31's record was reviewed on 09/14/11 at 1:35 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident was admitted into the facility from another facility on 09/09/11.</p> <p>An Elopement Risk Assessment, dated 09/09/11, indicated the resident moved about independently (question #1), had a diagnosis of Alzheimer's Disease (question #2), had poor</p> | F0226         | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.</b> The facility does follow the policy for reporting and investigation of unusual occurrences. The resident's whereabouts were not unknown.<b>F226 Plan of correction 1) Immediate action taken for those residents identified:</b> Wanderguard was placed immediately on resident # 31 and physician was notified. <b>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</b> An audit was completed on 09-14-11 and no other residents were identified. <b>3) What measures will be put into place or what systemic</b></p> | 10/20/2011           |

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|   | <p>judgement/impaired safety awareness (question #3), and had a history of wandering (question #4). The assessment indicated the resident was at risk for elopement. The Elopement assessment indicated, "if the answer to #1 is YES, and either #4, #5, #6, #7, or #8 is YES, the nurse must proceed to care planning and initiate interventions." The Nursing Note on the assessment was left blank.</p> <p>A Nurses' Note, dated 09/09/11 at 9 p.m., indicated, "...Resident alert and orientated to self with confusion noted...has unsteady gait and wanders at times without assistance..."</p> <p>A Nurses' Note, dated 09/10/11 at 4:05 a.m., indicated, "...confusion noted...resident has unsteady gait and wanders at times without assistance..."</p> <p>A Nurses' Note, dated 09/10/11 at 11:35 a.m., indicated, "Resident attended church service at main lobby. Walked out of facility unattended. Assisted back to unit by daughter and staff. Wanderguard placed on right ankle..."</p> <p>During an interview on 09/14/11 at 2:05 p.m., the Administrator indicated he had came in the building right after church was over. He indicated the resident had followed the family outside and the</p> |   | <p><b>changes will be made to ensure that the deficient practice does not recur:</b> An in-service was presented regarding abuse prevention, investigation reporting, and resident assessment. All staff who suspects abuse will report to the Administrator/DON immediately. Measures will be taken to protect the resident. An investigation will be conducted to include resident, staff, and family interviews as appropriate. The occurrence will be reported to the appropriate state agencies as required. Routine elopement assessments will continue to be completed upon admission and change of condition as determined by the MDS. Those residents identified at risk will have appropriate measures taken. In-service training will be conducted for all new employees and staff as needed on abuse reporting. <b>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Will review all of the unusual occurrence report forms during the monthly quality assurance meeting for appropriate investigating and timely reporting. The Administrator will be responsible for monitoring.</p> |                      |   |

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|                    | <p>daughter had brought him in and the facility then put a wanderguard bracelet on the resident. He indicated he did not see the resident go out the door but saw the daughter bring the resident back in. He indicated the resident had not been harmed and the facility should have already had something in place for the resident since he was an elopement risk.</p> <p>During a telephone interview with RN #5 (nurse on duty when the incident occurred) on 09/14/11 at 2:20 p.m., she indicated the resident was in church in the main lobby. She indicated the daughter had informed her she had found the resident in the parking lot. She indicated the daughter had said he had a history of wandering. She indicated she had reported this to the Administrator. She indicated the staff had not seen the resident leave the building.</p> <p>During a telephone interview with the resident's daughter on 09/14/11 at 5 p.m., she indicated she and her husband were in their car and getting ready to leave the parking when they saw her father in the parking lot. She indicated the resident was still under the carport. She indicated she assisted her father back into the building.</p> <p>During an interview on 09/15/11 at 11:35 a.m., the Administrator indicated he had</p> |               |   |                      |

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|   | <p>spoke with the resident's daughter and she had told him the resident had followed her out. He indicated he thought the resident was close enough behind the daughter going out the door that the resident was supervised by the daughter, so he did not report the incident. He indicated he did not see the resident leave the building.</p> <p>An undated, facility policy received from the Administrator as current on 09/15/11 at 1:40 p.m., titled, "Occurrence Management", indicated, "Policy: all residents shall benefit from a safe environment...define as an 'occurrence'. Examples:...Elopement...The Administrator and/or DNS (Director of Nursing Service) will be notified immediately...Based on their review of the occurrence and additional investigation if needed, the appropriate ISDH will be notified per their procedures...The initial investigation evaluates the immediate concerns surrounding occurrence and cause of occurrence..."</p> <p>3.1-38(a)</p> |   |   |                      |   |

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| F0253<br>SS=C | <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable interior related to torn wallpaper, dirty floors, wall carpet, baseboards, vents, cabinets, pill crushers, fall mats, broken seals in window, chipped paint and missing veneer on furniture and walls, door frames, discolored floor tiles, and cracked wall tiles throughout the facility. This had the potential to affect 86 of 86 residents who reside in the facility. (Front Lounge, A and B Wings, Dining Room, and Therapy Room)</p> <p>Findings include:</p> <p>During the environmental tour with the Environmental Director and the Maintenance Director on 9/14/11 beginning at 2:10 p.m., the following observations were made:</p> <p>A. Front Lobby:</p> <p>1. There were 6 areas of torn wallpaper behind the table.</p> | F0253 | <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Floor care staff will be inserviced on procedures to properly apply floor finish, cleaning along edges, and maintaining floors. This training will be completed by 10/20/11. Housekeeping Supervisor will monitor floor care procedures through the TELS Floor Audits on a Weekly basis. TELS Audits will be reviewed by Administrator monthly to ensure procedures are being monitored. Corporate Environmental Consultants will review floor care performance during their routine visits at the facility. 2. Housekeeping staff will be inserviced on proper cleaning procedures to maintain ceiling exhaust vents from dust and dirt build-up. This training will be completed by 10/20/11. Housekeeping Supervisor will monitor housekeeping staff cleaning procedures through the</p> | 10/20/2011 |
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|   | <p>2. The two end tables, coffee table and TV cabinet had missing wood chips and veneer along the top, side and bottom edges.</p> <p>3. The doorway frame from the Front Lobby to the Activity Room had numerous paint chips.</p> <p>4. The table by the Receptionist Office had missing veneer along the edges. The Maintenance Director indicated he touched up the areas as needed.</p> <p>B. Dining Room:</p> <p>1. The floor in the hallway in front of the Dining Room and the floor into the Dining Room had a 10 by 22 foot area which was dented, cracked and had discolored floor tile.</p> <p>2. The wall between the men and women's bathroom doors was dirty and scuffed. There was a buildup of dirt along the baseboard.</p> <p>3. The floor by the doorway to the DoN's (Director of Nurses) office had a buildup of wax and dirt.</p> <p>4. The floor by the wall of windows was dirty and had dried food crumbs.</p> |   | <p>TELS Resident Room Audit on a weekly basis. TELS Audits will be reviewed by Administrator monthly to ensure procedures are being monitored. Environmental Consultants will review the cleaning during their routine visits. 3. Maintenance staff will be inserviced on proper procedures to maintain the facility. The training will include the use of the Monthly Resident Room Check sheet, following routine Preventative Maintenance schedules utilizing the TELS Program which includes the completion of routine audits and tasks. This inservice will be completed by 10/20/11. Maintenance staff will develop a schedule for the repairs to the items that were identified during the survey process. This schedule will be completed and repairs per this schedule will commence by 10/20/11. Corporate Preventative Maintenance Crew will develop a schedule to come and provide additional resources to make the completed repairs. This schedule will be completed and repairs per this schedule will commence by 10/20/11. Main Dining Room flooring will be replaced by outside contractor once material is available. Bids for this replacement will be obtained by 10/20/11. Window Condensation will require repair or replacement of window glass section. Corporate Director of Property</p> |                      |   |

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|   | <p>5. The paneling under the serving line was scuffed with a 3 by 3 foot piece pulled back from the wall. There was a missing trim piece between two of the panels.</p> <p>C. A-Wing:</p> <p>1. Room one had dark stains running down the wall below the nightlight. The fall mat beside bed 1 had cracks in the vinyl, torn edges and was dirty. There were scuff marks on the walls on both sides of bed two. The window had a condensation between the glass making the window blurry.</p> <p>2. There was dried food on the wall carpet, in the hall, between rooms four and six.</p> <p>3. There was dried food stains on the wall carpet, in the hall, between rooms three and four.</p> <p>4. There was a buildup of dirt in the bathroom corners in room five.</p> <p>5. There was a condensation in between the glass of the window in room eight.</p> <p>6. The air vent in the bathroom of room nine was dusty and dirty.</p> |   | <p>Maintenance will conduct an audit of the windows referenced in the 2567 by 10/20/11 and a plan will be developed to determine which windows require priority repair or replacement. A schedule will be developed. Monitoring process will be completed through the TELS Program as routine audits are completed by Maintenance Supervisor. TELS Maintenance Audits will be reviewed by the administrator monthly to ensure compliance. Environmental Consultants will review maintenance performance through TELS Program and during routine visits.</p> |                      |   |

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|                    | <p>7. The floor along bed one in room fifteen was dirty. The baseboard behind the head of the bed was dirty with a dried substance. The corner of the wall under the sink in the bathroom had a buildup of dirt.</p> <p>8. There were four cracked tiles by the shower stall and door in the shower room.</p> <p>9. The nightstand in room 25 was chipped and had missing veneer along the bottom and top edges.</p> <p>D. Therapy Room:</p> <p>1. The bottom shelf of cabinets along the wall were dirty and had dried food spills.</p> <p>D. B-Wing</p> <p>1. On top of the medication cart there was a cardboard box containing paper pill cups and plastic glasses. The bottom of the cardboard box was wet. LPN #2 indicated the box was wet and needed to replace the box.</p> <p>2. There was torn wallpaper on the wall, in the hallway, between rooms 13 and 15.</p> <p>3. The vent in the B-wing lounge was rusty and there were stains on the ceiling tile surrounding the vent. The end table</p> |               |   |                      |

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|   | <p>had chipped wood and missing stain along the edges.</p> <p>During an interview at the end of the environmental tour, the Maintenance Director indicated he would make rounds on all of the windows with broken seals in them.</p> <p>During an interview on 9/15/11 at 2:10 p.m., the Environmental Director provided a layout of the facility indicating rooms with broken seals on the A-Wing were 1, 7, 8, 11, 12, 18, 20, 21, 24, and 26. The facility layout indicated windows affected on the B-Wing were 3, 4, 6, 10, 11, 13, 16, 17, 21, 24, and 26. The facility layout indicated the Front Lobby window was also affected. The Maintenance Director indicated he had went in every room and some of the windows were "really bad and some not so bad."</p> <p>E. The A-Wing medication crusher on the B-hall medication cart was observed on 9/12/11 at 9:25 a.m., the medication crusher was dirty with spills from medication running down the sides. The crusher plates had a black substance between them. LPN #10 indicated the medication crusher was dirty. LPN #10 indicated the medication crusher needed to be replaced.</p> |   |   |                      |   |

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| F0273<br>SS=D   | <p>F. The A-Wing medication crusher on the A-hall was observed on 9/13/11 at 11:25 a.m., the medication crusher was dirty with spills down the side. The crushers plates were dirty with a black substance.</p> <p>This Federal tag relates to Complaint IN00096562.</p> <p>3.1-19(e)</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p> <p>Based on record review and interview, the facility failed to complete an Admission Minimum Data Set (MDS) assessment within 14 days after a resident's admission into the facility, for 1 of 18 residents reviewed for MDS assessments in a sample of 18. (Resident #E)</p> <p>Findings include:</p> | F0273   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does complete admission MDS assessments as</b></p> | 10/20/2011           |   |

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|   | <p>Resident #E's record was reviewed on 09/13/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and stroke.</p> <p>The resident's record indicated the resident was admitted into the facility on 07/15/11. There was a lack of documentation to indicate the facility had completed an Admission MDS assessment within 14 days of the resident's admission into the facility.</p> <p>A Discharge with return to the facility anticipated MDS assessment, dated 08/02/11, indicated the resident had been transferred to the hospital.</p> <p>The record indicated an Admission/5-day MDS assessment had been completed on 08/22/11 after the resident had returned to the facility on 08/15/11.</p> <p>During an interview on 09/13/11 at 9:30 a.m., the Corporate MDS Nurse Consultant indicated an Admission MDS assessment should have been completed before 08/22/11. She indicated the facility had not completed an Admission MDS assessment timely.</p> <p>3.1-31(d)(1)</p> |   | <p>required.<b>F273 Plan of correction 1) Immediate action taken for those residents identified:</b> Regarding resident E, as stated in the 2567, upon return from the hospital the comprehensive assessment was completed on 08-22-11. <b>2) How other residents were identified:</b> An audit was completed on new admissions for the last 30 days and no other residents were identified. <b>3) System in place:</b>The facility employed a Registered Nurse with position of MDS coordinator. The corporate MDS consultant provided orientation and training in the completion of comprehensive and ancillary MDS assessments. All new admissions/re-admission will be communicated during morning meeting with the interdisciplinary team. All new admissions will have a comprehensive assessment completed within 14 days of their admission as required. <b>4) How the actions will be monitored and what quality assurance program is in place:</b> The DON/Designee will monitor by completing an audit of transmitted assessments on all new admissions. Any issues identified will be immediately addressed. Results of these audits will be discussed in the monthly quality assurance meeting x 6 months.</p> |                      |   |

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| F0278<br>SS=E      | <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure residents' Minimum Data Set (MDS) assessments were accurate, related to medications, race, diagnoses, and cognitive status for 5 of 18 residents reviewed for MDS assessments in a sample of 18. (Residents #B, #C, #E, #28, and #67)</p> | F0278         | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does complete</b></p> | 10/20/2011           |

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|   | <p>Findings include:</p> <p>1. Resident #E's record was reviewed on 09/13/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and stroke.</p> <p>The resident's admission physician's orders, dated 08/15/11, indicated the resident had an order for Cipro (antibiotic) 500 mg (milligrams), twice daily for seven days and Risperdal (anti-psychotic) 1 mg at bedtime.</p> <p>The Admission/5-day MDS assessment, dated 08/22/11 indicated the resident had received an antianxiety medication in the past seven days and had not received an antibiotic in the past seven days.</p> <p>During an interview on 09/13/11 at 9:30 a.m., the Corporate MDS Nurse Consultant indicated the MDS assessment had not been marked correctly.</p> <p>2. Resident #B's record was reviewed on 09/14/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, renal failure, stroke, and congestive heart failure.</p> <p>The Physician's Recapitulation Orders, dated 09/11, indicated on 07/28/11 Lasix</p> |   | <p>accurate MDS assessments.278<br/>PLAN OF CORRECTION:1)<br/><b>Immediate actions taken for those residents identified:</b>Regarding residents B, C, E, # 28, and # 67 MDS assessments were corrected. 2)<br/><b>How the facility identified other residents:</b>Audit will be conducted for accuracy of diagnosis, medications, race and cognition of all comprehensive assessments completed within the last 30 days. 3) <b>System in place:</b> The facility employed a Registered Nurse with position of MDS coordinator. The corporate MDS consultant provided orientation and training in the completion of comprehensive and ancillary MDS assessments. All new admissions/re-admissions will be communicated during morning meeting with the interdisciplinary team. All new admissions will have a comprehensive assessment completed within 14 days of their admission as required. 4) <b>How the corrective actions will be monitored:</b>An audit will be completed on at least 5 MDS assessments weekly for accuracy. Any issues identified will be addressed appropriately. DON/designee will monitor and will be discussed during the monthly quality assurance meeting x 6 months.</p> |                      |   |

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|   | <p>(diuretic) 40 mg daily was ordered for the resident.</p> <p>A Physician's Order, dated 07/27/11, indicated an order for regular insulin to be given four times a day after the resident's blood sugar was monitored. The dose of the regular insulin was ordered by the results of the blood sugars.</p> <p>The resident's Medication Administration Record (MAR), dated 07/11, indicated the resident had received insulin on July 28, 29, 30, and 31, 2011 and August 1 and 2, 2011.</p> <p>The resident's Admission/5 day MDS assessment, dated 08/03/11, indicated the resident had not received insulin or injections and had not received a diuretic in the past seven days.</p> <p>During an interview on 09/14/11 at 11:10 a.m., the B-Unit Manager #1 indicated the resident had been on insulin and Lasix during the observation period of the MDS assessment.</p> <p>3. Resident #67's record was reviewed on 09/15/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, deep vein thrombosis (blood clot) and leukemia.</p> |   |   |                      |   |

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|   | <p>A Significant Change MDS assessment, dated 08/04/11, indicated the resident had received an antipsychotic in the past seven days, and had not received an anticoagulant and antibiotic in the past seven days.</p> <p>The Physician's Orders, dated 07/28/11, indicated and order for Amoxicillin (antibiotic) three times daily for five days, Prozac (antidepressant) daily, and Coumadin (anticoagulant) daily.</p> <p>The MAR, dated 07/11, indicated the resident had received the Amoxicillin on 07/29/11 and the Prozac and Coumadin on 07/29/11 through 07/31/11.</p> <p>During an interview on 09/15/11 at 1:45 p.m., the RN Corporate Nurse Consultant indicated the MDS assessment had been incorrect.</p> <p>4. Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, seizures, and diabetes.</p> <p>An admission MDS assessment, dated 5/26/11, indicated the resident's race was (race documented) and had a diagnosis of Down Syndrome.</p> <p>The resident's record lacked documentation of a diagnosis of Down</p> |   |   |                      |   |

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|   | <p>Syndrome.</p> <p>During an interview with the Nurse Consultant, on 9/14/11 at 10:18 a.m., she indicated the resident was (race stated). She indicated the MDS was marked wrong.</p> <p>During an interview with the Nurse Consultant, on 9/14/11 at 10:30 a.m., she indicated the resident did not have a diagnosis of Down Syndrome. She indicated the MDS was marked wrong.</p> <p>5. Resident #28's record was reviewed on 9/13/11 at 2:50 p.m. Resident #28's diagnoses included, but were not limited to, congestive heart failure, diabetes, and chronic renal insufficiency.</p> <p>A quarterly MDS assessment, dated 6/15/11, lacked documentation the resident's cognition was assessed.</p> <p>A social service note, dated 9/7/11, indicated the resident had a cognition score of 15 (cognitively intact).</p> <p>During an interview with the Corporate MDS Nurse, on 9/13/11 at 4:06 p.m., she indicated the cognition section of the MDS assessment should have been done.</p> <p>3.1-31(g)</p> |   |   |                      |   |

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| F0280<br>SS=E      | <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents care plans were developed and updated related to, medications, elopement risk, bladder incontinency, indwelling catheter, splint, and 1/2 tray on wheelchair for 7 of 18 residents reviewed for care plans in a sample of 18. (Residents #B, #C, #D, #F, #31,#67, and #71)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on</p> | F0280         | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure that careplans are developed and updated.F280 PLAN OF CORRECTION:1) Immediate actions taken for those residents identified: Resident F has been discharged. Resident B care plan was updated; lasix,</b></p> | 10/20/2011           |

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|   | <p>09/14/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, renal failure, stroke, and congestive heart failure.</p> <p>The Physician's Recapitulation orders, dated 09/11, indicated the resident received Lasix (diuretic) 40 milligrams (mg) daily, aspirin 325 mg daily, regular insulin given four times daily by the results of the blood sugar, and oxygen at two liters per minute.</p> <p>The care plan with a last revised date of 09/03/11, lacked documentation to indicate the resident had a care plan for the Lasix, aspirin, insulin, and oxygen usage.</p> <p>During an interview on 09/14/11 at 2:15 p.m., the RN Corporate Nursing Consultant indicated the resident did not have a care plan for the Lasix, aspirin, insulin, and oxygen usage.</p> <p>2. Resident #67's record was reviewed on 09/15/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, deep vein thrombosis (blood clot) and leukemia.</p> <p>A Significant Change MDS (Minimum Data Set) assessment Care Area Assessment (CAA) Summary, dated</p> |   | <p>aspirin, insulin, and oxygen were added. Resident # 67 care plan was updated for urinary incontinence and potential for pressure ulcers. Resident # 31 care plan was updated to reflect the attempt to leave facility. Resident D care plan was updated to reflect the splint and the ½ tray on the wheelchair. Regarding resident C has been admitted to the hospital. Upon readmission, care will be updated. Resident # 71 care plan was updated to reflect indwelling catheter. 2) <b>How the facility identified other residents:</b> An audit will be completed on all residents who have had a comprehensive assessment within the last 30 days to ensure that all medications, elopement risk, bladder incontinence, indwelling catheters, splints, ½ trays have been addressed on the care are appropriate. 3) <b>System in place:</b>Physician orders will be reviewed during morning clinical meeting as well as updating care plans during this time.The facility employed a Registered Nurse with position of MDS coordinator; in which is she is being trained by the regional MDS Consultant. 4) How the corrective actions will be monitored:Physician orders and 24 hour report will be reviewed 5 x times a week during morning clinical meeting. The MDS coordinator will be responsible for monitoring for quality assurance</p> |                      |   |

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|   | <p>08/04/11, indicated the facility was going to proceed with a care plan for urinary incontinence and pressure ulcers.</p> <p>The resident's undated care plans, printed from the computer by the Administrator on 09/15/11, lacked documentation to indicate a care plan for urinary incontinence and pressure ulcers had been implemented for the resident.</p> <p>3. Resident #F's record was reviewed on 09/13/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, stroke and convulsions.</p> <p>A CAA summary, dated 08/05/11, indicated the resident triggered urinary incontinence and indwelling catheter on the Significant Change MDS assessment, dated 08/05/11. The CAA indicated the facility was going to proceed with a care plan for urinary incontinence and indwelling catheter.</p> <p>The resident's care plans, dated 5/4/11, indicated there was a lack of documentation to indicate a care plan for the urinary incontinence and indwelling catheter.</p> <p>During an interview on 09/13/11 at 3 p.m., the B-Unit Manager #1 indicated there was no care plan for the urinary</p> |   | at least 5 days a week. Results of these audits will be discussed in the monthly quality assurance meeting x 6 months. |                      |   |

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|   | <p>status of the resident.</p> <p>4. Resident #31's record was reviewed on 09/14/11 at 1:35 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident was admitted into the facility from another facility on 09/09/11.</p> <p>An Elopement Risk Assessment, dated 09/09/11, indicated the resident moved about independently, had a diagnosis of Alzheimer's Disease, had poor judgement/impaired safety awareness, and had a history of wandering. The assessment indicated the resident was at risk for elopement.</p> <p>The resident's care plan, last revised on 09/12/11 lacked documentation to indicate the resident was at risk for elopement.</p> <p>During an interview on 09/14/11 at 2:05 p.m., the Administrator acknowledged there was no care plan for the resident's wandering.</p> <p>5. Resident D's record was reviewed on 9/13/11 at 9:35 a.m. Resident D's diagnoses included, but were not limited to, stroke, problems with swallowing, and hemiplegia (one sided weakness).</p> <p>Resident D was observed on 9/13/11 at</p> |   |   |                      |   |

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|   | <p>9:30 a.m., 10:02 a.m., and 2:15 p.m., sitting in her wheelchair. The resident had a splint on her left hand and a half tray on her wheel chair.</p> <p>The resident's care plans, dated 12/10/10 and updated 8/14/11, indicated a lack of documentation of a care plan for the splint or the 1/2 tray to the resident's wheelchair.</p> <p>During an interview on 9/13/11 at 2:15 p.m., the A Wing Unit Manager #6 indicated there should be a care plan for the resident's splint and 1/2 tray on the wheelchair.</p> <p>6. Resident #71's record was reviewed on 9/13/11 at 3:35 p.m. Resident #71's diagnoses included, but were not limited to, seizures, dementia, and congestive heart failure.</p> <p>Physician order's indicated the resident has had an indwelling catheter since 7/11/11.</p> <p>The resident's record care plans, dated 2/23/11 and updated 9/13/11, lacked documentation of a care plan for an indwelling catheter.</p> <p>During an interview with the B Hall Unit Manager #1, on 9/14/11 at 1:05 p.m., she indicated she could not find a care plan for an indwelling catheter, but the resident</p> |   |   |                      |   |

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| F0282<br>SS=E   | <p>should have had one.</p> <p>7. Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, seizures, and diabetes.</p> <p>Resident C was readmitted to the facility on 8/4/11 with an order for Lovenox (blood thinner) 30 milligrams injection daily.</p> <p>The resident's record lacked a care plan for a blood thinner.</p> <p>During an interview with the A Unit Manager #6, on 9/14/11 at 11:25 a.m., she indicated the resident should have a care plan for the Lovenox.</p> <p>3.1-35(c)(1)<br/>3.1-35(d)(2)(B)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br/>Based on observation, record review, and interview, the facility failed to ensure</p> | F0282   | <b>The filing of this plan of correction does not constitute an admission that the alleged</b>                  | 10/20/2011           |   |

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|   | <p>physician's orders were followed related to medications , laboratory tests, and an apical pulse not taken prior to administration of a heart medication for 8 of 18 residents in sample of 18 (Residents C, D, F, #28, #41, #60 and #71) and for 1 resident in supplemental sample of 13. (Resident #20)</p> <p>Findings include:</p> <p>1. During the first medication observation pass on 9/13/11 at 8:58 a.m., LPN #10 was observed to administer a liquid form of the medication citalopram (antidepressant) in the amount of 5 ml (milliliters) to Resident D orally. The resident's September 2011, MAR (Medication Administration Record) indicated the medication was to be administered through the resident's peg tube (feeding tube) daily.</p> <p>Resident D's physician's orders, on 9/13/11 at 10:00 a.m., indicated "citalopram 10 mg (milligrams)/5 ml solution give 5 mls via peg tube daily." The physician's orders indicated the resident was to receive "nectar thick liquids."</p> <p>During an interview on 9/13/11 at 12:55 a.m., the DoN (Director of Nursing) indicated LPN #10 should not have gave</p> |   | <p><b>deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure that physician's orders are followed.F282 PLAN OF CORRECTION1) Immediate actions taken for those residents identified:</b> Regarding resident D, the nurse no longer works for the facility. The resident was assessed on 09-13-11, lung sounds were clear; resident did not have a negative outcome related to this practice. Resident # 20 was assessed on 09-15-11 to include vital signs; residents pulse was 80. Resident F has been discharged. Regarding resident # 28 the labs were drawn and reported to the physician. Regarding resident C, a medication error was completed, physician was notified and there was no negative outcome. Resident C O2 sats were documented in the progress notes and not on the Medication Administration Record. Regarding resident # 41, on 09-01-11 resident was sent to hospital for an evaluation related to confusion. Urinalysis was completed at the hospital and resident was treated for a UTI. Regarding resident # 71 medication error was completed; the CBC and Dilantin level was</p> |                      |   |

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|   | <p>the medication orally.</p> <p>2. During the third medication pass on 9/14/11 at 8:45 a.m., LPN #11 was observed to administer digoxin (heart medication) to Resident #20. LPN #11 was not observed to take the resident's apical pulse. The resident's September 2011, MAR indicated "obtain pulse."</p> <p>Review of Resident #20's physician's orders on 9/14/11 at 9:40 a.m., indicated "hold if pulse is below (arrow pointing down) 60."</p> <p>During an interview on 9/14/11 at 10:05 a.m., LPN #11 indicated she had forgot to take the resident's apical pulse.</p> |   | <p>drawn and reported to physician. Regarding resident # 60 CBC was drawn and reported to the physician. <b>2) How the facility identified other residents:</b>An audit was completed of all labs and lab orders were re-evaluated by the physician. The Pharmacist came in and completed an audit of physician orders. Any issues identified were addressed. No other resident on thickened liquids were affected. <b>3) System in place:</b>In-service will be provided for nurses regarding lab services, tracking, notification, medication administration, following physician orders, and medication error procedures. Nurse proficiencies will be completed on random nurses 3 days a week. New lab orders are reviewed in the morning clinical meeting. Labs are communicated when drawn during shift to shift report. As physician orders for labs are obtained by the nurse; the nurse will complete the lab requisition and the DON/Designee will audit to ensure requisition has been completed. <b>4) How the corrective actions will be monitored:</b>The DON/Designee will audit labs for completeness and physician notification 3 x week and audits will be discussed monthly during quality assurance x 6 months. Nurse proficiencies will be completed on random nurses at least 3 x a week regarding medication pass and</p> |                      |   |

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|   | <p>3. Resident #F's record was reviewed on 09/13/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, stroke and convulsions.</p> <p>A Physician's Order, dated 07/27/11, indicated an order for a CBC (complete blood count), Chem Profile (electrolytes) every two weeks.</p> <p>The record indicated a CBC and a Chem Profile had not been completed until 09/06/11.</p> <p>During an interview on 09/13/11 at 4:35 p.m., the B-Unit Manager #1 indicated she had notified the laboratory company and they had not received the order for a CBC and Chem Profile every two weeks.</p> <p>4. Resident #28's record was reviewed on 9/13/11 at 2:50 p.m. Resident #28's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and chronic renal insufficiency.</p> <p>A physician's order, dated 8/5/11, indicated "PT/ (pro-time) INR (international normalized ratio) (blood clotting tests) wkly (weekly)beginning</p> |   | <p>following physician orders. The DON/Designee will be responsible for the coordination/monitoring. The results will be discussed monthly in quality assurance x6 months.</p> |                      |   |

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|   | <p>8/11/11. Liver and Lipid profile (cholesterol test) et (and) HGA1c (test to see how well blood sugars are being controlled)</p> <p>A care plan, dated 4/6/11, indicated "...on anticoagulant therapy...labs as ordered..."</p> <p>A nurses' note, dated 9/8/11 at 3:40 p.m., indicated "writer spoke to (physician name) regarding bleeding from left and right feet, new orders to hold coumadin (blood thinner) for 4 days and then do PT/INR in one week..."</p> <p>The resident's record lacked documentation of the PT/INR laboratory results for 8/11/11 or weekly after that or of a liver and lipid profile and a HGA1C being completed.</p> <p>During an interview on 9/14/11 at 2:10 p.m., the A Wing Unit Manager#6 indicated a form for the laboratory tests had not been completed so the lab never drew them.</p> <p>5. Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, tracheostomy, aphasia, and diabetes mellitus.</p> <p>A. The physician's order recapitulation,</p> |   |   |                      |   |

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|   | <p>dated 5/11, indicated an order on 8/4/11 for Lovenox (blood thinner) 30 milligrams in 0.3 milliliters inject subcutaneously every day.</p> <p>The resident's MAR, dated 8/11, indicated the Lovenox was not administered by the initials being circled on 8/4/11 through 8/8/11.</p> <p>During an interview on 9/14/11 at 2:05 p.m., LPN #11 indicated the circled initials on the MAR means the medication was not administered.</p> <p>During an interview on 9/15/11 at 1:05 p.m., the Corporate Nurse Consultant indicated she asked the nurses who had circled their initials and they indicated the medication was not available. She indicated the medication had been delivered form the pharmacy on 8/5/11.</p> <p>B. Resident C's physician order, dated 8/5/11, indicated "check o2 (oxygen) sat (saturation) daily and as needed..."</p> <p>Resident C's MAR, dated 9/11, lacked documentation to indicate the resident's oxygen saturations had been checked daily.</p> <p>During an interview on 9/14/11 at 2:20 p.m., LPN #11 indicated the residents</p> |   |   |                      |   |

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|                    | <p>oxygen saturations had not been checked daily as ordered.</p> <p>6. Resident #41's record was reviewed on 9/15/11 at 9:45 a.m. Resident #41's diagnoses included, but were not limited to, diabetes type II, hemiplegia, and depressive disorder.</p> <p>A physician's order, dated 8/24/11 at 8 p.m., indicated "May straight cath to rule out confusion."</p> <p>A nurse's note, dated 8/24/11 at 8:21 p.m., indicated "Resident displayed signs of confusion. Writer attempted to straight cath resident, attempt unsuccessful, writer notified next shift."</p> <p>An physician's order, dated 8/25/11 (no time), indicated "Clarification: UA (urinalysis)/C + S (culture and sensitivity) et (and) you may straight cath if needed."</p> <p>The nurse's notes lacked documentation of any further attempts to obtain the urine specimen.</p> <p>During an interview with the A Hall Unit Manager #6, on 9/15/11 at 1:43 p.m., she indicated the urine specimen was not obtained.</p> <p>7. Resident #71's record was reviewed</p> |               |   |                      |

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|   | <p>on 9/13/11 at 3:35 p.m. Resident #71's diagnoses included, but were not limited to, seizures, dementia, and congestive heart failure.</p> <p>A physician's order, dated 8/19/11 at 2:30 p.m., indicated discontinue Welchol ( medication for cholesterol) 65 (sic) mg (milligrams) tid (three times a day).</p> <p>A physician's order, dated 8/30/11 at 2:05 p.m., indicated Colestipol (medication for cholesterol) pck (pack) 5 grams tid per peg tube.</p> <p>A medication record for 8/11, indicated the Colestipol was initialed as given on 8/31/11 at 5 p.m.</p> <p>Physician recapitulation orders, dated 9/11, indicated "Colestipol...give 1 packet (=5 grams) via peg tube 3 times a day..." and had "D/C (discontinue)" written on the order. Cholestyramine (medication for cholesterol) packet give one packet (=5 grams) via peg tube tid mix as directed was written. The resident already had an order for Cholestyramine packet give 1 packet via peg tube 2 times a day.</p> <p>A medication record for 9/11, indicated Cholestyramine was being given 5 times a day and the Colestipol was not being given.</p> |   |   |  |  |   |  |

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|                    | <p>During an interview with LPN #2, on 9/14/11 at 11:10 a.m., she indicated when it was written on the physician's recapitulation, it was written wrong. The resident should not have been getting Cholestyramine 5 times a day. They wrote Cholestyramine instead of Colestipol.</p> <p>B. Physician recapitulation orders, dated 8/11, indicated an order for a Dilantin (medication for seizures) level every week and a CBC (complete blood count test) monthly.</p> <p>The resident's record lacked documentation of Dilantin levels every week and a CBC in the month of August.</p> <p>The last lab requisitions made out for Dilantin levels were for the month of July.</p> <p>During an interview with LPN #2, on 9/14/11 at 10 a.m., she indicated she called the lab and they did not have results for Dilantin levels or CBC results because they were not drawn in July because the form for the laboratory was not filled out..</p> <p>8.. Resident #60's record was reviewed on 9/14/11 at 1:30 p.m. Resident #60's diagnoses included, but were not limited to, dementia, hypertension, and anemia.</p> |               |   |                      |

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| F0309<br>SS=D   | <p>The resident was admitted to the facility on 8/19/11 with an order for a CBC.</p> <p>The resident's record lacked results of a CBC being done.</p> <p>During an interview with the B Unit Manager #1, on 9/14/11 at 3:15 p.m., she indicated the CBC had not been completed because staff had not clarified the order for when the physician wanted the CBC to be done.</p> <p>3.1-35(g)(1)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services related to not assessing and calling 911 in an emergency situation for a resident who was in respiratory distress for 1 of 2 resident's reviewed with respiratory distress in a total sample of 18 residents. (Resident G)</p> | F0309   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure</b></p> | 10/20/2011           |   |

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|   | <p>Findings include:</p> <p>Resident G's closed record was reviewed on 9/15/11 at 10:30 a.m. Resident G's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and diabetes mellitus.</p> <p>Resident G's readmission physician's orders, dated 8/10/11, indicated oxygen at 4 liters via mask continuously and bipap (bilevel positive airway pressure machine) {used to treat sleep apnea} settings 15/15 at 50% at bedtime and as needed for respiratory distress. The resident's code status was full cardiopulmonary resuscitation.</p> <p>The nurses' notes indicated:<br/>8/10/11 at 8:00 p.m., "Admission Note. Resident come (sic) back on stretcher to unit alert verbally responsive oriented to name and place assisted by family...no respiratory distress noted at this time respiration even, unlabored lung sounds...no wheezing...SP O2 (oxygen level in blood) 95%...no respiratory distress- family at bedside..."<br/>8/11/11 at 3:26 a.m., "Resident resting comfortably in bed resp (respirations) even et (and) unlabored. Lung sounds clear...sp o2 100%... Communicating needs well. no anxiety noted..."</p> |   | <p><b>that the necessary care and services are provided.F309 PLAN OF CORRECTION1) Immediate action taken for those residents identified:</b><br/>Resident G is no longer here at the facility. <b>2) How the facility identified other residents:</b>No other residents in the facility received bi-pap therapy. <b>3) System in place:</b>Nurses were in-serviced following residents G episode on code status (08-25-2011), a system was put in place to identify residents that are full code status (09-12-2011), an audit was completed to identify all residents code status. Nurses were re-educated regarding physician notification and alternate notification if the primary does not respond in a timely manner. Staff will be educated to notify the physician and if a response is not received in a timely manner the resident will be sent to the emergency room if the resident's condition is determined to be unstable. <b>4) How the corrective actions will be monitored:</b>The 24 hour report will be reviewed during morning meeting; any issues identified will be addressed. Code status will be monitored on scheduled rounds by members of the quality assurance team at least 3 days a week x6 months</p> |                      |   |

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|   | <p>"Late Entry" 8/11/11 at 9:00 a.m.,<br/>"Resident switched to nasal mask for bipap. Tolerating nasal mask well, no respiratory distress noted. Saturating at this time between 90-95%. Resident was repositioned and made comfortable..."</p> <p>8/11/11 at 11:32 a.m., "resident awake in bed, resting comfortably...oxygen infusing at 4 liters via nasal canula with sp o2 at 94%. Display (sic) anxiety at 0730, as needed xanax (a medication for anxiety medication) 1 mg (milligram) given, improvement observed 45 minutes after medication given. Respiration even and unlabored with lung sound (sic) clear bilaterally...no acute distress noted..."<br/>(The physician's order are for a mask not nasal canula).</p> <p>8/11/11 at 5:30 p.m., "at about 5:30 p.m., two CNAS"'s came to me while I was feeding in the parlor and stated '(Resident G's name) mask is off' writer rushed to resident's room. sp o2 was 72% mask was reapplied sp o2 went up to 95%, will continue to monitor."</p> <p>8/11/11 at 10:21 p.m., (The computer indicated the charting was "created date 8/12/11 13:13 {1:13 p.m.}), indicated "on my way to take lunch about 9:55 p.m., I stopped in and checked on resident. daughter stated 'i don't think she doing to good (sic).' checked sp o2 was 90% ran got oxygen tank and another nurse for assistance walked in room I held mask on</p> |   |   |                      |   |

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|   | <p>her face for a greater seal other nurse called (physician name) checked her blood sugar reading was 310 checked code status called (physician name), no answer, while other nurse was with resident on my way back I walked into room seen (sic) resident was breathing unlabored, sp o2 82% (normal range 90-100%) with nasal prongs on took nasal prongs off and put bi pap back on and did sternal rubs sp o2 went up to 86%, daughter stated "I already called 911." simultaneously as I checked for a pulse, the medics enter (sic) room with stretcher. gave report..." There was a lack of documentation of an assessment of the resident's lungs sounds or vital signs. 8/11/11 at 11:00 p.m., "(Physician name) notified nurse that resident expired."</p> <p>The ambulance "Patient Care Report", dated 8/11/11, indicated "...Times recvd (received) 21:56 (9:56 p.m.) At patient 22:04 (10:04 p.m.)...22:04 BP (blood pressure) 0/0 palpated, pulse 0 None, Respiratory 0/Absent SP O2 0%...Skin Temp (temperature) =Cool, Skin color=Cyanotic (bluish/gray color due to no oxygen)...Lung sounds ...absent...Pupil reaction...No reaction...Pupil dilation...constricted...Upon arrival found a...female sitting in a semi-fowlers position in bed with nurse at bedside...pt (patient) was found to be apnic (no</p> |   |   |                      |   |

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|   | <p>respirations), pulseless, pupils were constricted and unresponsive..."</p> <p>During an interview on 9/13/11 at 10:20 a.m., the resident's daughter indicated that her mother had been having breathing problems all day on 8/11/11. She indicated the nurse put the machine on her mom's finger (to check for oxygen saturation in the blood) and the oxygen saturations were low. She indicated the nurses kept coming in and out of her mom's room. She indicated one of the nurses' had taken her mom off the bipap and the other nurse had come into the room. She indicated she had to call 911 herself. She indicated when she told the nurse she wanted 911 called the nurse told her she couldn't call 911. She indicated the nurses just kept calling her mom's name and did not do anything, She indicated she had told the nurse to call 911 and the nurses did not do anything to help her mom so she had called 911 herself. She indicated when she called 911 they had asked where her mom's nurse was.</p> <p>During an interview on 9/16/11 at 2:25 p.m., LPN #17, the nurse who had been taking care of the resident on 8/11/11, indicated she had tried to call the physician about the resident's status to send her out to the hospital but had not</p> |   |   |                      |   |

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|   | <p>gotten any answer. She indicated the other nurse who was also working tried to call the physician too. She indicated the other nurse had gotten a hold of the physician and was told to keep the resident on the bipap. She indicated the resident did not become unresponsive and always had a faint pulse. She indicated she had checked the resident's chart for the code status of the resident. She indicated she had felt a faint pulse when the medics came.</p> <p>During an interview on 9/16/11 at 2:55 p.m., RN #18 indicated she had been called down to put the resident's bipap back on early in the evening. She indicated then later at the end of the shift she was called down to help with the resident when "she started to go bad." She indicated she had left the resident's room to check with the other nurse on the status of the other nurse calling the physician. She indicated the resident's breathing was more labored. She indicated she did not call 911. She indicated the other nurse was trying to get a hold of the physician. She indicated the resident's eyes were closed and her breathing was labored. She indicated the resident would open her eyes about half way. She indicated if you could not get a hold of the resident's physician there was an alternate physician to call. She</p> |   |   |                      |   |

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|   | <p>indicated if she is unable to reach the physician and if the condition is "grave" she calls 911 right away. She indicated she had heard the daughter called 911.</p> <p>During an interview on 9/19/11 at 9:00 a.m., the Director of Nurses (DoN) indicated the nurses should have called 911 for the resident and not tried to call the resident's physician. She indicated the nurses had never called 911 the resident's daughter had. She indicated she could not get a clear picture of what had happened that night. She indicated she had gotten statements from both nurses and had tried to talk to the resident's daughter, but she did not want to talk to her. She indicated she was not sure why the nurse had gotten the oxygen tank when she already had oxygen in the room. She indicated she thought the nurse panicked. She indicated it did not make any sense, She indicated she had asked if the nurses had started CPR (cardiopulmonary resuscitation) and had been told CPR was started by the medics when they got to the facility. She indicated both nurses had told her the resident had a pulse and the one nurse was checking for a pulse when the medics came in. She indicated RN#18 had told her she had sent the physician a text and had not wanted to say she had sent the physician a text when she talked to the surveyors.</p> |   |   |                      |   |

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|                    | <p>The facility's "Internal Investigation",dated 8/12/11, received from the DON on 9/19/11 at 9:30 a.m., the investigation included a written statement form RN #18, which indicated "...(physician name) was texted of residents status. Daughter stated she wanted her mother sent out. This was also texted to (physician name) and he replied okay..."</p> <p>During an interview on 9/19/11 at 9:45 a.m., the Corporate Nurse Consultant indicated if the resident's daughter wanted 911 called the nurse should have called 911.</p> <p>A facility policy, titled "Physician Notification for Change in Condition" dated 9/2005, received from Corporate Nurse Consultant as current indicated "...For situations requiring immediate action, call an ambulance and transport the resident to the emergency room (ER) with later notification of the physician..."</p> <p>A facility policy titled "Emergencies", dated 9/2005, received from the DON as current, indicated "...To provide emergency care to resident's with serious or potentially life threatening injuries or illness...In the event of emergencies requiring medical support not available</p> |               |   |                      |

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| F0314<br>SS=G   | <p>within the facility, the staff will immediately call 911 for emergency assistance."</p> <p>This Federal tag relates to complaint IN00096566.</p> <p>3.1-37(a)</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to provide treatment and assess residents with pressure ulcers for 5 of 7 residents with pressure ulcers in a sample of 18</p> | F0314   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed</b></p> | 10/20/2011           |   |

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|   | <p>residents, which resulted in 1 resident being admitted to the hospital with an infected decubitus ulcer and who then had to have her leg amputated. (Residents B, C, D F, and G)</p> <p>Findings Include:</p> <p>1. Resident G's closed record was reviewed on 9/15/11 at 10:30 a.m. Resident G's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and diabetes mellitus.</p> <p>An admission MDS (minimum data set) assessment, dated 3/18/11, indicated resident G had moderate cognitive impairment, required extensive assistance of two staff members for bed mobility and transfers. The resident had three stage IV pressure ulcers (full thickness of skin and subcutaneous tissue lost exposing bone or muscle), one stage III pressure ulcer (full thickness of skin is lost, exposing the subcutaneous tissues) and 2 unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar (dead tissue) in the wound bed) upon admission.</p> <p>A care plan, dated 3/24/11, indicated the resident had unstageable pressure ulcers to the left and right heels, a stage IV</p> |   | <p><b>as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does provide the treatment and assess residents with pressure sores.F314 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Resident G is no longer here at the facility. Resident D dressing to her foot was changed and a medication error was completed. Resident C is no longer here at the facility. Resident B is no longer in the facility. Resident F is no longer here at the facility. <b>2) How the facility identified other residents:</b>An audit will be completed on all residents checking their skin. <b>3) System in place:</b>An in-service will be provided for nurses and CNA's regarding prevention of pressure sores. A braden scale will be completed on all residents; those identified at risk will be care planned. Nurses will re-educated on completing admission orders including reviewing medications, nutritional interventions for wound healing. The DON/Designee and dietary manager will review orders for all re-admissions and compare orders with previous orders to ensure nutritional interventions and medications for wound healing are resumed. All residents with pressure sores will</p> |                      |   |

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|   | <p>pressure ulcer to the left buttock and a stage III pressure ulcer to the coccyx. The interventions included, but were not limited to, complete Braden scale per facility policy and keep heels elevated while in bed.</p> <p>The resident's record lacked documentation of a completed Braden scale assessment.</p> <p>An admission nursing assessment, dated 4/21/11, indicated the resident was re-admitted to the facility and had pressure ulcers on both heels which were necrotic tissue (dead tissue) and had a stage I pressure ulcer on her coccyx.</p> <p>The resident's pressure ulcer assessments indicated the following measurements for the pressure ulcer to the right heel:<br/>4/25/11 unstageable, 7.5 by 6.8 centimeters 100% black (eschar), with no drainage..<br/>5/2/11 unstageable 7.5 by 10 centimeters depth 0.1 centimeters 100% eschar, no drainage and no signs of infection.<br/>5/9/11 unstageable 10.5 by 10.5 centimeters, depth 0.2 centimeters 100% eschar, with no drainage and no signs of infection.</p> <p>A physician's order, dated 4/21/11, indicated to cleanse the resident's left heel</p> |   | <p>be screened by therapy for proper positioning. <b>4) How the actions will be monitored:</b>The DON/Designee will monitor for preventative devices by coordinating scheduled rounds by the quality assurance team 3 x weekly, including monitoring of all direct care staff on all shifts. The results of these audits will be reviewed monthly during quality assurance.</p> |                      |   |

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|   | <p>with wound cleanser pat dry and spray with Granulex twice a day.</p> <p>The resident's treatment administration record, dated 5/11, indicated the treatment had been completed on 5/10/10 twice, 5/11/10 twice and 5/12/11 once.</p> <p>The resident's nurses' notes, dated 5/12/11, indicated:<br/>1:33 p.m., "...emesis x (times) 1, blood pressure up...(physician name) notified...Zofran (a medication for nausea and vomiting)...every 6 hours for emesis/nausea...Resident refused medication..."<br/>1:52 p.m., "New order received...Zofran ...every six hours as needed..."<br/>6:07 p.m., "new order for ultram (pain medication) 50 mg (milligrams) one tablet every 6 hours as needed for pain..."<br/>6:10 p.m., "(physician name) here today. Assessed residents feet and decided to send resident to (name of hospital) as a direct admit due to a possible infection to Left heel..."</p> <p>The Nurses' notes, dated 5/10/11 through 5/12/11 lacked documentation of an assessment of the resident's left heel pressure ulcer.</p> <p>A pressure ulcer progress report, dated 5/10/11, indicated the same measurements</p> |   |   |                      |   |

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|   | <p>from the 5/9/11 assessment.</p> <p>During an interview on 9/15/11 at 2:23 p.m., the wound nurse indicated she had completed the assessment on 5/9/11, but had entered the assessment in the computer on 5/10/11 on the pressure ulcer progress report.</p> <p>During an interview on 9/13/11 at 10:20 a.m., the resident's family member indicated she had come to the facility and her mother had complained of pain to her foot. She indicated she had removed the dressing to check on her mother's foot. She indicated her mother's foot was red swollen and had puss coming from the pressure ulcer. She indicated she went to the nurses' station to get someone to come and check her mothers foot. She indicated a nurse came and checked the foot. She indicated the doctor was in the building and he came and looked at her foot and sent her mom to the hospital for infection. She indicated her mother had to have an amputation.</p> <p>During an interview on 9/15/11 at 2:23 p.m., the wound nurse indicated daily wound assessments should have been completed. She indicated there should have been an assessment of any changes in the wound documented in the nurses' notes. She indicated someone should</p> |   |   |                      |   |

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|   | <p>have noticed a change in the pressure ulcer.</p> <p>During an interview on 9/16/11 at 10:48 a.m., the wound nurse indicated if the wound was 100 % eschar you could not determine the depth. She indicated the wound doctor came in and did rounds and she got the measurements from him. She indicated she was not sure how the wound doctor got the depth when the pressure ulcer was 100% eschar.</p> <p>During an interview on 9/15/11 at 4:10 p.m., the DON (Director of Nurses) indicated the resident's daughter came to the nurses' station and asked to see the wound nurse. She indicated the unit manager who no longer works at the facility went with the resident's daughter to check the resident's foot. She indicated the unit manager then got the doctor who was in the building to go look at the resident's foot. She indicated the physician said he was sending the resident to the hospital for a direct admit because the foot looked infected. She indicated she was not able to answer if the nurse had done the treatment to the resident's foot earlier that day or why she had not noticed the changes in the resident's pressure ulcer.</p> <p>A hospital history and physical, dated</p> |   |   |                      |   |

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|   | <p>5/12/11, indicated "...was seen in NH (Nursing Home), found to have infected LT (left) foot, was directly admitted to the hospital...LT foot pain...Left foot: she exhibits tenderness and swelling Infected LT heel with active drainage.."</p> <p>An infectious disease consult, dated 5/13/11, indicated "...was admitted 5/12/11 for infected left foot...nursing home resident who was noted to have swollen left heel associated with foul smelling drainage and eschar formation...Assessment: 1. Infected left foot with probable osteomyelitis (bone infection)...Plan...may need amputation..."</p> <p>A MRI (Magnetic Resonance Imaging), dated 5/13/11, indicated "MRI of the left foot is abnormal and demonstrates findings indicative of soft tissue inflammatory process along the plantar (bottom) and posterior (back) aspect of the left calcaneum (heel bone). The infectious process do involve the plantar fascia and plantar muscular as well as the attachment of the Achilles tendon. Moderate changes or osteomyelitis of the posterior aspect of the left calcaneum are noted and there is some bony instruction and bone marrow edema visualized..."</p> <p>The culture of the left foot wound, dated 5/12/11, indicated many staphylococcus</p> |   |   |                      |   |

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|                    | <p>aureus (methicillin resistant) (MRSA) and many escherichia coli..."</p> <p>An admission note, dated 6/24/11, indicated the resident was re-admitted to the facility at 1:00 p.m.. The resident had a left AKA (above the knee amputation)..."</p> <p>2. Resident D's record was reviewed on 9/13/11 at 9:35 a.m. Resident D's diagnoses included, but were not limited to, stroke, problems with swallowing, and hemiplegia (one sided weakness).</p> <p>A Braden scale assessment for pressure ulcer risk, dated 8/10/11, indicated the resident was at mild risk for developing pressure ulcers.</p> <p>A quarterly MDS assessment, dated 8/11/11, indicated the resident was severely impaired with decision making. The resident required extensive assistance to total dependence upon staff for bed mobility, transfers, toilet use, dressing, and personal hygiene. The resident had one stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed).</p> <p>A physician's order, dated 7/11/11, indicated "clean rt (right) heel w/wound</p> |               |   |                      |

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|                    | <p>(with wound) cleanser, pat dry, apply aquacel w/Santyl (a debridement ointment) , cover with 4 x 4 kerlix, secure w/tape charge every other day &amp; as needed."</p> <p>A care plan, dated 4/24/11 and updated 8/30/11, indicated "Stage III pressure ulcer present to right heel...Interventions: Administer treatments as ordered and assess effectiveness...heels up while in bed....Specialty mattress..."</p> <p>Resident D was observed on 9/13/11 at 9:30 a.m. and 10:02 a.m., sitting in her wheelchair. The dressing on the resident's right foot was dated 9/10/11.</p> <p>During an interview on 9/13/11 at 10:05 a.m., the DON indicated the dressing on the resident's right foot was dated 9/10/11. The DON indicated the dressing should have been changed if the order was to be changed every other day.</p> <p>The resident's TAR (treatment administration record), dated 9/11, indicated the treatment for the resident's right heel had not been initialed as completed on 9/12/11.</p> <p>The pressure ulcer assessment, dated 9/7/11, indicated the pressure ulcer on the resident's right heel was 0.7 by 0.6</p> |               |   |                      |

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|   | <p>centimeters with a depth of 0.3 centimeters. The wound base was 70 % granulation tissue and 30% slough.</p> <p>Resident D was observed on 9/13/11 at 11:05 a.m., lying in bed, with the wound nurse present. The resident's right heel was resting on the bed. The wound nurse indicated the resident's heel was resting on the bed and not elevated. The wound nurse indicated the nurse who worked on 9/12/11 had not changed the dressing and was counseled. The wound nurse removed the dressing from the resident's right heel. There was a quarter sized amount of brown/red drainage noted on the dressing. The wound nurse indicated the pressure ulcer measured 0.9 by 0.5 centimeters and was 0.2 centimeters in depth. The wound nurse indicated there was 80% yellow slough and 20% granulation tissue at the base of the pressure ulcer. There was a bath blanket which had been folded over twice (four layers) under the resident. The resident was lying on an air flow mattress. The wound nurse indicated the bath blanket was used for turning the resident in bed. She indicated she was not aware of any issues of having the bath blanket folded so many times placed under the resident on the air mattress.</p> <p>Resident D was observed with a shoe on</p> |   |   |                      |   |

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|   | <p>her right foot on 9/13/11 at 2:15 p.m. and 5:20 p.m., 9/14/11 at 8:48 a.m., and 9/19/11 at 8:45 a.m.</p> <p>During an interview on 9/19/11 at 8:47 a.m., the Wound Nurse indicated the shoes could cause more pressure to the resident's heel and she would take the resident's shoe off. She indicated she would rather the staff put on footie socks than shoes on the resident.</p> <p>An undated CNA assignment sheet, provided by the A wing unit manager #6, on 9/16/11 at 10:30 a.m., as current, indicated for resident D there was a lack of documentation to indicate the resident was to have her heel off the bed.</p> <p>3. Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, tracheostomy, aphasia, and diabetes mellitus.</p> <p>A quarterly MDS assessment, dated 8/10/11, indicated the resident was severely impaired with decision making. The resident was dependent upon staff for bed mobility, transfers, toilet use, and personal hygiene.</p> <p>A care plan, dated 5/16/11 and updated 9/13/11, indicated "...pressure ulcer</p> |   |   |                      |   |

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|   | <p>present...right heel and left lateral foot...heels up while in bed..."</p> <p>The pressure ulcer assessments, indicated the following:<br/>9/7/11, Left lateral foot 9.5 by 2.7 centimeters 100% eschar<br/>9/14/11, 9.5 by 4.0 centimeters, 30% granulation tissue and 70% eschar.</p> <p>9/7/11, Right heel 2.3 by 1.6 centimeters 100% eschar.<br/>9/14/11, Right heel 2.0 by 2.0 centimeters 100 % eschar.</p> <p>Resident C was observed with her heels resting on the bed on 9/13/11 at 2:05 p.m.</p> <p>During an interview at the above date and time, the Corporate Nurse Consultant indicated the resident's heels were not elevated.</p> <p>Resident C was observed with her right heel resting on the bed on 9/13/11 at 4:46 p.m.</p> <p>During an interview on 9/13/11 at 4:50 p.m., LPN #11 indicated the resident's right heel was resting on the bed.</p> <p>Resident C was observed on 9/16/11 at 10:45 a.m., lying in bed with her heels resting on the bed. CNA #16 was present</p> |   |   |                      |   |

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|   | <p>at the time of the observation and she indicated she needed to get the resident another pillow to put under her legs.</p> <p>Resident C was observed on 9/16/11 at 12:05 p.m., the resident's heel was resting on the bed.</p> <p>During an interview on 9/16/11 at 12:10 p.m., the Wound Nurse indicated the resident's heel was on the bed. She indicated she was going to talk to therapy about something to help with positioning for the resident.</p> <p>An undated CNA assignment sheet, provided by the A wing unit manager #6 as current, on 9/16/11 at 10:30 a.m., indicated for resident C there was a lack of documentation to indicate the resident was to have her heels off the bed.</p> <p>4. Resident #B's record was reviewed on 09/14/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, renal failure, stroke, and congestive heart failure.</p> <p>A care plan, dated 08/02/11, indicated the resident had a stage IV (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present) pressure ulcer present on the left great toe and a stage II (partial thickness loss) on the coccyx related to immobility. The</p> |   |   |                      |   |

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|   | <p>interventions included, "...Heels up while in bed..."</p> <p>Resident #B was observed laying in bed with his heels on the bed, and no pillow or support located on the bed on 09/13/11 at 9:25 a.m., 09/14/11 at 9:15 a.m., and 09/15/11 at 8:23 a.m.</p> <p>During an observation of the resident on 09/15/11 at 8:30 a.m. with LPN #2 present, the resident's heels were on the bed. LPN #2 indicated she would get a pillow to float the resident's heels on.</p> <p>5. During an observation of Resident #F on 09/13/11 at 9:15 a.m. with the B-Unit Manager #1 present, Resident #F was laying in bed. The bed had a low air loss mattress, the resident's right heel was on the mattress. There was a regular bottom sheet, a draw sheet, a paper incontinent pad under the resident. The resident also had an incontinent brief on.</p> <p>During an interview at the time of the observation, the B-Unit Manager #1 indicated there should not have been that much linen and a brief under the resident on a low air loss bed.</p> <p>Resident #F's record was reviewed on 09/13/11 at 1:20 p.m. The resident's diagnoses included, but were not limited</p> |   |   |                      |   |

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|   | <p>to, stroke and convulsions.</p> <p>The resident's care plan, dated 08/30/11, indicated the resident had a stage II pressure area to his right lateral foot related to immobility. The interventions included, "...Heels up while in bed...Specialty Mattress..."</p> <p>The manufactures directions for use for mattresses, received from the Wound Nurse LPN #4 on 09/14/11 at 3:10 p.m., indicated, "...LINEN NOTE: Deep-pocketed sheets are recommended...Multiple layering of linens or under pads beneath the resident can negatively affect the mattress's pressure management capabilities and should be avoided..."</p> <p>A facility policy, titled "Wound Prevention Protocol", dated 1/2005, received from the Corporate Nurse Consultant as current, indicated "... Identify those residents that are high risk for developing pressure areas using the Braden Scale...Use pillows, foam wedges...Elevate the heels by placing a pillow lengthwise under the resident's calves...Report any change in skin condition to physician and family. Document notification in the nurses' notes...Document the location of area, color, drainage if present..."</p> |   |   |                      |   |

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|   | <p>A facility policy, titled "Skin Condition and Pressure Ulcer Assessment", dated 12/2004, received from the Corporate Nurse Consultant as current, indicated "...Pressure Ulcer Risk Assessment will be performed at the following times: a. Admission b. Updated quarterly...Skin observations are made daily, during the performance of...administering treatment procedures...Dressings which are applied to pressure ulcers...will include the date and initial of licensed nurse who performed the procedure. Dressings will be checked daily for placement, cleanliness and signs and symptoms of infection...The licensed nurse is responsible for notifying the attending physician and the Director of Nursing of any suspected infection in the wound and to initiate an Infection Report when appropriate...A licensed nurse will observe he condition of wound...daily, or with dressing changes as ordered, and document signs and symptoms of deterioration..."</p> <p>This Federal tag relates to complaints IN00096562 and IN00096566</p> <p>3.1-40(a)(1)<br/>3.1-40(a)(2)</p> |   |   |                      |   |

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| F0315<br>SS=D      | <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure a catheter tubing was positioned correctly to reduce the risk for infection for 3 of 4 residents with indwelling catheters in a sample of 18. (Residents B, C, and #71)</p> <p>Findings include:</p> | F0315         | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality</b></p> | 10/20/2011           |

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|   | <p>1. During the initial A-Wing tour with LPN #13 on 9/12/11 beginning at 10:10 a.m., Resident C was observed in her room laying on her back in bed. Resident C's indwelling catheter bag was laying on the floor.</p> <p>Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, seizures, and aphasia.</p> <p>A physician's order, dated 8/5/11, indicated to change the indwelling catheter monthly and as needed for occlusion and leaking.</p> <p>A care plan, dated 5/19/11, indicated "Resident had foley catheter related to wounds...Foley catheter care every shift and as needed..."</p> <p>During an interview on 9/15/11 at 11:12 a.m., LPN #2 indicated the catheter tubing should not be on the floor.</p> <p>2. During the initial B-Wing tour with LPN #13, on 9/12/11 at beginning at 11:50 a.m., Resident B was in his room, laying in his bed. The resident's indwelling catheter tubing and bag was laying on the floor.</p> <p>Resident B was observed on 9/15/11 at 11:10 a.m., in his room, sitting up in a wheelchair. The resident's indwelling catheter tubing was on the floor.</p> <p>Resident B's record was reviewed on 09/14/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, renal failure, stroke, and congestive heart failure.</p> |   | <p><b>care. The facility does ensure catheter tubing is positioned correctly.F315 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Resident C is no longer in facility. Resident B is no longer in the facility. Regarding resident # 71 there was no negative outcome. <b>2) How the facility identified other residents:</b>All resident with a catheter will be re-assessed. <b>3) System in place:</b>In-service will be provided for nursing staff on catheter care and catheter positioning. CNA's will be provided with a skills check off for catheter care and positioning. All residents will continue to be re-assessed quarterly and with a significant change. <b>4) How the actions will be monitored:</b>The DON/Designee will monitor catheter positioning during scheduled rounds by members of the quality assurance team at least 3 x weekly, including monitoring of all direct care staff on all shifts. The results of these audits will be reviewed during monthly Quality Assurance meeting x6 months.</p> |                      |   |

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|   | <p>The readmission orders, dated 07/27/11, indicated the resident had an order for an indwelling catheter.</p> <p>A care plan, dated 08/19/11, indicated the resident had a urinary catheter. The interventions included, "Give catheter care per facility procedure..."</p> <p>During an interview on 9/15/11 at 11:12 a.m., LPN #2 indicated the catheter tubing should not be on the floor.</p> <p>3. During an observation, on 9/13/11 at 2:52 p.m., resident #71's catheter tubing was touching the mat on the floor beside the bed. During an interview at the time of the observation, LPN #2 indicated the tubing should not be touching the mat.</p> <p>Resident #71's record was reviewed on 9/13/11 at 3:35 p.m. Resident #71's diagnoses included, but were not limited to, seizures, dementia, and congestive heart failure.</p> <p>The physician's order recapitulation, dated 9/11, indicated the resident had an order for an indwelling catheter.</p> <p>3.1-41(a)(2)</p> |   |   |                      |   |

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| F0322<br>SS=D      | <p>Based on the comprehensive assessment of a resident, the facility must ensure that 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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy tube (feeding tube) received the appropriate services related to unqualified CNA disconnecting and turning off a resident's gastrostomy feeding tube for 1 of 8 residents with tube feedings in a sample of 18. (Resident E)</p> <p>Findings include:</p> <p>Resident #E's record was reviewed on 09/13/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and stroke.</p> <p>The Physician's Recapitulation Orders, dated 09/11, indicated an order, dated 08/23/11, for Jevity (liquid feeding) 1.5 at 80 milliliters (ml) an hour for 18 hours.</p> <p>A physician's telephone order, dated 09/09/11, indicated an order to increase the resident's tube feeding to 22 hours.</p> | F0322         | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure that residents with g-tubes receive the appropriate services.F322 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Regarding resident E an order was received to keep G-Tube feeding connected an extra hour on 09-12-11. <b>2) How the facility identified other residents:</b>No other residents were affected by the deficient practice. <b>3) System in place:</b>An in-service was provided for nursing staff and therapy department regarding their scope of practice. CNA's will inform nursing of residents with tube feeding infusing prior to</p> | 10/20/2011           |

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|   | <p>The resident's Medication Administration Record, dated 09/11, indicated the resident's order for the tube feeding was Jevity 1.5 at 80 ml an hour for 22 hours. The tube feeding was to be on at 2 a.m. and turned off at 12 a.m.</p> <p>During an observation, on 9/12/11 at 12:05 p.m., Resident E was not in her room and her tube feeding was hanging on the pole in her room. During an interview at the time of the observation, with the B Unit Manager #1, she indicated the resident was in therapy and should have her tube feeding infusing. She indicated she did not know why therapy did not take it with them.</p> <p>During an observation, on 9/12/11 at 12:10 p.m., PTA #12 was bringing Resident E back to her room. During an interview at the time of the observation, PTA #12 indicated the resident was sitting at the nurses's station and she took her to therapy around 11:15 a.m. She indicated her tube feeding was not hooked up at that time.</p> <p>During an observation, on 9/12/11 at 12:11 p.m., LPN #20 was hooking up Resident E's tube feeding. LPN #20 indicated she was Resident E's nurse today and did not unhook the resident's</p> |   | <p>getting resident up. Therapy will take the pump with the resident to therapy unless otherwise ordered by physician. <b>4) How the actions will be monitored:</b>The DON/Designee will monitor residents with feeding tubes on scheduled rounds by members of the quality assurance team at least 3 x weekly, including monitoring of all direct care staff on all shifts. The results of these audits will be reviewed monthly at Quality Assurance meeting x6 months.</p> |                      |   |

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| F0323<br>SS=D   | <p>tube feeding.</p> <p>During an interview with CNA #19, on 9/12/11 at 12:20 p.m., she indicated "I got (Resident E's name) up around 11 a.m. I had to unhook the tube feeding in order to get her up with the hoyer (mechanical lift). I thought the nurse would hook her back up." She indicated she was not sure if CNA's were suppose to unhook tube feedings.</p> <p>This Federal tag relates to Complaint IN00096562.</p> <p>3.1-44(a)(2)</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident received adequate supervision, related to a resident exiting the building unattended for 1 of 3 residents at risk for elopement, in a sample of 18. (Resident #31)</p> <p>Findings included:</p> | F0323   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure that resident's receive</b></p> | 10/20/2011           |   |

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|   | <p>Resident #31's record was reviewed on 09/14/11 at 1:35 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident was admitted into the facility from another facility on 09/09/11.</p> <p>An Elopement Risk Assessment, dated 09/09/11, indicated the resident moved about independently (question #1), had a diagnosis of Alzheimer's Disease(question #2), had poor judgement/impaired safety awareness(question #3), and had a history of wandering(question #4). The assessment indicated the resident was at risk for elopement. The Elopement assessment indicated, "if the answer to #1 is YES, and either #4, #5, #6, #7, or #8 is YES, the nurse must proceed to care planning and initiate interventions. The Nursing Note on the assessment was left blank.</p> <p>The resident's care plan, last revised on 09/12/11 lacked documentation to indicate the resident was at risk for elopement.</p> <p>A Nurses' Note, dated 09/09/11 at 9 p.m., indicated, "...Resident alert and orientated to self with confusion noted...has unsteady gait and wanders at times without assistance..."</p> |   | <p><b>adequate supervision.F323 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Resident # 31 care plan was updated to reflect the attempt to leave facility. As stated in the 2567 a wanderguard bracelet was placed on resident E.2) <b>How the facility identified other residents: An audit was completed on all residents who have had an elopement risk assessment completed. All resident identified at risk had appropriate interventions in place.3) System in place:An in-service will be provided for nursing staff on assessments and care plan intervention for those residents identified at risk. Elopement risk assessments will continue to be completed on all residents an admission/re-admission, quarterly, and significant change. 4) How the actions will be monitored:The Administrator/Designee will check all residents with wanderguards weekly for function. The DON/Designee will monitor/coordinate daily scheduled rounds 3 x week by the members of the quality assurance team to check for placement of wanderguards. The MDS coordinator will monitor elopement risk assessments to ensure that</b></p> |                      |   |

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|   | <p>A Nurses' Note, dated 09/10/11 at 4:05 a.m., indicated, "...confusion noted...resident has unsteady gait and wanders at times without assistance..."</p> <p>A Nurses' Note, dated 09/10/11 at 11:35 a.m., indicated, "Resident attended church service at main lobby. Walked out of facility unattended. Assisted back to unit by daughter and staff. Wanderguard placed on right ankle..."</p> <p>During an interview on 09/14/11 at 2:05 p.m., the Administrator indicated he had came in the building right after church was over. He indicated the resident had followed the family outside and the daughter had brought the resident in and the facility then put a wanderguard bracelet on the resident. He indicated he did not see the resident go out the door but saw the daughter bring the resident back in. He indicated the resident had not been harmed and the facility should have already had something in place for the resident since he was an elopement risk.</p> <p>During a telephone interview with RN #5 (nurse on duty when the incident occurred) on 09/14/11 at 2:20 p.m., she indicated the resident was in church in the main lobby. She indicated the daughter had informed her she had found the resident in the parking lot. She indicated</p> |   | <p><b>appropriate interventions are in place for those identified/determined to be at risk.</b></p>             |                      |   |

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|                    | <p>the daughter had said he had a history of wandering.</p> <p>During a telephone interview with the resident's daughter on 09/14/11 at 5 p.m., she indicated she and her husband were in their car and getting ready to leave the parking when they saw her father in the parking lot. She indicated the resident was still under the carport. She indicated she assisted her father back into the building.</p> <p>A facility policy, dated 03/08, titled, "Elopement Risk Assessment", received from the Director of Nursing as current, indicated, "...In order to attempt to identify which resident(s) may be at risk for harm should an elopement take place, all residents will be assessed on admission...6. The licensed nurse completing the assessment shall be responsible for selecting and implementing appropriate interventions for a resident with a total score of 4 or more. 7. Any resident who scores points in #4...requires consideration of placement of a security transmitter bracelet, if available, in addition to all other interventions. 8. Establish a care plan when resident is determined to have the potential for elopement. The care plan should be implemented as soon as the risk is identified..."</p> |               |   |                      |

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| F0328<br>SS=D   | <p>3.1-45(a)(2)</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:<br/>Injections;<br/>Parenteral and enteral fluids;<br/>Colostomy, ureterostomy, or ileostomy care;<br/>Tracheostomy care;<br/>Tracheal suctioning;<br/>Respiratory care;<br/>Foot care; and<br/>Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a PICC (Peripherally Inserted Central Catheter) was assessed for length and arm circumference and dressing changes were completed for 2 of 5 residents reviewed for PICC lines in a sample of 18. (Residents #B and #F)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 09/14/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to, renal failure, stroke, and</p> | F0328   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure resident's with PICC lines are assessed.F328 PLAN OF CORRECTION: 1) Immediate action taken for those residents identified: Resident B is no longer here in the facility. 2) How the facility identified other</b></p> | 10/20/2011           |   |

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|                    | <p>congestive heart failure.</p> <p>The Physician's Orders, dated 07/27/11, indicated an orders to measure the PICC catheter weekly and record, measure the arm circumference weekly, and to change the PICC dressing one time weekly.</p> <p>The Medication Administration Record (MAR), dated 08/11, lacked documentation to indicate the PICC catheter had been measured, the arm circumference had been measured and PICC dressing change had been completed as ordered.</p> <p>During an interview on 09/14/11 at 11:10 a.m., the B-Unit Manager #1 indicated the PICC catheter had not been measured, the arm circumference had not been measured and the dressing had not been changed as ordered.</p> <p>2. Resident #F's record was reviewed on 09/13/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, stroke and convulsions.</p> <p>The Physician's Orders, dated 07/27/11, indicated to measure the PICC line and circumference of the resident's right arm weekly.</p> <p>The resident's MAR, dated 08/11, indicated the PICC line and right arm circumference was measured on 08/02/11. The MAR lacked documentation to indicate the PICC line and right arm circumference had been measured after 08/02/11 through 08/31/11 when the PICC line had been discontinued.</p> <p>During an interview on 09/14/11 at 11:10 a.m., the B-Unit Manager #1 indicated the resident's PICC line and right arm circumference had not been measured as ordered.</p> |               | <p><b>residents:</b>One other resident in the facility has a PICC line, the length of the external catheter and circumference are being measured. <b>3) System in place:</b>An in-service will be provided for nursing staff regarding care of mid-line and PICC line catheters. When the nurse obtains an order the information will be put into the computer and a mid-line/PICC line flow sheet will be generated; includes the measuring the length of the external catheter and circumference with dressing change. <b>4) How the actions will be monitored:</b> All physician orders will be reviewed during the clinical meeting. Any orders for mid-lines and PICC lines will be audited for appropriate maintenance and care during the clinical meeting for quality assurance. The DON/Designee will be responsible for monitoring.</p> |                      |

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| F0329<br>SS=J      | <p>A facility policy, titled "MIDLINE CATHETER DRESSING CHANGE", dated 8/15/08, received from the Corporate Nurse Consultant as current, indicated "...Dressing changes using transparent dressings are performed...At least weekly...Length of external catheter and upper arm circumference...is obtained...During dressing changes..."</p> <p>3.1-46(a)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> |               |   |                      |

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|   | <p>Based on record review and interview, the facility failed to monitor a PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) for a resident who was receiving Coumadin (blood thinner), which resulted in the resident having a critically high PT and INR. The resident was admitted into the hospital with a diagnoses of abnormal coagulation (blood clotting) profile and subconjunctival hemorrhage (bleeding in the eyes). This affected 1 of 3 residents who received Coumadin in a sample of 18. (Resident #67). In addition to the resident in immediate jeopardy, the facility failed to monitor and receive results timely for PT/INR's as ordered resulting in harm or the potential for harm that is not immediate jeopardy to 2 of 3 residents who received Coumadin in a sample of 18. And the facility failed to ensure resident's were free of unnecessary drugs related to a resident on a low potassium diet who was receiving a potassium supplement for 1 of 2 residents on a potassium restricted diet in a sample of 18. (Residents #E and #28)</p> <p>The immediate jeopardy began on 08/01/11 when the facility failed to monitor the resident's PT and INR after 08/01/11 and the resident continued to receive Coumadin. The Administrator, Director of Nursing (DoN), and the RN</p> | F0329   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does monitor residents labs as ordered.F329PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b>Regarding resident E labs were drawn and results were communicated to the physician. Regarding resident # 28 labs were drawn and results were reported to the physician; resident remains on potassium per physician orders. A copy of the order to remain on potassium was provided to the surveyor at the time of the survey. Regarding resident # 67 the facility had self-identified during an audit that the resident involved did not have and order for PT/INR level since last PT/INR drawn on 8/1/11. Physician was notified and PT/INR level was drawn as ordered on 9/14/11. Physician was notified of abnormal results on 9/14/11. <b>2) How the facility identified other residents</b>An audit was completed on residents with a strict potassium diet and there are no other residents in the facility. Audit was completed of all residents receiving Coumadin on</p> | 10/20/2011           |   |

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|   | <p>Corporate Consultant were notified of the immediate jeopardy at 4:35 p.m. on 09/15/11. The immediate jeopardy was removed on 09/16/11, but noncompliance remained at the level of isolated, no actual harm with potential for more than minimal harm.</p> <p>Findings include:</p> <p>1. During an interview on 09/15/11 at 10:05 a.m., the B-Unit Manager #1 indicated Resident #67 was in the hospital due to a critical PT/INR.</p> <p>Resident #67's record was reviewed on 09/15/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, deep vein thrombosis (blood clot) and leukemia.</p> <p>The resident's admission orders, dated 07/28/11, indicated the resident was readmitted into the facility from the hospital on 07/28/11.</p> <p>A physician's telephone order, dated 07/28/11, indicated an order for Coumadin 5 mg (milligrams), one tablet daily to start on 07/29/11 and to obtain a PT/INR on 08/01/11.</p> <p>The resident's PT/INR laboratory results, dated 08/01/11, indicated the PT was 19.9</p> |   | <p>9/14/11 to identify if PT/INR levels were drawn as ordered, and a total of 13 residents are currently receiving Coumadin . Notified physicians of all residents on Coumadin and obtained standing orders to draw weekly PT/INR levels. PT/INR levels were drawn as ordered on 9/14/11 and 9/15/11, and no other levels were elevated. 3 residents were identified on Heparin subcutaneously. Physicians for all 3 residents were notified, and the heparin was discontinued on all 3 residents. 2 of the 3 residents were placed on Aspirin 81mg daily. All 3 physicians declined PTT levels to be drawn, stating that PTT levels are not drawn when Heparin is administered subcutaneously. 3) <b>System in place:</b>Instituted PT/INR Quality Assurance flow sheets on 9/15/11 for each resident to log results and tracking next scheduled draw dates and dosage changes. An in-service was provided for licensed nurses regarding completion of PT/INR flow sheets, and re-in-serviced regarding lab notification of orders, Coumadin side effects/dangers and importance of monitoring levels, drug interactions with Coumadin such as antibiotics, signs and symptoms of Coumadin toxicity, and timely physician notification of elevated PT/INR results. Any licensed nurse who has not</p> |  |  |   |  |

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|   | <p>(normal 20.7-30.5) and the INR was 1.98 (normal 2.00-3.00). The PT/INR results indicated the physician had been notified of the results and the facility was to continue the same dose of Coumadin.</p> <p>There was a lack of documentation to indicate the resident's PT/INR was to be monitored after 08/01/11.</p> <p>The resident's Medication Administration Record (MAR), dated 08/11 indicated the resident had received the Coumadin 5 mg daily except on 08/01/11.</p> <p>The resident's MAR, dated 09/11, indicated the resident had received the Coumadin 5 mg daily September 1 through the 13, 2011.</p> <p>The resident's Nurses' Notes indicated:</p> <p>09/10/11 at 00:00 (12 a.m.), "Infection Note...resident bilateral eyes reddened no drainage...(Physician's Name) notified...order for neosporin (antibiotic) eye drops..."</p> <p>09/10/11 at 18:56 (6:56 p.m.), "...bilateral eyes remains reddened with no drainage noted. resident (sic) denies itching or irritation..."</p> <p>09/11/11 at 03:54 (3:54 a.m.), "...bilateral</p> |   | <p>attended the in-service will not be permitted to work until in-serviced. DON/designee will review in daily clinical review meeting 5 days per week all PT/INR results, telephone orders , admission and re-admission orders for PT/INR and Coumadin orders, and PT/INR flowsheets to ensure that PT/INR's are obtained as ordered and physicians notified of results. These reviews will be done 5 days per week indefinitely. Consultant Pharmacist will review all residents receiving Coumadin monthly. The DON/ designee will be responsible the coordination of monitoring.4)</p> <p><b>How the actions will be monitored</b>The results of these audits will be reviewed in QA&amp;A monthly x3 months, then quarterly thereafter.</p> |                      |   |

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|                    | <p>eyes remains reddened with no drainage noted. resident (sic) denies itching or irritation at this time..."</p> <p>09/11/11 at 15:34 (3:54 p.m.), "...Bilartal (sic) eyes remain red..."</p> <p>09/11/11 at 19:23 (7:23 p.m.), "...bilateral eyes remain reddened. (Physician's Name) made aware...no new orders..."</p> <p>09/12/11 at 12:56 (12:56 p.m.), "...Bilateral eyes remain red. No complaints of discomfort..."</p> <p>09/12/11 at 21:58 (9:58 p.m.), "...Bilateral sclera red. Denies any complaints of pain or itching..."</p> <p>09/13/11 at 02:24 (2:24 a.m.), "...Hemmorhagic (sic) left eye...Denies pain or discomfort at this time..."</p> <p>09/13/11 at 23:46 (11:46 p.m.), "...bilateral eyes remains red. no (sic) drainage noted. no (sic) complaint of visual disturbance..."</p> <p>09/14/11 at 02:24 (2:24 a.m.), "...Bilateral sclera remains red..."</p> <p>09/14/11 at 14:05 (2:05 p.m.), "... spoke with (Physician's Name) related to PT and INR, new orders for weekly PT and</p> |               |   |                      |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155650 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/21/2011 |
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|                    | <p>INR..."</p> <p>A Physician's Order, dated 09/14/11, indicated an order to complete a PT and INR on 09/14/11 and then weekly.</p> <p>The PT/INR results, dated 09/14/11, indicated the resident's PT was high at 103.7 (normal 10-12) and the INR value was critical at 12.9 (normal 2-3).</p> <p>A Physician's Order, dated 09/14/11, indicated an order to transfer the resident to the Emergency Room to be evaluated and treated due to a critical PT/INR.</p> <p>The Emergency Room notes, dated 09/14/11 at 9:44 p.m., indicated the resident's PT was 103.5 and INR was 12.8, and Aqua-Mephyton (blood clotting agent) 5 mg was administered to the resident.</p> <p>The Emergency Room History and Physical, dated 09/15/11, indicated, "...Conjunctivae/corneas subconjunctival hemorrhage present...Diagnoses: Abnormal coagulation profile, Subconjunctival hemorrhage, and Coagulopathy (defect in the body's ability to clot blood)..."</p> <p>There was a lack of documentation to indicate the resident had a care plan for</p> |               |   |                      |

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|                    | <p>the Coumadin and risk factors of the Coumadin until 09/15/11.</p> <p>During an interview on 09/15/11 at 1:10 p.m., the B-Unit Manager #1 indicated the PT and INR had not been monitored after 08/01/11. She indicated she noticed the resident was on Coumadin on 09/14/11 and we called and received an order to check the resident's PT and INR.</p> <p>During an interview on 09/15/11 at 2:25 p.m., the DoN indicated the nurses should have questioned the residents red sclera. She indicated she was unsure if the facility had a policy for monitoring residents on a blood thinner.</p> <p>During an interview on 09/15/11 at 2:30 p.m., the DoN indicated she did not know about the resident's red eyes and if she had known she would have gotten an order to check the resident's PT and INR. She indicated the facility had went through all the resident's charts on 09/14/11 after concerns were voiced about some of the residents PT and INR's.</p> <p>A professional resource, titled, "2010 Nursing Spectrum Drug Handbook", page 1238, indicated, "...warfarin sodium (Coumadin)...Monitor INR regularly in all patients..."</p> |               |   |                      |

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|                    | <p>2. Resident #E's record was reviewed on 09/13/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and stroke.</p> <p>A Physician's Order, dated 08/17/11, indicated and order for coumadin 5 mg daily and to obtain a PT/INR on 08/18/11 and then weekly.</p> <p>The record indicated the resident had a PT/INR completed on 08/18/11 and 08/30/11 (12 days later).</p> <p>The record indicated the resident had a PT/INR completed on 09/02/11 and the facility received the results of the PT/INR on 09/06/11 (4 days later).</p> <p>During an interview on 09/13/11 at 1:10 p.m., the B-Unit Manager #1 indicated the resident should have had a PT/INR on 08/25/11.</p> <p>During an interview on 09/13/11 at 1:30 p.m., the B-Unit Manager #1 indicated the lab had been informed of the weekly PT/INR and they missed the lab on 08/25/11. She indicated the facility's fax machine was broke so the PT/INR results dated 9/2/11 had not come through until the machine was fixed on 9/6/11.</p> <p>3. Resident #28's record was reviewed on 9/13/11 at 2:50 p.m. Resident #28's</p> |               |   |                      |

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|   | <p>diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and chronic renal insufficiency.</p> <p>A. The resident's physician's orders, dated 8/4/11, indicated Coumadin 5 milligrams daily and Cipro (an antibiotic medication) 750 milligrams every 12 hours for a wound infection.</p> <p>A pharmacy form, dated 8/5/11, indicated "URGENT! COUMADIN DRUG INTERACTION NOTIFICATION...Resident receives Coumadin...and cipro- recommend checking INR Q (every) 3 days while taking cipro. The combination of medications has potential for serious drug interactions..." Handwritten on the form "...order for PT/INR weekly..."</p> <p>A physician's order, dated 8/5/11, indicated "PT/INR wkly (weekly) beginning 8/11/11..."</p> <p>A care plan, dated 4/6/11, indicated "...on anticoagulant therapy...labs as ordered..."</p> <p>A nurses' note, dated 9/8/11 at 3:40 p.m., indicated "writer spoke to (physician name) regarding bleeding from left and right feet, new orders to hold coumadin for 4 days and then do PT/INR in one week..."</p> |   |   |                      |   |

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|   | <p>The resident's record lacked documentation of any PT/INR laboratory results for 8/11/11 or weekly after that.</p> <p>During an interview on 9/13/11 at 4:55 p.m., the A Wing Unit Manager #6 indicated she was not able to find any PT/INR lab results. She indicated the nurse had called the doctor because the resident's wounds on his feet were bleeding and had gotten the order to hold the coumadin.</p> <p>During an interview on 9/14/11 at 1:35 p.m., the Corporate Nurse Consultant indicated the PT/INR laboratory tests had not been done for the resident. She indicated the laboratory was coming to draw a stat PT/INR this afternoon. She indicated they were going to audit all other residents on coumadin to be sure no other laboratory test had been missed.</p> <p>B. Resident #28's physician's re-admission orders, dated 8/4/11, indicated the resident was on a regular low sodium and low potassium diet. The resident also had an order for klor-con (a potassium supplement) 40 meq (milliequivalents) daily.</p> <p>During an interview on 9/15/11 at 11:00 a.m., the DoN (Director of Nurses)</p> |   |   |                      |   |

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|   | <p>indicated she would try to find out why the resident was on a potassium restricted diet and was receiving a potassium supplement.</p> <p>During an interview on 9/15/11 at 2:47 p.m., the Registered Dietician indicated the resident had been re-admitted to the facility on the low potassium diet. She indicated the resident had a renal diagnoses to support the potassium low diet. She indicated she had missed the order for the potassium supplement when she had reviewed the resident's chart.</p> <p>The immediate jeopardy began on 08/01/11 when the facility failed to monitor the resident's PT and INR after 08/01/11 and the resident continued to receive Coumadin. The Administrator, Director of Nursing (DoN), and the RN Corporate Consultant were notified of the immediate jeopardy at 4:35 p.m. on 09/15/11. The immediate jeopardy was removed on 09/16/11, but noncompliance remained at the level of isolated, no actual harm with potential for more than minimal harm.</p> <p>The immediate jeopardy that began on 08/01/11 was removed on 09/16/11 when the facility had audited the residents who received Coumadin for PT/INR's and Physicians were notified and PT/INR lab</p> |   |   |                      |   |

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|   | <p>orders were obtained if the residents did not have an order. The facility found no other resident on Coumadin with elevated PT/INR levels. PT/INR Quality Assurance flow sheets were initiated to monitor all PT/INR lab results and Coumadin dosage. An inservice on anticoagulants, PT/INR's, and side effects of the medication had been completed for the nurses at the facility. Five nurses were interviewed and they were able to state the facility protocol for Coumadin and signs and symptoms of adverse reactions to Coumadin usage. The Director of Nursing will review the PT/INR results, flow sheets, physician orders, and physician notification five days a week. The Consultant Pharmacist will review all residents receiving Coumadin monthly. The audits will continue to be completed and utilized by the Quality Assurance Committee.</p> <p>3.1-48(a)(3)</p> |   |   |                      |   |

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| F0332<br>SS=D   | <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 11 residents (Residents D, #20 and #21) observed receiving medications. 3 errors in medication administration were observed during 40 opportunities for error in medication administration. This resulted in a medication error rate of 7.5%. (LPN #10 and RN #11). This affected 1 resident in a sample of 18 (Resident D) and 2 residents in a supplemental sample of 13 (Residents #20 and #21)</p> <p>Findings include:</p> <p>1. During a morning medication observation pass on 9/13/11 at 8:58 a.m., LPN #10 was observed to administer the following medications to Resident D:<br/>Amantadine (anti-infective) 25 milligrams/2.5 milliliters<br/>Amlodipine Besylate (heart medication) 10 milligrams<br/>Citalopram (antidepressant medication)10</p> | F0332   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does administer medications per the physician's order.F332 PLAN OF CORRECTION1) Immediate action taken for those residents identified: A medication error was completed; there was no negative outcome for resident D. Regarding resident # 20 a medication error was completed and there was no negative outcome for the resident. Regarding resident #21 the time for her Prilosec was changed to the appropriate time; a medication error was completed and there was no negative outcome for the resident. LPN #11, disciplinary action was opposed per facility policy. 2) How the facility identified other</b></p> | 10/20/2011           |   |

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|   | <p>milligrams/5 milliliters<br/>docusate sodium (a stool softener) 100 milligrams, 2 capsules<br/>Lisinopril (blood pressure medication) 40 milligrams<br/>Promod protein (supplement) 30 milliliters<br/>Metoprolol (blood pressure medication) 50 milligrams<br/>Namenda (Alzheimer's medication) 10 milligrams<br/>Thera-M (supplement) tablet<br/>Vitamin C (supplement) 250 milligrams</p> <p>LPN #10 was not observed to administer Resident D's Senna Laxative 8.6 milligrams, 2 tablets twice a day.</p> <p>Review on 9/13/11 at 10:00 a.m., of the physician's orders for September 2001, indicated an order for the Senna Laxative 8.6 milligrams, 2 tablets twice a day on 12/15/10.</p> <p>During an interview on 9/13/11 at 10:10 a.m., the Nurse Consultant indicated the nurse had "missed" the medication.</p> <p>2. During a morning medication observation pass on 9/14/11 at 9:00 a.m., LPN #11 was observed to administer the following medications to Resident #20:<br/>Exelon (Alzheimer's medication) patch 4.6 milligrams/24 hour<br/>Zoloft (antidepressant) 25 milligrams<br/>Cymbalta (antidepressant) 30 milligrams<br/>Sinemet (Parkinson;s medication) 25-100 milligrams two tablets<br/>Divalproex(seizure medication) 250 milligrams<br/>Isosorbride Mononitrate (blood pressure) 60 milligrams<br/>Pepcid (stomach medication) 20 milligrams<br/>Plavix (heart medication) 75 milligrams</p> |   | <p><b>residents:</b>The Pharmacist Consultant will come out to review all physician orders. Any recommendation will be communicated with the physician. The Pharmacy Technician will complete an audit of all medication and treatment carts for available medications. <b>3)</b></p> <p><b>System in place:</b>The facility has now gone to electronic medical record. All nurses were trained on physician order input and medication administration and utilizing electronic MAR and TAR. Nurses and QMA's were in-serviced on medication administration. Proficiencies will be completed on all nurses and QMA's on medication administration. The Pharmacist Consultant will continue to review all medication orders at least monthly and provide medication administration recommendations to DON. <b>4) How the actions will be monitored:</b> Proficiencies on medication administration will be done on random shift with random nurses/QMA's at least 3 days a week. Any issues identified will be re-addressed with in-service training and/or disciplinary action.</p> |                      |   |

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|   | <p>Lanoxin (heart medication) 0.125 milligrams<br/>Aspirin 325 milligrams</p> <p>Review on 9/14/11 at 9:30 a.m. of a physician telephone order dated 8/26/11, indicated "1. Decrease (arrow pointing down) Cymbalta (antidepressant) to 30 mg (milligrams) daily x (times) 10 days then 2. D/C (discontinue) Cymbalta 30 mg..."</p> <p>The August 2011, MAR (medication administration record) indicated the resident received the Cymbalta 30 mg on 8/27/11.</p> <p>The resident's record indicated the resident was sent to the hospital on 8/28/11 and returned on 09/02/11.</p> <p>A physician's clarification telephone order, dated 09/02/11, indicated "...Resume previous order to decrease (arrow pointing down) Cymbalta 30 mg daily x 10 days than D/C...."</p> <p>The September 2011, MAR indicated the Cymbalta 30 mg had been administered daily from September 3 through September 14.</p> <p>During an interview on 9/14/11 at 10:00 a.m., the DoN indicated the Cymbalta 30 mg should have been discontinued on 9/12/11.</p> <p>3. During the morning medication observation pass on 9/14/11 at 8:45 a.m., LPN #11 was observed to administer the following medications to Resident #21:<br/>Tylenol 650 mg<br/>There-M (supplement) tablet<br/>Amlodipine (heart medication) 5 mg<br/>Hydrochlorothiazide (blood pressure) 12.5 mg<br/>Lexapro (antidepressant) 10 mg</p> |   |   |                      |   |

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| F0365<br>SS=D      | <p>Metoprolol (blood pressure medication) 25 mg<br/>Omeprazole (stomach medication) 40 mg</p> <p>The pharmacy label on the Omeprazole 40 mg indicated "Give 1 capsule daily at 6am - peptic ulcer." The medication was administered two hours and forty five minutes later than the pharmacy label indicated and after breakfast.</p> <p>During an interview on 9/14/11 at 9:40 a.m., the DoN indicated the facility needed to change the time of the medication to 6:00 a.m.</p> <p>Review on 9/16/11 at 3:10 p.m. of the "2010 Nursing Spectrum Drug Handbook," page 857, indicates "...Administration: Give 30 to 60 minutes before a meal, preferably in morning...."</p> <p>3.1-48(c)(1)</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> |               |   |                      |

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|   | <p>Based on observation, record review, and interview, the facility failed to ensure a resident received thickened liquids as designed to meet the resident's needs related to a nurse administering regular liquids to a resident during the medication pass for 1 resident in a sample of 18 residents. (Resident D)</p> <p>Findings include:</p> <p>During the first medication observation pass on 9/13/11 at 8:58 a.m., LPN #10 was observed to administer a liquid form of medication and medication crushed and placed in applesauce. LPN #10 was observed to give the resident several drinks of water from a plastic glass. There was a Styrofoam drinking container on the resident's bedside table with the words "thick" written on the container. LPN #10 was observed to continue to give the resident unthickened water throughout the medication pass.</p> <p>During an interview on 9/13/11 at 9:48 a.m., LPN #10 indicated she had given the resident unthickened water.</p> <p>Review of Resident D's physician's orders, on 9/13/11 at 10:00 a.m., indicated Resident D was to receive "nectar thick liquids."</p> | F0365   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does provide thickened liquids per the physician's order.F365 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Regarding resident D, the nurse no longer works for the facility. The resident was assessed on 09-13-11, lung sounds were clear; resident did not have a negative outcome related to this practice. <b>2) How the facility identified other residents:</b>The nurse was not assigned to any other residents with thickened liquids. <b>3) System in place:</b>All staff will be in-serviced on how to identify residents on thickened liquids. Residents on thickened liquids are provided pre-thickened liquids at the bedside. The electronic administration record and physician orders are available during medication pass and residents on thickened liquids are communicated during shift to shift report utilizing the 24 hour report. <b>4) How the actions will be monitored:</b> Proficiencies on medication administration will be done on random shift with</p> | 10/20/2011           |   |

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| F0367<br>SS=D      | <p>During an interview on 9/13/11 at 12:55 a.m., the DoN (Director of Nursing) indicated LPN #10 should not have give the resident unthickened water.</p> <p>3.1-21(a)(3)</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a low potassium diet received low potassium foods for 1 of 2 meals observed for 1 of 2 residents with a low potassium diet in a total sample of 18 residents. (Resident #28)</p> <p>Findings include:</p> <p>Resident #28's record was reviewed on 9/13/11 at 2:50 p.m. Resident #28's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and chronic renal insufficiency.</p> <p>Resident #28's physician's re-admission orders, dated 8/4/11, indicated the resident was on a regular low sodium and low potassium diet.</p> | F0367         | <p>random nurses/QMA's at least 3 days a week. Any issues identified will be re-addressed with in-service training and/or disciplinary action.</p> <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does provide diet as order by the physician.F367 PLAN OF CORRECTION1) Immediate action taken for those residents identified: Regarding resident # 28 the diet was changed to a regular diet. 2) How the facility identified other residents:No other residents were affected and no other residents are receiving a low potassium diet. 3) System in placeThe dietary staff will be re-inserviced on following the</b></p> | 10/20/2011           |

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|   | <p>Resident #28 was observed during the evening meal on 9/13/11 at 6:08 p.m.. The resident received a turkey fritter, tomato relish, sliced orange, black eyed peas, and bread and butter.</p> <p>The menu for the low potassium diet, indicated the resident was to receive the turkey fritter, 1/2 cup of cooked vegetables, tomato relish, sugar cream pie and bread and butter.</p> <p>During an interview on 9/13/11 at 6:15 p.m., the Dietary Manager indicated the resident should have gotten green beans not the black eyed peas. She indicated the resident was given fruit for dessert but he should not have been given a sliced orange for the fruit.</p> <p>3.1-21(b)</p> |   | <p>menu for therapeutic diets. All resident on a specialized diet are identified on their computer generated card which is printed on a daily basis. The dietary staff compares the specialized diet to the menu spread sheet for the appropriate food item. Resident on a special diet, the cook will double check the spread sheet prior to sending the tray out to the resident. <b>4) How the actions will be monitored:</b> The dietary manager or designee will observe the meal service on random meals at least 3 x week. The dietary manager will be responsible for monitoring. The results of these audits will be reviewed in the monthly Quality Assurance meeting x6 months.</p> |                      |   |

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| F0441<br>SS=D      | <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br/>Based on observation, record review, and interview, the facility failed to position a resident's feeding tube and catheter tubing correctly to prevent the possible spread of infection for 1 of 4 residents with a</p> | F0441         | , The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's | 10/20/2011           |

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|   | <p>catheter and feeding tube in a total sample of 18. (Resident C)</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, seizures, and aphasia.</p> <p>A physician's order, dated 8/5/11, indicated to change the indwelling catheter monthly and as needed for occlusion and leaking.</p> <p>A physician's order, dated 9/1/11, indicated to change the resident's tube feeding to Glucerna 1.5 at 85 cc's (cubic centimeters) an hour times 18 hours. On at 6 a.m. and off at 12:00 a.m.</p> <p>A care plan, dated 5/19/11, indicated "Resident had foley catheter related to wounds...Foley catheter care every shift and as needed..."</p> <p>Resident C was observed on 9/13/11 at 9:21 a.m., lying in bed. The resident's feeding tube tubing was wrapped around the resident's catheter tubing.</p> <p>During an interview on 9/13/11 at 9:25 a.m., LPN #10 indicated the resident's feeding tube tubing was wrapped around</p> |   | <p><b>desire to comply with the regulatory requirements and continue to provide quality care. The facility does position feeding tubes and catheter tubing correctly.F441 PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Resident C is no longer here at the facility. <b>2) How the facility identified other residents:</b>No other residents were affected. <b>3) System in place:</b>An in-service will be provided to nursing staff and CNA's regarding care of feeding tubes and catheters. Proficiencies on the care of feeding tubes and catheter care will be done with random nursing staff. <b>4) How the actions will be monitored:</b> Will monitor on daily scheduled rounds at least 3 x weekly on random shifts by members of the quality assurance team for proper positioning of catheters and feeding tubes, including monitoring of all direct care staff on all shifts. The DON/Designee will be responsible to coordinate monitoring.</p> |                      |   |

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| F0456<br>SS=D   | <p>the resident's catheter tubing. She indicated the tubing should not be wrapped around like that.</p> <p>3.1-18(b)(1)<br/>3.1-18(b)(2)</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and record review, the facility failed to ensure patient care kits were kept in operating condition related to expired tracheostomy care kits for 1 of 1 wing (A-Wing) in the facility. This had the potential to affect 1 resident with tracheostomy on the A-Wing. (Resident C)</p> <p>Findings include:</p> <p>During the environmental tour with the Environmental Director and the Maintenance Director on 9/14/11 beginning at 2:10 p.m., the following observations were made:</p> <p>In the A-Wing oxygen room in the top cabinet there were six expired</p> | F0456   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does ensure supplies are not expired.F456 PLAN OF CORRECTION1) Immediate action taken for those residents identified: The expired and opened trach care kits were thrown away. 2) How the facility identified other residents:Resident C was discharged from the facility. During her stay her personal trach care supplies were stored in her room. One other resident in the facility had a trach, however</b></p> | 10/20/2011           |   |

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| F0502<br>SS=D   | <p>tracheotomy care kits with the expiration dates of March 2011 and August 2011. There were two tracheotomy care kits with the expiration dates of September 2011, these kits had been opened and placed back in the cabinet. The Environmental Director was observed to throw the kits away.</p> <p>Resident C's record was reviewed on 9/14/11 at 8:50 a.m. Resident C's diagnoses included, but were not limited to, stroke, tracheostomy, aphasia, and diabetes mellitus.</p> <p>3.1-19(bb)</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory services were completed as ordered for 2 of 18 residents reviewed for laboratory tests in a sample of 18. (Resident #E and #28)</p> <p>Findings include:</p> <p>1. Resident #E's record was reviewed on 09/13/11 at 8:30 a.m. The resident's diagnoses included, but were not limited</p> | F0502   | <p>his personal trach care supplies are kept in his room, and are not expired. <b>3) System in place:</b>An inservice will be provided for the nurses and QMAs regarding checking expiration dates of trach supplies. The central supply manager will check the supply room weekly and rotate stock to the front with expiration dates as needed. <b>4) How the actions will be monitored:</b> The central supply manger will be responsible for checking supplies in the oxygen room and discarding expired and open supplies. The result of these audits will be reviewed in the monthly Quality Assurance meeting x6 months.</p> <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does monitor labs per the physician's order.F0502 PLAN OF CORRECTION:1) Immediate</b></p> | 10/20/2011           |   |

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|   | <p>to, Alzheimer's disease and stroke.</p> <p>A Physician's Order, dated 08/17/11, indicated and order for coumadin 5 mg daily and to obtain a PT/INR on 08/18/11 and then weekly.</p> <p>The record indicated the resident had a PT/INR completed on 08/18/11 and 08/30/11 (12 days later).</p> <p>During an interview on 09/13/11 at 1:10 p.m., the B-Unit Manager #1 indicated the resident should have had a PT/INR on 08/25/11.</p> <p>During an interview on 09/13/11 at 1:30 p.m., the B-Unit Manager #1 indicated the lab had been informed of the weekly PT/INR and they missed the lab on the 08/25/11.</p> <p>2. Resident #28's record was reviewed on 9/13/11 at 2:50 p.m. Resident #28's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and chronic renal insufficiency.</p> <p>The resident's physician's orders, dated 8/4/11, indicated Coumadin 5 milligrams daily and Cipro (an antibiotic medication) 750 milligrams every 12 hours for a wound infection.</p> |   | <p><b>action taken for those residents identified:</b> Regarding resident E the PT/INR was drawn and reported to the physician. Regarding resident # 28 the PT/INR was drawn and reported to the physician. <b>2) How the facility identified other residents:</b>An audit was completed of all labs and lab orders were re-evaluated by the physician. <b>3) System in place:</b>An In-service will be provided for nurses regarding lab services, tracking, notification, medication administration, following physician orders, and medication error procedures. Nurse proficiencies will be completed on random nurses 3 days a week. New lab orders are reviewed in the morning clinical meeting. Labs are communicated when drawn during shift to shift report. As physician orders for labs are obtained by the nurse; the nurse will complete the lab requisition and the DON/Designee will audit to ensure requisition has been completed. <b>4) How the actions will be monitored:</b> The DON/Designee will audit labs for completeness and physician notification 3 x week and audits will be discussed monthly during quality assurance x 6 months. Nurse proficiencies will be completed on random nurses at least 3 x a week regarding medication pass and following</p> |                      |   |

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|   | <p>A pharmacy form, dated 8/5/11, indicated "URGENT! COUMADIN DRUG INTERACTION NOTIFICATION...Resident receives Coumadin...and cipro- recommend checking INR Q (every) 3 days while taking cipro. The combination of medications has potential for serious drug interactions..." Handwritten on the form "...order for PT/INR weekly..."</p> <p>A physician's order, dated 8/5/11, indicated "PT/INR wkly (weekly) beginning 8/11/11..."</p> <p>A care plan, dated 4/6/11, indicated "...on anticoagulant therapy...labs as ordered..."</p> <p>A nurses' note, dated 9/8/11 at 3:40 p.m., indicated "writer spoke to (physician name) regarding bleeding from left and right feet, new orders to hold coumadin for 4 days and then do PT/INR in one week..."</p> <p>The resident's record lacked documentation of any PT/INR laboratory results for 8/11/11 or weekly after that.</p> <p>During an interview on 9/13/11 at 4:55 p.m., the A Wing Unit Manager #6 indicated she was not able to find any PT/INR lab results. She indicated the nurse had called the doctor because the</p> |   | <p>physician orders. The DON/Designee will be responsible for the coordination/monitoring. The results will be discussed monthly in quality assurance x6 months.</p> |                      |   |

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| F0514<br>SS=D   | <p>resident's wounds on his feet were bleeding and had gotten the order to hold the coumadin.</p> <p>During an interview on 9/14/11 at 1:35 p.m., the Corporate Nurse Consultant indicated the PT/INR laboratory tests had not been done for the resident. She indicated the laboratory was coming to draw a stat PT/INR this afternoon. She indicated they were going to audit all other residents on coumadin to be sure no other laboratory test had been missed.</p> <p>3.1-49(a)</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 record review and interview, the</p> | F0514   | The filing of this plan of  | 10/20/2011           |   |

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|   | <p>facility failed to ensure resident's clinical records were accurately documented related to not documenting a late entry in the nurses' note for 1 of 18 resident's reviewed for complete and accurate clinical records in a total sample of 18. (Resident G)</p> <p>Findings include:</p> <p>Resident G's closed record was reviewed on 9/15/11 at 10:30 a.m. Resident G's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and diabetes mellitus.</p> <p>Resident G's readmission physician's orders, dated 8/10/11, indicated oxygen at 4 liters via mask continuously and bipap settings 15/15 at 50% at bedtime and as needed for respiratory distress. The resident's code status was full cardiopulmonary resuscitation.</p> <p>The nurses' notes indicated:<br/>8/11/11 at 10:21 p.m., (The computer indicated the charting was "created date 8/12/11 13:13 {1:13 p.m.}), indicated "on my way to take lunch about 9:55 p.m., I stopped in and checked on resident. daughter stated 'i don't think she doing to good (sic).' checked sp o2 was 90% ran got oxygen tank and another nurse for assistance walked in room I held mask on</p> |   | <p><b>correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does clinical reocrds are accurate.F514</b></p> <p><b>PLAN OF CORRECTION:1) Immediate action taken for those residents identified:</b> Resident G is no longer here at the facility. <b>2) How the facility identified other residents:</b>No residents were affected. <b>3) System in place:</b>An in-service will be provided for nursing staff on how to insert a late entry in the electronic medical record and ongoing in-services will be provided to nursing staff. <b>4) How the actions will be monitored:</b> The Super user will continue to complete daily audits 5 x week by running quality assurance reports. Any issues identified are addressed with the appropriate employee. Items of additional in-service training are identified and staff are provided further training as needed. The Super user will be responsible for monitoring. The results of these audits will be reviewed in monthly Quality Assurance x6 months.</p> |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155650 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>09/21/2011 |
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|   | <p>her face for a greater seal other nurse called (physician name) checked her blood sugar reading was 310 checked code status called (physician name), no answer, while other nurse was with resident on my way back I walked into room seen (sic) resident was breathing unlabored, sp o2 82% (normal range 90-100%) with nasal prongs on took nasal prongs off and put bi pap back on and did sternal rubs sp o2 went up to 86%, daughter stated 'I already called 911.' simultaneously as I checked for a pulse, the medics enter (sic) room with stretcher. gave report..." There was a lack of documentation of an assessment of the resident's lungs sounds or vital signs.</p> <p>There was a lack of documentation to indicate this entry was a late entry.</p> <p>During an interview on 9/16/11 at 2:25 p.m., LPN #17, the nurse who had been taking care of the resident on 8/11/11, indicated she had charted the next day because she had realized she had not documented things as they occurred and had marked out the charting she had done the night before.</p> <p>This Federal tag relates to complaint IN00096566.</p> <p>3.1-50(a)(1)</p> |   |   |                      |   |

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| F0516<br>SS=D   | <p>3.1-50(a)(2)</p> <p>A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview, the facility failed to safeguard closed clinical records and resident records against loss and destruction for 1 of 1 Medical Records office, related to 10 boxes and 29 folders of resident files and thinned out forms not protected from the sprinkler system.</p> <p>Findings include:</p> <p>During the environmental tour on 9/14/11 beginning at 2:10 p.m. with the Maintenance Director and the Environment Director the following was observed.</p> <p>In the Medical Records office there were 10 large boxes and 29 folders sitting on top of the metal</p> | F0516   | <p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. The facility does safeguard the clinical records. F516 PLAN OF CORRECTION:1) Immediate action taken for those residents identified: All over flow medical records were placed in plastic tubs to protect from the water sprinkler system. 2) How the facility identified other residents:No residents were affected. 3) System in</b></p> | 10/20/2011           |   |

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|   | <p>cabinets. The boxes and folders were not protected from the water sprinkler system.</p> <p>During an interview at the time of the observation, the Maintenance Director indicated the resident files were not protected from the water sprinkler system.</p> <p>3.1-50(d)</p> |   | <p><b>place:</b>The facility no longer utilizes paper charts and has gone to electronic medical records. Iron Mountain will be contacted for the protection and storage of the medical records of residents that have been discharged. Current resident's medical records will be stored in plastic tubs and file cabinets to protect against the sprinkler system. <b>4) How the actions will be monitored:</b> The Administrator will monitor during rounds that medical records are secured.</p> |                      |   |