

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 30, 31, November 1, 4, 5, 6, 7, 8, 2013</p> <p>Facility number: 000009 Provider number: 155022 AIM number: 100274760</p> <p>Survey team: Courtney Mujic, RN-TC - October 30, 31, November 4, 5, 6, 7, 8, 2013. Beth Walsh, RN - October 30, 31, November 1, 4, 5, 6, 7, 2013. Karina Gates, Generalist</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 10 Medicaid: 60 Other: 11 Total: 81</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 11/19/13 by Suzanne Williams, RN</p>	F000000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>The Heritage House of Shelbyville respectfully requests consideration for paper compliance. The findings were primarily related to documentation and re-education to facility policy, which</p>	

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

TITLE

(X6) DATE

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

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			have been corrected and included as attachments accompanying the 2567.	

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	<p>The diagnoses for Resident #103 included, but were not limited to, the following: history of pulmonary embolism, hypertension and history of myocardial infarction.</p> <p>The November, 2013 Physician's Orders indicated Resident #103 was to receive a 2 mg tab of Warfarin (anticoagulant medication) daily on Tuesday and Friday effective 10/2/13. It indicated she was to receive a 4 mg tab of Warfarin daily on Sunday, Monday, Wednesday, Thursday and Saturday effective 10/2/13.</p> <p>During review of Resident #103's care plans, no care plan addressing her anticoagulation medication use was found.</p> <p>During an interview with MDS Coordinator #7 on 11/8/13 at 10:55 a.m. she indicated Resident #103 did not have a care plan addressing her Warfarin use, but she should. She further indicated the care plan should include interventions such as check labs, notify MD as needed, watch for signs of bleeding, and monitor falls.</p> <p>2. The clinical record for Resident #94 was reviewed on 11/5/13 at 1:30 p.m.</p>		<p>Resident #103 has a current care plan for anticoagulation medication use and antipsychotic medications. The care plan (attachment N) is in place and available for the IDT team use. A copy of the care plans written, were provided to the survey team on 11/8/13 prior to survey exit.</p> <p>Resident #94 has a current care plan written for Zyprexa use. The care plan (attachment O) is available for IDT use.</p>		

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	<p>The diagnoses for Resident #94 included, but were not limited to: dementia with psychotic features.</p> <p>The November, 2013 Physician's Orders indicated Resident #94 was to receive 2.5 mg of Zyprexa (antipsychotic medication) twice daily effective 10/30/13.</p> <p>During a review of Resident #103's care plans, no care plan addressing her antipsychotic medication use was found.</p> <p>During an interview with MDS Coordinator #8 on 11/5/13 at 3:02 p.m., she indicated there should be a care plan addressing Resident #94's Zyprexa use.</p>		<p>Resident #41 has a current care plan (attachment P) written that addresses his potential for pain dated 11/5/13.</p> <p>Resident #21 has a current care plan (attachment Q) written and in place for his potential for pain and discomfort. A copy of the care plans prepared for resident #41 and #21 were provided to the surveyor on 11/5/13. The findings for F279 acknowledge the survey team received the care plan copies on that date.</p> <p>For other residents who have the potential to be affected by this finding. On 11/11/13, the facility pharmacy</p>		

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			<p>prepared a list of residents who receive anticoagulation medications. The IDT team reviewed and ensured that a care plan for anticoagulation medications was in place for all residents listed.</p> <p>Residents who receive antipsychotic medications were listed by the facility pharmacy. The IDT team reviewed and ensured that each resident listed had a current care plan in place for antipsychotic medication use.</p> <p>Prior to survey exit when it was discovered that the requested care plan for resident #41 and #21 could not be</p>	

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			<p>located, the IDT team reviewed and ensured that all residents with the specific</p> <p>pain controls need and those with a potential for pain/discomfort had been care</p> <p>planned if applicable.</p> <p>The facility has duplicated the</p> <p>paper care plan for residents on anticoagulation medications, antipsychotic</p> <p>medications, and pain medications, with a digital copy that can be made</p> <p>available if/when the primary cannot be located.</p> <p>Care plan IDT reviews will include</p> <p>updates as needed to the primary documented care plan and updating the digital</p> <p>copy.</p>		

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			<p>Nursing administration receives physician orders weekly. Physician orders will be reviewed and monitored, the care plan will be updated as needed to reflect physician order changes. During at least quarterly IDT care plan reviews scheduled, for every resident, the IDT will assess the care plans for completeness based on the current MDS and resident needs. New resident admissions will have a chart review after 24 hours, 48 hours, and 5-7 days to ensure care plans are available for resident conditions and care delivery needs.</p> <p>Any concerns identified while</p>		

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	<p>3. During an interview on 10/31/13 at 12:24 p.m., Resident #41 indicated he had pain in both knees and has had the pain for awhile.</p> <p>The clinical record for Resident #41 was reviewed on 11/5/13 at 1:00 p.m. The diagnoses for Resident #41 included, but were not limited to: chronic pain, arthritis, gout, and diabetes mellitus.</p>		<p>being monitored will be corrected immediately, with concerns added to the</p> <p>nursing department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	

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	<p>During a review of the clinical record, there was an order for acetaminophen 325 mg (milligram) 2 tablets by mouth 4 times daily for chronic pain and an order for diclofenac (pain medication) 75 mg, 1 tablet two times daily for chronic pain. Both orders were initiated on 11/30/12. Also, chronic pain was addressed during Medical Doctor/Nurse Practitioner (MD/NP) visits on 4/17/13 and 10/30/13. The Nursing Assessment/Full for readmission on 11/30/12 indicated Resident #41 had joint pain. A pain/potential for pain care plan was not located in the clinical record.</p> <p>During an interview with the MDS Coordinator, on 11/5/13 at 2:09 p.m., she indicated she was unable to locate a pain/potential for pain care plan in the clinical record, but she will continue to look for one.</p> <p>At 2:26 p.m. on 11/5/13, the MDS Coordinator indicated she thought there was a pain/potential for pain care plan that was developed because Resident #41 had complained of pain in the past, but she was unable to determine where the care plan for pain/potential for pain was.</p>			

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	<p>The MDS Coordinator indicated, on 11/5/13 at 3:05 p.m., care plans were usually developed within 1-2 weeks of a physician order/diagnosis, written by the MD.</p> <p>4. During an interview, on 10/31/13 at 12:53 p.m., Resident #21 indicated he had pain in his back.</p> <p>The clinical record for Resident #21 was reviewed on 11/5/13 at 1:30 p.m. The diagnosis for Resident #21 included, but was not limited to: osteoarthritis.</p> <p>During a review of the clinical record, the November Physician's Orders indicated an order for hydrocodone/acetaminophen (pain medication) 5/325 mg 1 tablet 4 times daily, initiated on 9/11/13, and lidoderm 5% (pain reliever), initiated on 11/20/12, to be applied topically to lower back daily. During MD/NP visits on 4/24/13 and 8/14/13, osteoarthritis and analgesic (pain medication) use was addressed as a concern. On the Weekly Nursing Summary for 10/23/13, 10/16/13, 10/2/13, and 9/25/13, the category "pain" was marked "yes" (no location noted). A pain/potential for pain care plan was not located in the clinical record.</p>			

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	<p>During an interview with LPN #1, on 11/5/13 at 1:50 p.m., she indicated she would mark that Resident #21 had pain on the Weekly Nursing Summary, because the Resident had indicated he would have pain in his knees, but the medication would help after awhile, when administered.</p> <p>On 11/5/13 at 1:55 p.m., the MDS Coordinator indicated she was unable to locate a pain/potential for pain care plan in the clinical record, but she will look further for the care plan.</p> <p>At 2:26 p.m., on 11/5/13, the Care Plan Coordinator indicated she thought there was a pain/potential for pain care plan initiated but she was unable to locate it.</p> <p>A care plan for potential for pain/discomfort, dated 11/5/13, was received from the Care Plan Coordinator, for Resident #41 and #21, on 11/5/13 at 3:00 p.m.</p> <p>3.1-35(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update a fall care plan after a resident experienced a fall for 1 of 33 residents reviewed for care plans. (Resident #67)</p> <p>Findings include:</p> <p>Resident #67's clinical record was reviewed on 11/5/2013 at 12:57 p.m. Diagnoses included but were not limited to; frequent falls, Alzheimer's dementia.</p> <p>A nurses note indicated, "10/27/13 at 5:15 p.m.: CNA called this nurse to</p>	F000280	F 280	12/06/2013			
		The corrective action for this finding will address resident #67. For resident #67, a Fall Scene Investigation					
		Report (FSI) had been completed, however the report was inadvertently placed					

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	<p>residents B/R (bathroom). Res (resident) on floor. VS (vital signs) stable. No injuries noted. Neuro (neurological) checks started WNL(within normal limits). Had incont (incontinence) of BM (bowel movement) will cont (continue) to monitor."</p> <p>Review of Resident #67's clinical record indicated his fall care plan was not updated; the most recent date of update was 9/6/2013.</p> <p>An interview with the Director of Nursing (D.O.N.), on 11/5/2013 at 1:30 p.m., indicated she isn't sure why they didn't update the care plan or write an IDT note except that maybe they haven't gotten to it yet. She said they try to have the IDT team meet within 24 hours after the fall occurred.</p> <p>An interview with the D.O.N., on 11/6/2013 at 11:27 a.m., indicated they missed reviewing this fall. The IDT team just met yesterday afternoon for review of this fall. She indicated, "We missed it because the paper was under another paper sitting on my desk."</p> <p>3.1-35(b)(2)</p>		<p>with Fall Scene Investigation Reports (FSI) that were previously reviewed by</p> <p>the fall committee. Once the oversight was discovered, the Director of Nursing</p> <p>Services reviewed the fall investigation for this resident with the fall</p> <p>committee and the care plan was updated to reflect fall reduction</p> <p>interventions. The C.N.A. assignment sheet was also updated to reflect the fall</p> <p>interventions.</p> <p>For all residents with the</p> <p>potential to be affected by this finding, the Director of Nursing Services now</p> <p>has a designated location for Fall Scene Investigation Reports (attachment J),</p> <p>that will be reviewed by the fall committee to be placed. Daily (M-F) the Fall</p>		

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			<p>Scene Investigation Reports will be reviewed by the fall committee for completeness, appropriate intervention(s), and care planning.</p> <p>Beginning 11/18/13, the unit nurses were in-serviced to implement fall interventions in the post fall unit investigation (attachment L, M). The C.N.A. assignment sheet will be updated to reflect fall intervention(s) implemented. The page 4 on the FSI includes a check if care plan was updated to include fall interventions. The fall committee will then review the fall investigation documentation for interventions, updated C.N.A. assignment sheet and care plan. The Fall Scene Investigation Report will be signed by unit staff post fall review and fall committee</p>	

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			<p>to confirm it had been reviewed and implemented.</p> <p>The Director of Nursing Services, designee, and IDT team will monitor and review all completed fall investigations, a review of the fall interventions, C.N.A. assignment sheet and IDT care plan updates. The fall log will be used to track individual resident fall patterns, frequency of falls, and effectiveness of fall interventions then reviewed for QAPI.</p> <p>Any concerns identified while being monitored will be corrected immediately, with concerns added to the</p>	

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			nursing department monthly QAPI review to amend the process as needed to resolve or correct findings.	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician's orders for daily weight were followed for 1 of 33 residents reviewed for following physician's orders. (Resident #104)</p> <p>Findings include:</p> <p>The clinical record for Resident #104 was reviewed on 10/31/13 at 11:30 a.m. She was admitted on 10/29/13.</p> <p>The diagnoses for Resident #104 included, but were not limited to: diabetes mellitus 2-poorly controlled, chronic stage 3 kidney disease and chronic non-healing lower extremity ulcers.</p> <p>The November, 2013 Physician's Orders for Resident #104 indicated, "10/30/13 WEIGH RESIDENT DAILY CALL IF MORE THAN A 2 LBS GAIN IN 1 DAY OR IF MORE THAN 5 LBS GAIN IN 1 WEEK."</p> <p>Review of Resident #104's weights on 11/8/13 at 12:30 p.m. indicated on</p>	F000282	<p>F 282</p> <p>The corrective action for this finding will address resident #104 and all residents who have the potential to be affected by this finding.</p> <p>Nursing administration compiled a list of those residents who have physician orders to be weighed daily, weekly, or other than the normal monthly weight cycle.</p>	12/06/2013

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	<p>10/30/13, she refused to get up and get weighed. The entry for 10/31/13 was blank. The entry for 11/1/13 indicated a weight of 148.8 lbs. There were no entries for dates beyond 11/1/13.</p> <p>During an interview with the DON (Director of Nursing) on 11/8/13 at 12:37 p.m., she indicated, "I wasn't aware she was a daily weight. They should be weighing her daily. It's not in the weight book. I don't see it anywhere else."</p> <p>3.1-35(g)(2)</p>		<p>The residents with daily or weekly weight orders have been added to the TAR for the specific resident. The unit nurse will initial TAR as confirmation resident weight was acquired and documented in weight binder per order. The C.N.A assignment sheet will be updated as needed for daily and weekly weights.</p> <p>Nursing administration or designee will review the TAR for the residents listed as a daily or weekly weight to confirm completion. The weight binder will be reviewed to verify completeness.</p> <p>The TAR and weight binder will be monitored for four weeks on</p>	

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			<p>the residents</p> <p>with daily and weekly weight orders, then bi-weekly, then 1 X monthly for 4</p> <p>months. If weight documentation remains current, scheduled monitoring will be</p> <p>dc'd then on going quarterly reviews will be initiated.</p> <p>Any concerns identified while</p> <p>being monitored will be corrected immediately, with concerns added to the</p> <p>nursing department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was properly flushed during administration in a gastrostomy tube. This affected 1 of 1 resident who had a gastrostomy tube in the facility. (Resident #99.)</p> <p>Findings include:</p> <p>An observation of LPN #6, on 11/7/2013 at 12:04 pm, indicated she did not flush Resident #99's gastrostomy tube (g-tube) before or after administering the resident's reglan and tylenol. Both medications were administered with approximately 120 ml of water each.</p>	F000322	F 322	12/06/2013

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	<p>Resident #99's clinical record was reviewed, on 11/7/2013 at 12:40 pm. Diagnoses included but were not limited to; Parkinson's, and history of traumatic brain injury.</p> <p>Review of the resident's MD orders, indicated, "Date 8/3/2013: Flush g-tube with 350 ml of water on day and evening shifts (twice daily). Date 10/2/2013: Tylenol 650 mg (20.3 ml) per G-tube. Date 8/2/2013: Reglan 10mg per G tube."</p> <p>An interview with the Director of Nursing (D.O.N.), on 11/7/2013 at 2:50 pm, indicated the nurse should have flushed the g-tube with water after medication administration "so the tube doesn't get sticky and the feeding doesn't get occluded."</p> <p>A policy, titled 'Tube feedings, Gastrostomy/Jejunostomy', provided by the D.O.N., on 11/8/2013 at 12:09 pm, indicated, "Bolus feeding Step Action. 15. All medications given per tube require a post flush. Some medications require pre and post medication administration."</p> <p>An interview with the Administrator, on 11/8/2013 at 11:45 am, indicated he reviewed with the nurse yesterday the correct process for administering</p>		<p>A physician order for resident #99 indicates G tube is to be flushed with 350ml of water on day and evening shift (twice daily). The medical record for November 2013 reflected this order was in compliance.</p> <p>The unit nurse identified in this finding as LPN #6, received education from the Administrator during the survey that a separate water flush should have occurred when medications are administered via G tube. The Director Nursing Services provided re-education to LPN #6 and all nurses to the Administering Medications via the Gastrostomy Tube (G Tube) skills check off (attachment A). PRN nurses who</p>	

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	<p>g-tube meds and flushes. She acknowledged she gave Resident #99 the two medications without flushing before or after the meds were given because she had diluted the medications with approximately 120 cc of water and felt this was enough to flush the medications. She indicated she did also administer the residents ordered flushes for the shift (at different times) and that she felt this was sufficient enough for flushing the g-tube.</p> <p>3.1-44(a)(2)</p>		<p>were not available</p> <p>when re-education was provided will receive the training on the G Tube skills</p> <p>check off prior to working a scheduled shift. (attachment B, M)</p> <p>Annually for established nurses and on hire, the Director of Nursing Services or designee will coordinate a skills check off that will include G Tube Medication Administration. Nursing administration will monitor compliance through G tube medication administration observation to ensure compliance with established facility process.</p> <p>As noted, there is only one resident (#99) with medications</p>	

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			<p>administered via G tube in the facility.</p> <p>Nursing administration or designee will observe each nurse that provides a G tube medication administration at least 1 X the week of 12/2/13-12/6/13. Any nurse that requires prompting will be observed the following week. The process will continue for six months to ensure all nurses continued to be observed requiring no additional prompting to administer the separate water flush as specified in the facility skills check off.</p> <p>Any concerns identified while being monitored will be corrected immediately, with concerns added to the nursing department monthly QAPI review to amend the process as needed to</p>	

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			resolve or correct findings.	

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure water temperatures were kept below 120 degrees Fahrenheit in order to prevent potential injury for 4 residents out of 42 residents residing on the '5 points' unit. The facility also failed to implement an intervention in response to a fall and thoroughly assess a fall for 2 of 2 residents reviewed out of 2 who met the criteria for accidents. (Resident #'s; 18, 67, 57, 21, 40, 76)</p> <p>Findings include:</p> <p>1. An observation on 10/31/2013 at 11:45 am, indicated the water temperature in the bathroom sink in Resident #57's room was 122 degrees Fahrenheit.</p> <p>An observation and interview with the Maintenance Director, on 10/31/2013 at 12:15 pm, indicated the water temperature in the bathroom sink in Resident #21 and Resident #40's room got up to 123 degrees</p>	F000323		12/06/2013			

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	<p>Fahrenheit for approximately 8 seconds. In Resident #76's room the water temperature in the bathroom sink reached 122 for approximately 10 seconds.</p> <p>An observation with the Maintenance Director, on 10/31/2013 at 12:30 pm, in the mechanical room, indicated the main water valve thermometer read 124 degrees Fahrenheit. The Maintenance Director then sent the Maintenance Technician to go turn on a few sinks, which he did and then the thermometer went down and hovered around 112 degrees and the Maintenance Director said "see, its set at 112 degrees." He confirmed the hot water sitting, not yet circulated, was running at about 124 degrees, but said he has the mixing valve set at 112. He indicated that if he were to turn the water down further, then "the residents will start complaining that the water temperature is too low." The Maintenance Director indicated he "put in a new mixing valve/temperate valve about 2-3 weeks ago."</p> <p>An interview with the Maintenance Technician, on 10/31/2013 at 12:40 pm, indicated, "The mixing valve was replaced about 3 weeks ago."</p> <p>An interview with the Maintenance</p>		F 323	

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	<p>Director, on 10/31/2013 at 12:45 pm, indicated he would turn down the main water valve and then recheck the temperature.</p> <p>Review of a policy, provided by the Administrator, on 10/31/2013 at 2:20 pm, indicated, "Purpose: It is the policy for Heritage House to maintain water temperature at the point of use in the range of 100 F (one hundred degrees Fahrenheit) and 120 F (one hundred twenty degrees Fahrenheit).</p> <p>An interview with the Administrator, on 10/31/2013 at 2:40 pm, indicated he believes "point of use" means at any time the water is used for patient care.</p> <p>2. Resident #18 's clinical record was reviewed on 11/5/2013 at 10:35 am. Diagnoses included but were not limited to; dementia, gait instability, depression, bipolar disorder, diabetes.</p> <p>A Nursing progress note indicated, "10/15/2013 at 12:30 am. Res (resident) found on L (left) side propped up on elbow. Res smiling...No s/s (signs or symptoms) pain/discomfort. No indication of hitting head. Res assisted up et (and</p>		<p>This corrective action for ensuring water temperatures</p>	

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	<p>then) to toilet...Neuro (neurological) checks initiated et WNL (within normal limits)."</p> <p>An IDT (interdisciplinary team) note, dated 10/15/2013, indicated, "IDT met today to discuss this residents fall that occurred on 10/15/2013 at 12:30 am in her room. (Resident #18's name) did have her gripper socks on, she had her brief changed at 11:00 pm, her bed was wet when she fell. (Resident's name) attempted to self transfer et (and then) fell. No injuries. Intervention is to check this resident hourly at night while in bed for incontinence."</p> <p>A "Resident care plan record" ADL flowsheet indicated for the month of October, the resident is incontinent of bladder on average 2-3 times per night shift.</p> <p>A care plan indicated, "Toilet before meals, and at hs (hour of sleep) check resident q (every) 2 hours at night." Another intervention indicated, "10/15/2013 check resident hourly for incontinence."</p> <p>An interview with CNA #2, on 11/6/2013 at 2:43 pm, indicated Resident #18's toileting schedule is every two hours. She works until 10</p>		<p>remain within the required temperature range will address residents identified</p> <p>in this finding as # 40, 57, 21, and</p>	

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	<p>pm, and the resident goes to bed between 7 and 8 pm. She's pretty sure she's just check and change every 2 hours throughout the entire night shift.</p> <p>An interview with CNA #3, on 11/6/2013 at 2:40 pm, indicated, the resident is frequently incontinent. She is a check and change. She is checked on every two hours, she's a deep sleeper. She will frequently wet the bed because she's a heavy wetter and the brief won't hold.</p> <p>A document titled 'ADL sheet' indicated, "Functional Maintenance Program. Toileting Program. Before and after meals before going to bed and PRN upon Rising! Resident: (Resident #18 's name). Month: November 2013."</p> <p>An interview with Minimum Data Set (MDS) Coordinator #7 and MDS Coordinator #8, on 11/7/2013 at 10:30 am, indicated when a fall occurs, the CNA's do a huddle on the unit right away to determine what happened and what kind of intervention would be best to start right away. Then the IDT team meets and once they decide on the new intervention, the MDS Coordinators actually update the care plan. The</p>		<p>76. The corrective action will also address other residents that have the potential</p> <p>to be affected. The temperatures noted in the</p>		

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	<p>D.O.N. is the one who brings the new intervention back to the CNA's.</p> <p>An interview with the D.O.N., on 11/7/2013 at 10:35 am, indicated she isn't sure why she didn't update the CNA assignment sheet. She should've done it with the latest intervention of hourly toileting at night.</p> <p>3. Resident #67's clinical record was reviewed on 11/5/2013 at 12:57 pm. Diagnoses included but were not limited to; frequent falls, alzheimer's dementia.</p> <p>A nurses note indicated, "10/27/13 at 5:15pm: CNA called this nurse to residents B/R (bathroom). Res (resident) on floor. VS (vital signs) stable. No injuries noted. Neuro (neurological) checks started WNL(within normal limits). Had incont (incontinence) of BM (bowel movement) will cont (continue) to monitor."</p> <p>Review of Resident #67 's clinical record indicated his fall care plan was not updated. The most recent date of update was 9/6/2013. No IDT (interdisciplinary team) note found in clinical record.</p>		<p>finding that were acquired during the water temperature testing, were peak</p> <p>temperatures for 10 seconds or less. After the temperature peaked it was noted</p>		

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	<p>An interview with the Director of Nursing (D.O.N.), on 11/5/2013 at 1:30 pm, indicated she isn't sure why they didn't update the care plan or write an IDT note, except that maybe they haven't gotten to it yet. She says they try to have the IDT team meet within 24 hours after the fall occurred.</p> <p>An interview with the D.O.N., on 11/6/2013 at 11:27 am, indicated they missed reviewing this fall, the IDT team just met yesterday afternoon. She indicated, "We missed it because the paper was under another paper sitting on my desk".</p> <p>An IDT note provided at time of interview indicated, "Date: 11/5/2013 at 3 pm. IDT met to discuss fall on 10/27/2013. (Resident's name) fell in his BR (bathroom) at 5 pm. He had feces on him- stated using the toilet et (and then) lost his balance. (Resident's name) had on gripper socks. Orthostatic BP-lying 118/64, sitting 118/66 standing 120/68. Blood sugar 106. (Resident's name) had previously been to church. (Resident's name) was placed with 2 hr. toileting schedule while awake. No injury was noted at the time of fall."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>to have declined and hold within the required temperature range. The maintenance department during</p> <p>the survey inspected the water mixing valve, and circulating pump to confirm</p> <p>they were working properly. The</p>	

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			<p>water temperature was set minimally above the</p> <p>required temperature range at source for the purpose that when it reached the</p> <p>point of use, the temperature would stabilize within the require range. The</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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			<p>maintenance department did decrease the source temperature setting to be within</p> <p>the required range which also lowered the holding temperature at the point of</p>	

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			<p>use, remaining within the required range.</p> <p>A qualified plumber was brought</p>	

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			<p>into facility on 11/1/13 during the survey to inspect the water heating system,</p> <p>mixing valve, and circulating pump. The inspection confirmed the maintenance</p>	

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			<p>department findings that the system was working properly. Water temperature</p> <p>retesting was completed at that time and found to peak and stabilize within the</p>	

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			<p>required range. This information and the service ticket (attachment E) for the</p> <p>plumber was provided to the ISDH surveyor during the survey. The maintenance department will</p>	

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			<p>continue to monitor and record water temperatures weekly as indicated by the</p> <p>facility Water Temperature policy and procedure (attachment F), a copy of the</p>	

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			<p>policy was provided to ISDH surveyor during survey. If a water temperature is</p> <p>found to peak or hold above the required temperate range, the maintenance</p>	

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			<p>department will adjust the setting to decrease the temperature. Retesting will</p> <p>be conducted to ensure proper the water temperature range. The care plan for resident #18 was updated to eliminate</p> <p>the contradicting intervention. Fall</p>	

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			<p>interventions were updated on the care</p> <p>plan and added to the C.N.A. assignment sheet. The resident functional</p> <p>maintenance program was updated to reflect the current interventions. For resident #67, a</p>	

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			<p>Fall Scene</p> <p>Investigation Report (FSI) had been completed, however the report was</p> <p>inadvertently placed with Fall Scene Investigation Reports that were previously</p>	

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			<p>reviewed by the fall committee. Once the oversight was discovered, the Director</p> <p>of Nursing Services reviewed the fall investigation for this resident with the</p>	

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			<p>fall committee and the care plan was updated to reflect the fall interventions.</p> <p>For all residents with the</p>	

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			<p>potential to be affected by this finding, the Director of Nursing Services now</p> <p>has a designated location for Fall Scene Investigation Reports (attachment J) that</p>	

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			<p>will be reviewed by the fall committee. Daily (M-F) the Fall Scene</p> <p>Investigation Reports received will be reviewed by the fall committee for</p>	

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			<p>completeness and appropriate intervention(s). Beginning 11/18/13, the unit</p> <p>nurses were in-serviced to implement fall interventions (attachment L, M) in</p>	

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			<p>the post fall unit investigation. The C.N.A.</p> <p>assignment sheet will be updated to reflect the fall intervention(s)</p>	

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			<p>implemented. Page 4 of the FSI includes a check if care plan was updated to</p> <p>include fall interventions. The fall committee will then review the fall</p> <p>investigation for interventions, updated C.N.A. assignment sheet and care plan.</p>		

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			<p>The Fall Scene Investigation Report will be signed by unit staff post fall</p> <p>review and fall committee to confirm it has been reviewed and implemented. The Director of Nursing Services,</p>	

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			<p>designee, and IDT team will monitor and review completed fall investigations, a</p> <p>review of the fall interventions, C.N.A. assignment sheet and IDT care plan</p>	

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			<p>investigations, a review of the fall interventions, C.N.A. assignment sheet and</p> <p>IDT care plan updates. The fall log will be used to track individual resident</p>	

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			<p>fall patterns, frequency of falls, and effectiveness of fall interventions then</p> <p>reviewed for QAPI. Any concerns identified while</p>	

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			<p>being monitored will be corrected immediately, with concerns added to the</p> <p>nursing department monthly QAPI review to amend the process as needed to</p>	

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			resolve or correct findings.	

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	<p>1. The clinical record for Resident #42 was reviewed on 11/7/13 at 11:00 a.m. She was admitted to the facility on 4/19/13 from the hospital on 5 mg of Zyprexa (antipsychotic medication) daily.</p> <p>The diagnoses for Resident #42 included, but were not limited to: dementia with delusions/psychosis.</p> <p>The 6/4/13 geropsychological services note indicated, "...full psych test results pending. Interim recommendations-note that this pt (patient) has improved significantly psychiatrically since her 5/8/13 (symbol for "increase") in Zyprexa. However, she is also very somnolent now in the p.m. (w/(symbol for "increased") need for assist) recently and thus: 1) if this pt is also somnolent in the a.m., it is rec'd (recommended) her M.D. consider decrease Zyprexa back to 5 mg q 5 p.m. or 2) if this pt is alert/active in the a.m.. it is recommended her MD consider keep Zyprexa @ the same dose (7.5 mg) but (symbol for "change") time to hs (night)."</p> <p>The 6/5/13 Physician's Telephone Orders indicated a decrease in Zyprexa to 5 mg at 5:00 p.m.</p>		<p>services to this resident and the IDT. This resident is also prone to UTI's and</p> <p>pneumonia and known to exhibit behaviors as a symptom of these conditions. In</p> <p>this finding, the resident initially referenced is #42 however the detail on</p> <p>the 2567 also references resident #94. The details listed are in fact for</p> <p>resident #42 and do not apply to #94. It is believed references to #94 on the</p> <p>2567 were done in error. Assessment dates and other specifics listed match the</p> <p>records for #42.</p> <p>The hospice provider has now discontinued all PO medications for resident #42 except for Ativan (scheduled</p> <p>and PRN), and Oxyfast (scheduled).</p>	

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	<p>The 6/9/13 Psychological Testing Report indicated the following:</p> <p>"Findings/Recommendations:</p> <ol style="list-style-type: none"> 1. This appears to be a cognitively impaired individual with findings consistent with the psychiatric diagnoses of Resolving Depressive Disorder NOS; and Advanced (Moderately Severe) Alzheimer's Dementia without behavioral disturbance. 2. I plan to discontinue (name of company) psychological services given her recent/significant clinical progress regarding depression. 3. Regarding behavioral strategies and psychotropic medications, no immediate changes are recommended." <p>The 6/12/13 Physician's Telephone Order indicated an increase in Zyprexa to 7.5 mg daily.</p> <p>The 6/18/13, 5:00 p.m. nurses progress note indicated, "Spoke (symbol for "with") S.S. (Social Services) Director about resident's (symbol for "change") in mental status/behavior. Res (resident) is</p> 		<p>Resident #69 has a family member who was responsible to provide all medications. When medication delivery from the responsible party was delayed, an increase in behavior was noted and the antipsychotic medication dosage order was increased. The facility has implemented a measure that when medications are not delivered timely by an outside party, the facility acquire the medications from the house pharmacy to ensure the on hand supply is maintained. With medications available without interruption, it is believed the behaviors will be managed and dosage increases will not be necessary.</p>	

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	<p>agitated and anxious. Not participating in activities or therapy as before. Can be hateful, tearful or quiet. (Name of psychologist) phoned (symbol for "with") his rec's: Increase Zyprexa to 10 mg PO (by mouth) QD (everyday) @ 5 p.m. If increase causes too much sleepiness then consider (symbol for "changing") to Risperdal - @ least 1 mg QD. Left note for nurse practitioner to approve."</p> <p>The 6/19/13 Physician's Telephone Order indicated an increase in Zyprexa to 10 mg daily.</p> <p>July, 2013 through November, 2013 Behavior Logs indicated Resident #94 had no behaviors in this time period.</p> <p>The July 1, 2013 through November 6, 2013 IDT (Interdisciplinary Team Notes) and Nurses Progress Notes indicated Resident #42 had 14 falls in this time frame.</p> <p>The 4/26/13 Admission MDS (minimum data set) assessment indicated Resident #42 was independent in bed mobility, transfers, and walking in room. It indicated she required supervision only for walk in corridor and locomotion on unit. It indicated she</p>		<p>For all residents with the potential to be affected by this finding. Facility nurses will be in-serviced (attachment S) on psychotropic medication use and the reduction of unnecessary medications.</p> <p>In-service will also review the established facility policy for Psychoactive Medications (attachment T)</p> <p>The NP protocol, will be to consult with the house pharmacist and or review pharmacy recommendations prior to writing an order to increase a psychotropic medication. A 1 X order for psychotropic medication use may be written when determined necessary for a specific behavioral need that was controlled with non-medication interventions.</p>	

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	<p>required supervision and set up only for eating. It indicated she required a limited assist of 1 person for dressing, toilet use, and personal hygiene. It indicated the mobility device use was a walker only.</p> <p>The 7/13/13 Significant Change MDS (minimum data set) assessment indicated Resident #42 required extensive assistance of 2 plus persons for toilet use, bed mobility, and transfers. It indicated she required extensive assistance of 1 person for locomotion on unit, dressing, and personal hygiene. It indicated the mobility devices used were a walker and a wheelchair.</p> <p>The 8/19/13 Significant Change MDS (minimum data set) assessment indicated Resident #42 required extensive assistance of 2 plus persons for bed mobility, toilet use, and transfers. It indicated the activities of walk in room and walk in corridor did not occur. It indicated she required total dependence of 1 person for locomotion on unit. It indicated she required extensive assistance of 1 person for dressing, eating and personal hygiene. It indicated the mobility device used was a wheelchair only.</p>		<p>The resident chart will be reviewed during the monthly behavior management IDT meeting that includes the facility Social Services, Pharmacist, Geri Psych Service, Nurse manager or nurse. Team will review documented behaviors, interventions, and recommendations for the lowest psychotropic medication dosage that is determined to be effective for the resident.</p> <p>When resident behaviors are observed, re-directive interventions will be attempted</p>	

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	An interview was conducted with the DON and SSD (Social Services Director) on 11/7/13 at 12:38 p.m. regarding Resident #42's history of falls, lack of documented behaviors, significant change in medical condition, continued 10 mg daily of Zyprexa use, and no longer being followed by psychological services. The DON indicated, "What most of her falls seem to stem from was her need to get cooler because she was too warm. Now she's on hospice and has declined to the point where she cannot disrobe. I don't know if her being warm was considered as a symptom of anything. If (name of psychologist) quits seeing somebody, we monitor to see if he needs to pick them back up. In hindsight, seeing all of this, (name of psychologist) should have been back on board. Maybe the SSD asked him and he said no. I don't know. After psyche services quits seeing someone, the NP (Nurse Practitioner) or the resident's primary care physician will continue to follow them. It is not our practice to have our residents continue to see psyche services after they have determined that the resident has plateaued and there's nothing more he can do for them. It's like therapy, if a resident plateaus, there's no more they can do for them. The way I understand why		prior to administration of a PRN psychotropic. Intervention options are listed and available in the behavior binder located on each unit. The behavior management IDT will monitor compliance monthly by reviewing the behavior sheets, and the resident chart for documented behaviors. Review will include the interventions attempted, and effectiveness. Review the psychotropic used, frequency, and dosage. Other causal affects will be considered that may have contributed to the noted behavior. Psychotropic medication reductions will be initiated when advised and recommended by the behavior management IDT.		

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	<p>(name of psychologist) stopped following her is there is nothing more he could do for her." The SSD indicated, "We have a meeting every month. If she has a significant change, we can call him. She had a significant change health wise, end stage Alzheimer's, not with her behaviors..." The DON then indicated, "My thoughts are have (name of psychologist) come in and reevaluate her for a possible GDR (gradual dose reduction). With the dose being up...I just want to make sure we're doing what's best for her."</p> <p>An interview was conducted with LPN #9 regarding Resident #42's current behavioral and medical condition. She indicated Resident #42 did not have the ability to hit, kick, scream, or have any type of physically aggressive behaviors. She indicated she'd heard her yell for her husband, but that was it. She indicated she'd been caring for her on the Alzheimer's unit since May, 2013. She indicated Resident #42 would try to get out of her Broda chair. She indicated Resident #42 could barely speak and she hadn't known her to have any delusions. She stated, "She's declined so much since admission."</p> <p>An interview was conducted with</p>		<p>Any concerns identified while being monitored will be addressed immediately, with concerns added to the nursing department monthly QAPI review to amend the process as needed to resolve or correct findings.</p>	

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	<p>Activity Assistant #10 on 11/8/13 at 1:00 p.m. regarding Resident #42's behaviors and condition during an activity in the dining room with Resident #42 present at the activity. Resident #42 was sitting in her Broda chair with her arms folded, feet and knees up, head down, very still, not participating in the activity. Activity Assistant #10 indicated, "She pretty much just sits there."</p> <p>The following observations were made of Resident #42:</p> <p>On 11/1/13 at 12:35 p.m., she was sitting in her Broda chair in the hallway in front of the nurses station next to her husband. She was not yelling, physically aggressive, and there was no indication she was having any delusions.</p> <p>On 11/4/13 at 12:25 p.m., she was being fed lunch by a staff member. She was not yelling, physically aggressive, and there was no indication she was having any delusions.</p> <p>On 11/5/13 at 12:45 p.m., she was shaking in her Broda chair in the hallway in front of the nurses station. She was not yelling, physically aggressive, and there was no</p>			

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	<p>indication she was having any delusions.</p> <p>During an interview with the SSD on 11/8/13 at 1:30 p.m., she indicated it was still the plan to have the psychologist come in to reevaluate her. She then picked up the telephone, called the psychologist, and confirmed he would come in the following Monday to reevaluate Resident #42.</p> <p>2. Resident #69's clinical record was reviewed on 11/6/2013 at 1:10 pm. Resident # 69 was admitted on 5/18/2012. Diagnoses included but were not limited to; dementia with psychotic behaviors.</p> <p>Review of Resident #69's MD orders, indicated, "4/2/2013: Risperdal 0.25mg BID (twice daily). 7/17/2013: Risperdal 0.5 mg 2 times a day. 9/4/2013: Increase Risperdal to 0.5 mg q (every) am and 1 mg q HS (hour of sleep)."</p> <p>An interview with the Director of Nursing, on 11/6/2013 at 2 pm, indicated the psychologist makes recommendations and then the Nurse Practitioner or Primary care MD is the one that actually writes the orders for psychiatric medications.</p>			

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	<p>An interview with the Social Services Director (SSD), on 11/7/2013 at 1:50 pm, indicated she keeps AIMS (Abnormal involuntary movement scale) records and pharmacist reviews together and brings them with her to each monthly behavior meeting. The nursing staff completes the AIMS assessment. She keeps all the AIMS assessments in a binder. The resident ' s POA (power of attorney) brings in his prescriptions, buys them from an outside facility pharmacy. Since she's been working here, she can remember one time he went without the Risperdal for at least 7 days. When asked why his Risperdal was increased in July and September, instead of decreased due to results of AIMS assessment, the SSD indicated it could be because when he runs out of his meds he starts to have more behaviors and then its been increased because of this. She copies the AIMS assessments and gives them to Pharmacy and verbally tells them when the AIMS shows potential symptoms. She isn't sure what happened with this resident or why he hasn' t had a complete neurological exam.</p> <p>An AIMS assessment, dated 7/8/2013, indicated "Lips and perioral</p>			

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	<p>area (e.g. puckering, pouting, smacking) 3 (moderate). Interpretation of the AIMS score: A score of 3 or 4 in only one of the 7 body areas, resident should be referred for a complete neurological exam. "</p> <p>An interview with the Pharmacist Consultant, on 11/7/2013 at 4 pm, indicated the resident has had aggressive behavior, often running his wheelchair into others, cursing, kicking, hitting, screaming, trying to hit staff. She knows he has run out of his psychiatric medication, at most for about a week or two weeks. The reduction in the Risperdal on 11/5/2013 is directly a result from the nursing notes, it wasn't from review of the AIMS assessments. He may benefit from a different class of drug. There were three notes of incidents of tongue thrusting mentioned in the nurses notes one in September and twice in October. They review the nursing notes every 30 days. He was originally started on it in February 2012. He is on it for combative behaviors, he has a potential to not only hurt himself but also others, a history of hitting and kicking the nursing staff. Sometimes the MDS nurse comes to the behavior meetings, and the SSD generally runs</p>			

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	<p>the show. We (the pharmacists) did not know about the tongue thrusting, no one brought it up at the meeting, they should have but the SSD might not specifically know what to look for in terms of side effects. Nursing should be aware and know about side effects and report these to us. Now our plan is to GDR (gradual dose reduction) him off of Risperdal and try a different med, since he is experiencing a negative side effect of tongue thrusting.</p> <p>A "Behavior Meeting Notes", dated August 14, 2013, indicated "Resident #69's POA isn't bringing medication in right on time so he will go weeks without medication."</p> <p>A Social Services Progress note, dated 7/25/2013, indicated "Called (POA's name) about Risperdal being out since the 16th of July..."</p> <p>A nurses note, dated 10/11/2013 at 9 pm, indicated, "Resident recently noted to have tongue sticking out of mouth majority of the tongue..."</p> <p>A nurses note, dated 10/14/2013 at 8 pm, indicated, "Cont (continues) to stick tongue out of mouth..."</p> <p>3.1-48(a)(1)</p>				

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	3.1-48(a)(3) 3.1-48(a)(5)			

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	<p>An interview with LPN #1, on 11/6/2013 at 1 pm, indicated, "he yells out, and that is his main behavior. He yells out when he's in his wheelchair, and maybe gets it stuck on something or runs into something. Once he starts yelling out he's difficult to stop. We can give him as needed medication if necessary. He has the yelling out behavior quite frequently, daily, I think he's worse at night. I think he has sundowners."</p> <p>An interview with CNA #2, on 11/6/2013 at 2:46 pm, indicated Resident #69 sometimes gets combative, physically, and "he will put up his fist. He'll swing and kick at you."</p> <p>An interview with CNA #3, on 11/6/2013 at 2:32 pm, indicated the resident has behaviors about every other day on night shift (evening shift.) She indicated, "He sundowns really bad, gets worse at night. His behaviors are yelling out and hitting, especially when trying to provide him care. Usually we tell the nurse so she can address it medicinally, he has an as needed medication order and usually the nurse gives that and it works."</p>		<p>responsible parties who have elected to not use the facility pharmacy source preferring to bring in the medication(s) themselves.</p> <p>The family member for resident #69 as noted in the medical record was contacted by the unit nurse(s) repeatedly to notify him that the medications needed to be replenished. The family member had not returned facility phone calls and did not give authorization to the facility that would allow Heritage House to pick up the medications from the source utilized by the resident family.</p>				

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	<p>An interview with the Social Services Director (SSD), on 11/7/2013 at 1:50 pm, indicated the resident's POA (power of attorney) brings in his prescriptions, buys them from an outside facility pharmacy. Since she's been here, she can remember one time he went without the Risperdal for at least 7 days. They call the POA to let him know when the orders have been sent to the outside facility pharmacy, then again when they are ready for pickup, and then right before he's going to run out of a medication.</p> <p>An interview with the Pharmacist Consultant, on 11/7/2013 at 4 pm, indicated the resident has had aggressive behavior, often running his wheelchair into others, cursing, kicking, hitting, screaming, trying to hit staff. She knows he has run out of his psychiatric medication, at most for about a week or two weeks. She has offered to the facility that he be switched to the pharmacy, but it is her understanding the POA has not been agreeable to that.</p> <p>A Social Services Progress note, dated 7/25/2013, indicated "Called (POA's name) about Risperdal being out since the 16th of July..."</p>		<p>On the final day of survey, the family member did arrive unannounced to deliver the medication(s) to the unit nurse for resident #69. The survey team was aware prior to exit that the medications were delivered by the resident family member.</p> <p>To ensure medications are available for resident #69 and any resident that has a family member or responsible party that provides their medications to the facility. A notice (attachment G) was sent on November 29, 2013 to explain that when medications are not provided in advance of the on hand supply running out, the unit nurse will order the medication from the pharmacy utilized by the facility to avoid any lapse of prescribed medications being</p>				

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	<p>A "Behavior Meeting Notes", dated August 14, 2013, indicated "Resident #69's POA isn't bringing medication in right on time so he will go weeks without medication."</p> <p>An interview with the Director of Nursing, on 11/8/2013 at 2 pm, indicated she is not sure why the medication administration records are not documented correctly, to show when exactly the resident did not receive his Risperdal. She indicated, "If a resident misses a dose of medication, the nurse should be circling it, not signing it as given."</p> <p>3.1-25(a)</p>		<p>administered.</p> <p>The notice will also explain the billing method when this action is necessary and that this measure can be avoided when there is no interruption in the medications being provided and available for administration. The notice does state that this process will be implemented immediately.</p> <p>The unit nurse will make family member/responsible party notification for medication fill in accordance with facility policy and procedure Medication Supplied by Family/Responsible Parties (attachment U), when on hand supply is 7 days. If resident</p>	

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			<p>parties have not responded to unit nurse contact or delivered medication within 72 hours, the unit nurse will notify Director of Nursing Services or Administration. When it is verified that the resident party was notified or attempted to be notified with no action by the responsible parties, approval will be given to order a 7 day supply of the medication(s) from the facility pharmacy of choice.</p> <p>Continuous and uninterrupted medication administration for residents who have medications provided by an outside party will be monitored and audited using the Medication Administration Record by the Director of Nursing Services or designee. The MAR will be</p>	

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			<p>reviewed daily (M-F) X 4 weeks to ensure medications for residents with the</p> <p>potential to be affected by the finding are available for administration. Then</p> <p>1X weekly for 4 weeks. Then monthly ongoing.</p> <p>Any concerns identified while</p> <p>being monitored will be corrected immediately, with concerns added to the</p> <p>nursing department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications stored in medication carts were properly labeled for 2</p>	F000431	F 431	12/06/2013			

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	<p>residents whose medications were stored in 2 of 3 medication carts on the '5 points' unit. Resident #12 and Resident #44.</p> <p>Findings include:</p> <p>An observation and interview with LPN #6, on 11/7/2013 at 10:00 am, indicated Resident #12 provided the following medications to the facility, brought in from over the counter, and stored on Hall 3's medication cart. Resident #12's over the counter medications included bottles labeled; lycopene 10mg, bromelain 1000 gdu, B complex plus vita C, Grape seed 100mg, Cranberry dietary supplement, CoQ10 200mg, Aloe Vera 25mg. The bottles were missing a label of the residents name and the MD's name. LPN #6 indicated, "We don't share bulk medications, each bottle of medicine is only for a specific resident." On medication cart 2, Resident #44's over the counter acidiphilious and cranberry fruit 4200mg were not labeled with the resident's name or the MD's name.</p> <p>An interview and observation with the Director of Nursing (D.O.N.), on 11/7/2013 at 10:15 am, indicated says each over the counter medication brought in by a resident or</p>		<p>This corrective action will address the finding noted for residents #12 and 44. It will also address those residents who may have the potential to be affected.</p> <p>The over the counter medications, vitamins, and or supplements noted by the surveyor for resident #12 and 44, that were not labeled on inspection, were labeled prior to the end of survey. The unlabeled items for resident #12 were being maintained in a drawer within the medication cart exclusively for resident #12, the items were not comingled. Nursing administration conducted an audit during the survey and any item</p>				

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	<p>family member must be labeled with the following identifiers; resident's name, room number, and their MD's name. The D.O.N. then labeled the ones with missing identifiers.</p> <p>3.1-25(l)(1) 3.1-25(l)(2)</p>		<p>(over the counter item, vitamin, supplement, etc.) found unlabeled was labeled appropriately at that time. Prior to survey completion all medication carts were compliant with item labeling.</p> <p>The Director of Nursing Services has in-serviced the facility nurses (attachment D) on the policy for Medication Labeling for Over the Counter Medications (attachment C) for ensuring the items as noted in this finding are labeled appropriately before being placed in medication cart. The in-service included the information to be included on the label applied, label material to be used, and where given label supplies. The nurse in-service was completed on 11/18/13, and any PRN nurse</p>	

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			<p>that was unable to</p> <p>attend the in-service will be in-serviced prior to their next scheduled shift.</p> <p>The Director of Nursing Services</p> <p>or designee will monitor compliance through medication cart inspections on all medication carts using the Medication Audit Sheet (attachment K).Audits will be completed weekly on all medication carts for four weeks. If 4 x weekly audits are found to be in compliance, the audits will be completed once per month on all carts for five months. If monthly audits are found to be in compliance random cart audits will be completed for on-going monitoring.</p>	

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			Any concerns identified while being monitored will be corrected immediately, with concerns added to the nursing department monthly QAPI review to amend the process as needed to resolve or correct findings.	

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to use proper</p>	F000441		12/06/2013			

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	<p>infection control procedures regarding a resident's catheter use. This affected 1 of 1 resident in a random observations. (Resident #103)</p> <p>Findings include:</p> <p>The clinical record for Resident #103 was reviewed on 10/31/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #103 included, but were not limited to: neurogenic bladder.</p> <p>An interview was conducted with Resident #103 on 10/31/13 at 12:19 p.m. while she was sitting in her wheelchair in her room. One foot of her catheter tubing was laying on the floor underneath her wheelchair. When mentioned to Resident #103, she stated, "Is it not supposed to be?" She further indicated 2 staff members helped her get dressed at 9:30 a.m. that morning and put her in her wheelchair.</p> <p>A second observation was made on 10/31/13 at 1:25 p.m. of CNA #5 putting Resident #103's catheter bag back inside of the dignity bag. A foot of catheter tubing remained laying on the floor. CNA #5 then exited the room. An interview was conducted</p>		<p>F 441</p> <p>This corrective action will address the finding noted for resident #103. When finding was identified to nursing department, corrective action was taken at that time. Resident #103 has discharged to home as planned following survey exit. The corrective actions will also address those residents who may have the potential to be affected.</p> <p>Nursing administration has in-serviced the nursing department (attachment I, M) to the policy and procedure for Care of Foley Catheter Tubing (attachment H). Instruction was</p>	

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	<p>with CNA #5 immediately upon her exit of Resident #103's room regarding Resident #103's catheter. She indicated, "I just helped her to the restroom, so I put her catheter bag back in the dignity bag."</p> <p>An interview was conducted with RN #6 on 10/31/13 at 1:42 p.m. regarding Resident #103's catheter tubing placement on the floor. She indicated, "The tubing shouldn't be long enough to do that." At this time, an observation of Resident #103's catheter tubing was made with RN #6. RN #6 adjusted the bag and tubing to no longer rest on the floor and stated, "That's better."</p> <p>An interview was conducted with the Director of Nursing on 11/7/13 at 11:59 a.m. She indicated, "There is a potential for infection control issues if the tubing is laying on the floor. It could pick up dirt and bacteria, and it could go up the tubing. We should be aware of the location of the tubing, not touching the floor, when we put them (residents) in their wheelchair. If we notice it, we should take care of it. I will educate nursing staff about catheter tubing not resting on floor."</p> <p>3.1-18(b)</p>		<p>given to place catheter tubing within catheter storage bag which will reduce</p> <p>slack in tube and prevent from coming in contact with floor. If catheter tube</p> <p>is observed coming into contact with the floor, the tubing will be cleaned as</p> <p>instructed in accordance with the Care of Foley Catheter Tubing policy.</p> <p>Catheter Care (Foley) care plans (attachment R) have been updated to include interventions if/when the catheter tubing comes into contact with floor.</p> <p>Nursing administration has instructed department managers who conduct routine and</p>		

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			<p>structured facility</p> <p>rounds to observe foley catheter and tubing storage, specifically monitoring 3</p> <p>X weekly for tubing coming into contact with floor. Unit nurse will also</p> <p>monitor daily those residents on their hall who have foley catheters placed and</p> <p>proper storage of the catheter bag and tubing. Monitoring will be ongoing.</p> <p>Any concerns identified while</p> <p>being monitored will be corrected immediately, with concerns added to the</p> <p>nursing department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	