STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2011
NAME OF PROVIDER OR SUPPLIER WATERS OF YORKTOWN, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN47396	

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 4, 5, 6, 7, & 11, 2011 Facility number : 000143 Provider number: 155238 AIM number: 100283890 Survey team: Delinda Easterly RN TC Ginger McNamee RN Karen Lewis RN Betty Retherford RN Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 11 Medicaid: 43 Other: 23 Total: 77 Stage 2 Sample: 34 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2	F0000		

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

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

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	Quality review completed 10/17/11 Cathy Emswiller RN			

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F0156 SS=B	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview the facility failed to ensure residents were provided detailed information as to why Medicare coverage was being terminated and were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 3 of 3 residents reviewed who had received notification of Medicare non-coverage in a Stage 2 sample of 34. (Resident #'s 96, 59, 23) Findings include: During an interview with the Administrator on 10/5/11 at 11:00 a.m., information was requested related to any information the facility provided to Resident #'s 96, 59 and 23 related to Medicare coverage being terminated. A 10/6/11, 2:00 p.m., review of the notification of termination of Medicare	F0156	It is the intent of The Waters of Yorktown to provide detailed information as to why Medicare Coverage is being terminated; and to inform residents of possible charges that could be incurred as a result of the lack of Medicare coverage benefits.1. Residents #96, 59 and 23 were given Medicare Denial letters prior to the inservice on 8/18/2011. Residents #96, 59, and 23 were issued Medicare cut letters that omitted the potential charges and the reason for termination of Medicare benefits written in layman's terms for the resident to understand.2. 100% audit of all residents currently receiving Medicare benefits to ensure correct letter is issued in a timely manner. 3a. Business Office Manager and the MDS coordinator were inserviced on 8/18/2011 on the use of the correct Medicare of Non-Coverage letter.3b. The Business Office Manager or designee will issue the correct	10/31/2011

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	letters sent to Resident #'s 96, 59 and 23 indicated the letters lacked the following information, a. Detailed information as to why Medicare coverage was being terminated. b. Any charges the residents could be assessed as a result of Medicare cancellation. c. Facility rates that could be charged to the resident for non-covered services. During an interview with the Administrator on 10/6/11 at 2:00 p.m., he indicated he had no information to provide related to the residents having received any of the above information. 3.1-4(f)(3)		Medicare letter of non-coverage of services within 48 hours prior to Medicare services being terminated.4a.The CEO will review and monitor each Medicare letter of non-coverage by initialing and dating letters given to each resident to verify that the correct Medicare non-Coverage letter has been issued. This will be an ongoing process.4b. CEO/designee will review all audits in monthly QA meeting and review quarterly in QA meeting with Medical Director.	

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F0159 SS=B	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;			

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	and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on interview, the facility failed to ensure residents had ready access to their personal account funds managed by the facility for 3 of 13 sampled residents interviewed for ready access of personal account funds in a Stage 2 sample of 34. (Residents #8, #45, and #51) Findings include: 1.) During a family interview on 10/4/11 at 11:55 a.m., the daughter of Resident #8 indicated resident personal funds were not accessible on the weekends. 2.) During an interview on 10/4/11 at 10:20 a.m., Resident #45 indicated personal funds were not accessible on the weekends. 3.) During an interview on 10/5/11 at 8:10 a.m., Resident #51 indicated personal funds were not accessible on the weekends. 4.) A sign posted outside of the business office listed the banking hours as Monday-Friday, 8 a.m. to 4	F0159	It is the intent of The Waters of Yorktown to have resident funds available on weekends. 1.Residents # 8, 45 and 51 as well as all residents in facility will be invited and encourage to attend an informational meeting on 10/26/11 at 3:00 pm to inform them of the new resident banking hours on weekends and re-inforce the banking hours throughout the work week.2. Resident funds will be available between the hours of 10:00am to 2:00pm on Saturday and Sunday.3. All residents could be affected.4. The manager on duty, between 10:00am and 2:00pm on Saturday and Sunday will have access to resident funds to ensure they have accessibility to their accounts. Monday thru Friday hours are from 8:00 am to 4:00 pm.5a. The Business Office Manager or designee will review and monitor the manager on duty report every working Monday to verify and validate any resident account transactions.5b. CEO/designee will review all audits in monthly QA meeting and review quarterly in QA meeting with Medical Director.	10/24/2011

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	p.m. 5.) During an interview with the Office Administrative Secretary, on 10/7/11 at 8:30 a.m., she indicated the office manager or herself would come in on the weekends if residents needed access to their funds. This information was not included in the sign noted above and the residents and family member interviewed were unaware of this information. 3.1-6(f)(1)			

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F0172 SS=B	The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident. The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. Based on interview and record review the facility failed to ensure residents	F0172	It is the intent of the Waters of Yorktown to ensure that residents are made aware of how to contact	10/24/2011

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	were made aware of how to contact the State Long Term Care Ombudsman for 3 of 3 residents interviewed related to information regarding the State Long Term Care Ombudsman in a Stage 2 sample of 34. (Resident #'s 22, 10 and 5) **Findings include:** **1.) During an interview with the Resident Council President on 10/7/11 at 1:25 p.m., she indicated she did not remember ever having heard the term Ombudsman. She further indicated she did not know how to make contact with the Ombudsman.** **2.) Resident #22 indicated during an interview on 10/7/11 at 1:40 p.m., she was not familiar with the term Ombudsman. She indicated she had never heard the term Ombudsman. Resident #22 further indicated she had no idea how to contact the State Long Term Care Ombudsman.** **3.) During an interview with Resident #5 on 10/4/11 at 2:15 p.m., she indicated she did know who the Ombudsman was. She indicated she had not heard the**		the State Long-Term Care Ombudsman.1. Residents #22, 10 and 5 were invited to the meeting as well as all residents in the facility, on 10/21/11 at 1:30 pm to deliver the information on how to identify and contact the local Ombudsman.2. Meeting held with residents and the State Long -Term Care Ombudsman on 10/21/11 at 1:30 pm. All residents were encouraged to attend the meeting.3. This could affect all residents.4a. Meeting held with residents and the State Long -Term Care Ombudsman on 10/21/11 at 1:30 pm. All residents were encouraged to attend the meeting.4b. Multiple signs are posted within the facility stating the name and phone number of the local State Long-Term Care Ombudsman. In addition, the normal posting of the State required contact information is prominently displayed at wheelchair height in the facility.4c. The director of Social Services will review how to contact the local Ombudsman with those residents who attend monthly resident council meetings and once quarterly for those residents who do not attend other meetings.5. CEO/designee will audit Resident Council minutes for compliance and review monthly in QA meeting and quarterly in QA with Medical Director.	

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	term Ombudsman before. Resident #5 further indicated she did not know how to contact the Ombudsman. **4.) Review of the resident council minutes from January 2011 - September 2011, lacked any information related to the residents having been informed of the availability of the State Long Term Care Ombudsman. The resident council minutes lacked any information which would indicate the residents were made aware of how to make contact with the Ombudsman.** 5.) During an interview with the Activity Director on 10/11/11 at 8:30 a.m., she indicated she had mentioned the term ombudsman in the resident council meeting on occasion. She indicated she had not mentioned the Ombudsman's name at any time during a resident council meeting. She further indicated she had not documented in the resident council minutes that she had made the resident's aware of the term ombudsman and or told them where the number to contact the Ombudsman was posted in the facility.			

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	3.1-8(b)(4)			
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review, observation, and interview, the facility failed to ensure a resident identified at risk for weight loss was monitored for food replacements and received additional protein and calories as recommended by the dietician for 1 of 2 residents reviewed for prevention of weight loss in a Stage 2 sample of 34. (Resident #110) Findings include: The clinical record for Resident #110 was reviewed on 10/7/11 at 10:15 a.m.	F0325	It is the intent of The Waters of Yorktown to ensure that all residents identified at risk for weight loss will be monitored for food replacements and snack consumption. It is also the intent of the facility that those residents who have dietary recommendation be served to the resident.1. In regards to resident #110; resident remains on weekly weights. The kitchen staff and dietary manager were notified of the need to send resident's double portion meat and her super cereal immediately to resident. Also, to make sure that all residents with dietary recommendations were sent out on trays accurately.2. 100% audit	11/10/2011

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	Diagnoses for Resident #110 included, but were not limited to, status post hip fracture (9/2011), iron deficiency anemia, and chronic obstructive pulmonary disease. A dietary assessment, dated 9/20/11, indicated Resident #110 was underweight and had recently had a surgery for a fractured hip. The assessment indicated the resident had increased nutritional needs both calorie and protein. The assessment indicated the resident was started on extra meat with meals and hi calorie cereal for breakfast. The resident was also to receive a fortified food as a bedtime snack. A nutritional re-evaluation, dated 10/6/11, indicated Resident #110 was 64 inches tall and was being weighed weekly. The weekly weights were as follows: 9/14/11 (admission weight)= 94 pounds 9/20/11=90 pounds 9/27/11=90.4 pounds 10/3/11=93.2 pounds A health care plan problem, dated 9/13/11, indicated Resident #110 was at risk for weight loss related to her		to determine all residents who are identified as at risk for weight loss and who have dietary recommendations to be monitored for intakes on consumption form.3. All nursing and dietary staff will be inserviced on 11-4-11 addressing the new form for recording intakes of dietary recommendations, food replacements and ordered snacks; monitoring of trays for compliance with dietary orders and the importance of providing appropriate supplements, replacements and snacks.4a. Dietary /Designee will review/audit all residents requiring dietary recommendations and ordered snacks in weekly PAR meeting.4b. Nurses, CNA or designee will record the amount the resident consumes, of dietary recommendations, food replacements and ordered snacks on the consumption form.4c. Dietary manager or designee will monitor the food line two out of three meals (not to be the same two meal) to assure that all dietary recommendations are being served accurately. The dietary manager will monitor the line daily during working hours for one month, then weekly as an on-going process to maintain compliance.4d.Director of Nursing or designee will monitor the documentation of dietary recommendations, food replacement and ordered snacks on the consumption form. The	

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	diagnosis of dementia and chronic obstructive pulmonary disease. Approaches for this problem included, but were not limited to, "monitor intake of each meal","extra meat three times daily", "high calorie cereal" at breakfast, and health shake at bedtime. During an observation on 10/11/11 at 8:20 a.m., Resident #110 was eating her breakfast in her room. She was alone. Resident #110 had a small serving of scrambled eggs, a small serving of ground sausage, toast, coffee, and cranberry juice. She did not have any type of cereal on her tray. During an observation and interview with LPN #1 on 10/11/11 at 8:25 a.m., she indicated Resident #110 had not received a double portion of sausage with her breakfast. During a review of the September and October 2011 meal consumption records for Resident #110 , the records indicated the resident ate less than 75% at least half of the time. A notation on the bottom of the form indicated if the resident consumed less than 75%, a substitution was to be offered. The records lacked any documentation of a substitution being		monitoring will occur daily during working hours one month, weekly times one month and monthly as an on-going process to maintain compliance.5, CEO/designee will review all audits as completed in monthly QA meeting and quarterly in the QA meeting with the Medical Director.	

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	offered when the resident consumed less than 75% of a meal. The Medication Administration Records and Treatment Administration Records for September and October 2011 lacked documentation of any food replacements. The records also lacked any documentation of the bedtime health shake having been given and/or consumed. During an interview with the Director of Nursing (DoN) on 10/11/11 at 10:30 a.m., additional information was requested related to Resident #110 not receiving the cereal and double portion of meat at breakfast and the lack of documentation of the bedtime health shake and meal replacements noted above. The DoN indicated the facility did not currently have any method in place to document meal replacements and/or substations for residents who ate less than 75% of the meal. She indicated LPN #1 had obtained an additional serving of ground sausage and the high calorie cereal for Resident #110 that a.m. after she became aware the resident had not received these items. During an interview on 10/11/11 at 1:40 p.m., the DoN indicated she was			

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	unable to provide any documentation of the bedtime health shake having been given as recommended by the dietary assessment. Review of the current, undated, facility policy, titled "Nourishments: Supplemental Feeding", provided by the DoN on 10/11/11 at 3:25 p.m., included, but was not limited to, the following: "Policy: Supplements/nourishments will be provided as a component of therapeutic nutritional care for those residents who required it; interventions for supplements will be increased in the Care Plan indicating amount and frequency of service. Nutritional supplements should achieve maximum nutrition in lowest volume possible. Purpose: To supplement nutritional intake. Procedure: 1. A Care Plan is written for the service of all supplements.... ...3. The Care Plan intervention indicates the amount (number of			

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	ounces) and frequency of service of the supplement.... ...4. The food Service Supervisor monitors the resident's acceptance and tolerance of the supplement, making adjustments as necessary according to tolerance...." 3.1-46(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a resident was free from duplicate medication therapy for 1 of 10 residents reviewed for unnecessary medications in a	F0329	It is the intent of the Waters of Yorktown that residents be free from unnecessary drugs. 1. Resident #85 has had her drug regimen reviewed by nursing and the unnecessary drug was	11/10/2011

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	Stage 2 Sample of 34. (Resident #85) Findings include: 1.) The clinical record for Resident #85 was reviewed on 10/6/11 at 9:27 a.m. Diagnoses for Resident #85 included, but were not limited to, hypertension, dementia, and osteoporosis. Readmission orders, dated 8/3/11, indicated Resident #85 was to receive one Centrum Silver (multi-vitamin) tablet daily. The September 2011 Medication administration record (MAR) indicated Resident #85 received both a Centrum Silver tablet and a Thera-M vitamin tablet every day in September. During an interview with the Director of Nursing (DoN) on 10/7/11 at 9:30 a.m., additional information was requested related to the resident receiving two different multi-vitamin tablets daily in the month of September. During an interview on 10/7/11 at 11:21 a.m., the DoN indicated the pharmacy neglected to discontinue		clarified with the physician and discontinued 10/24/11.2a.Director of Nursing or designee will audit rewrites for all resident for any unnecessary drugs. Director of Nursing or designee will be assigned to audit rewrites monthly against all orders to alleviate any unnecessary drugs.2b. Director of Nursing or designee will clarify any unnecessary drugs with physician.3. Mandatory inservice for nurses on 11-4-11 to educate on the importance of monitoring resident's drug regimens for unnecessary drugs.4a. Pharmacist will review residents monthly to ensure residents are not receiving unnecessary drug. 4b. Pharmacy will come to the facility to audit all medication administration records, all treatment administration records, and carts for any unnecessary drugs.4c.CEO/designee will monitor all audits as completed in monthly QA meeting and review quarterly in QA meeting with the Medical Director.	

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	and/or clarify the previous order for Thera-M upon resident's readmission on August 3, 2011 and both vitamin orders remained on the September MAR. She indicated the nursing staff had not clarified the order and had given the Thera-M vitamin in error during the month of September 2011. 3.1-48(a)(7)			
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure the pharmacist noted and reported irregularities in regards to the duplicate therapy for 1 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 34. (Resident #85) Findings include: 1.) The clinical record for Resident #85 was reviewed on 10/6/11 at 9:27	F0428	It is the intent of The Waters on Yorktown to have the pharmacist review the drug regimen of each resident monthly.1. Resident #85 has had her drug regimen reviewed by nursing and the unnecessary drug was clarified with the physician and discontinued 10/24/11.2. A pharmacist will be in the facility monthly and review each resident and the drug regimen. A monthly report will be provided to the facility which will verify the pharmacist's presence in the	10/19/2011

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	a.m. Diagnoses for Resident #85 included, but were not limited to, hypertension, dementia, and osteoporosis. Readmission orders, dated 8/3/11, indicated Resident #85 was to receive one Centrum Silver (multi-vitamin) tablet daily. The September 2011 Medication administration record (MAR) indicated Resident #85 received both a Centrum Silver tablet and a Thera-M vitamin tablet every day in September. During an interview with the Director of Nursing (DoN) on 10/7/11 at 9:30 a.m., additional information was requested related to the resident receiving two different multi-vitamin tablets daily in the month of September. During an interview on 10/7/11 at 11:21 a.m., the DoN indicated the pharmacy neglected to discontinue and/or clarify the previous order for Thera-M upon resident's readmission on August 3, 2011 and both vitamin orders remained on the September MAR. She indicated the nursing staff		facility and the verification of the review of each resident's drug regimen.3. Mandatory inservice for nurses on 11-4-11 to educate on the importance of monitoring resident's drug regimens for unnecessary drugs.4a. Director of Nursing or designee will monitor the presence of the pharmacist and the review of each residents drug regimen, by obtaining and reviewing the monthly pharmacist's report.4b. CEO/designee will monitor compliance with pharmacy reports monthly in QA meeting and quarterly with the Medical Director.	

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	had not clarified the order and had given the Thera-M vitamin in error during the month of September 2011. A pharmacist "Consultation Report" indicated the pharmacist reviewed Resident #85's clinical record on 9/21/11. The report lacked any information related to the duplicate therapy of the Centrum Silver and Thera-M orders 3.1-25(i)			

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications to be returned to the pharmacy were stored in a sanitary and safe manner for 1 of 1 medication room observed for storage of medications.	F0431	It is the intent of The Waters of Yorktown to ensure medications that are scheduled for return to the pharmacy or for destruction will be stored in a sanitary manner in the medication room.1. The facility on 10-5-11 removed all medications from the hand washing sink and completed the pharmacy disposition sheets.	11/04/2011

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	Findings include: During an observation with LPN #1 on 10/5/11 at 11:00 a.m., the large tub-like handwashing sink in the central medication room was completely full of various medications in bottles, punch cards, and bags of IV fluids. LPN #1 indicated the medications were to be returned to the pharmacy for credit. During an observation with LPN #2 on 10/5/11 at 11:20 a.m., the medications in the handwashing sink were reviewed. The sink contained a bag of IV fluids and multiple partial vials of insulin to be destroyed. The sink contained over 25 medication punch cards to be returned to the pharmacy. The names of the medications and the amounts to be returned for credit included, but were not limited to, the following: Amlodipine (an antihypertensive medication) 10 milligrams (mg) -13 tablets Aspirin 81 mg-13 tablets Hydralazine (an antihypertensive medication) - 50 mg - 45 tablets Lisinopril (an antihypertensive medication) - 10 mg -16 tablets Torsemide (a diuretic) 10 mg - 38 tablets		Medications were destroyed that required destruction and other remaining drugs returned to pharmacy.2.This could potentially affect all residents.3a. On 10-7-11 DON placed a sign on the hand washing sink stating no medications are to be placed in the sink for storage, but are to be placed in a designated area in the medication room.3b. On 11-4-11 mandatory inservice to educate the nurses on the proper and timely disposal of medications and/or return to pharmacy.3c.The DON or designee will monitor the medication room to ensure proper storage of medication, during working hours daily for one month then as an on-going process for proper disposal and/or return of all discontinued medications.4. CEO/designee will monitor all audits monthly as completed in QA meeting and quarterly with Medical Director.	

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	Warfarin (a blood thinner) 2.5 mg - 30 tablets Warfarin 1 mg - 28 tablets K-dur (a potassium supplement) 20 meq - 11 tablets Mirtazepine (a hypnotic medication) 15 mg - 19 tablets Ambien (a hypnotic medication) 5 mg - 22 tablets Sertraline (an antidepressant medication) 25 mg - 27 tablets During an interview with LPN #2 on 10/5/11 at 11:25 a.m., she indicated the medications stored in the sink were to be destroyed as indicated or sent back to the pharmacy for credit. When queried if the sink was ever used for handwashing, she indicated "It could be if it didn't have all that junk in it." 3.1-25(m)			
F0514 SS=D	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. 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.			

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	Based on record review and interview, the facility failed to ensure meal consumption records were complete and accurately documented for 2 of 2 residents reviewed for documentation of food replacement in a Stage 2 sample of 34. (Residents #110 and #66) Findings include: 1.) The clinical record for Resident #66 was reviewed on 10/7/11 at 8:35 a.m. Diagnoses included, but were not limited to, depression and unavoidable weight loss secondary to end-stage dementia. During a review of the August, September and October 2011 meal consumption records for Resident #66 , the records indicated the resident ate less than 75% at least half of the time. A notation on the bottom of the form indicated if the resident consumed less than 75%, a substitution was to be offered. The records lacked any documentation of a substitution being offered when the resident consumed less than 75% of a meal. 2.) The clinical record for Resident	F0514	It is the intent of The Waters of Yorktown to maintain an accurately documented medical record, in accordance with accepted professional standards and practices.1. In regards to resident # 66 and 110; on 10/7/11 the residents two food consumption logs were merged into one Food Acceptance Record for the remaining days of the month to ensure accuracy of the residents' intakes.2. The dietary manager will audit food acceptance records for each resident to ensure that residents have only one food acceptance record and that it is accurate.3. Mandatory staff inservice 11-4-11 to educate nursing staff on the importance of having only one food acceptance record for each resident. To insure documentation is accurate.4a. Dietary manager/Designee will monitor food acceptance records for accuracy during working hours daily for one month, weekly for one month and then monthly as an ongoing process.4. CEO/designee will review all audits monthly as completed in QA meeting and quarterly with the Medical Director.	11/04/2011

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	#110 was reviewed on 10/7/11 at 10:15 a.m. Diagnoses for Resident #110 included, but were not limited to, status post hip fracture (Sept. 2011), iron deficiency anemia, and chronic obstructive pulmonary disease. During a review of the September and October 2011 meal consumption records for Resident #110 , the records indicated the resident ate less than 75% at least half of the time. A notation on the bottom of the form indicated if the resident consumed less than 75%, a substitution was to be offered. The records lacked any documentation of a substitution being offered when the resident consumed less than 75% of a meal. The clinical record contained 2 different meal consumption records for Resident #110 for the time period of September 13 through September 30, 2011. The amount of food and fluids consumed on the two forms did not match on any of the recorded days. 3.) During an interview with the Director of Nursing (DoN) on 10/11/11 at 10:30 a.m., additional information was requested related to the lack of			

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	food replacement documentation for Resident #110 and #66 as noted above and the double consumption records for Resident #110 that did not match. The DoN indicated she would have to check on why Resident #110 had 2 meal consumption records for the September time period noted above. The DoN indicated the facility did not currently have any method in place to document meal replacements and/or substations for residents who ate less than 75% of the meal. During an interview on 10/11/11 at 1:30 p.m., the DoN indicated she did not know why two separate food consumption records had been completed for Resident #110 for 9/13/11 through 9/30/11 noted above and did not know why the information on the forms did not match. 3.1-50(a)(1) 3.1-50(a)(2)			