

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00143148.</p> <p>Complaint IN00143148 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: February 3, 4, 6, 7, 10, 11, 2014</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Survey Team: Ginger McNamee, RN,TC Karen Lewis, RN Toni Maley, BSW (2/3, 4, 6, 10, 11, 2014) Karen Koeberlein, RN, (2/3, 4, 6, 7, 10, 2014)</p> <p>Census bed type: SNF: 8 SNF/NF: 53 Residential: 23 Total: 84</p> <p>Census payor type: Medicare: 11</p>	F000000	<p>Submission of the plan of correction and credible allegation does not constitute an admission by the certified provider at Community Northview Care Center. The Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and services at this health facility. Community Northview Care Center as licensed and certified provider recognizes it obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. If you have any questions, please contact me. Thank you!</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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	<p>Medicaid: 38 Other: 35 Total: 84</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of laboratory results for 1 of 5 residents reviewed for unnecessary</p>	F000157	The correction action accomplished for those residents affected by the deficient practice are: Resident did not have a negative outcome. Physician orders have been reviewed and	03/13/2014	

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	<p>medications. (Resident #94)</p> <p>Findings include:</p> <p>The clinical record for Resident #94 was reviewed on 2/7/14 at 9:54 a.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and paranoia, depression, fracture of hip, and pain.</p> <p>Lab results completed on 12/9/13 and 1/8/14 were filed in the resident's clinical record. A nurses note, dated 12/9/13, indicated PT/INR (prothrombin time/International Normalized Ratio) results were called to the physician and "awaiting return call from MD for any orders." A nurses note, dated 12/12/13, (3 days) indicated the physician's office returned the call and gave new orders based on the lab result. A nurses note, dated 1/8/14, indicated PT/INR results were called to the physician and "Awaiting return phone call. 2nd Shift nurse notified." As of 2/11/14 at 1:16 p.m., no other documentation in nurses notes related to lab results.</p> <p>During an interview with the Director of Nursing on 2/10/14 at 1:33 p.m., additional information was requested</p>		<p>verified. Other residents having the potential for this practice will be identified and the corrective action taken: All residents with PT/INR orders have been reviewed and verified. No negative outcomes have been noted in the past 18 months.</p> <p>The systemic changes made to ensure that this deficient practice does not recur are: All new physician orders will be reviewed in the Daily Quality Assurance Meeting. Weekly printout of lab orders will be crossed checked with lab results. Nurses will be in-serviced on March 06, 2014 on following up with physician on all lab orders. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Weekly printout of lab orders will be reviewed with lab results as they are received and follow up will done Monday-Friday with the Director of Nursing/designee for 6 months. Weekend abnormal lab results will be called to the Nurse On Call. The Director of Nursing will report audits to the monthly Quality Assurance Committee for review for 6 months or as deemed necessary by the interdisciplinary team.</p>				

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	<p>related to the lack of physician notification of the PT/INR results for Resident #94.</p> <p>During an interview with the Director of Nursing on 2/11/14 at 1:21 p.m., she indicated the physician had not been notified timely of the PT/INR results on 12/9/13 or 1/8/14.</p> <p>Review of the current, undated facility policy, titled,"LABORATORY BLOOD DRAW PROCEDURE", provided by the Administrator on 2/11/14 at 12:44 p.m., included, but was not limited to, the following:</p> <p>"LABORATORY BLOOD DRAW PROCEDURE... ...4. WHEN LAB RESULT RECEIVED IT IS TO BE CALLED TO PHYSICIAN.... ...6. IF YOU DO NOT RECEIVE A CALL BACK BY END OF SHIFT YOU NEED TO RELAY IN REPORT FOR FOLLOW UP. PASS LAB RESULT FORM TO ONCOMING NURSE FOR FOLLOW UP...."</p> <p>3.1-5(a)(2)</p>				

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure meal service was provided in a manner to enhance or maintain resident dignity regarding lengthy meal waits and being served a meal that differed from what was ordered without offering an explanation or apology for 4 of 4 residents reviewed for dignity while dining (Resident #29, #9, #16 and #B).</p> <p>Findings include:</p> <p>1.) Resident #29's record was reviewed on 2/6/13 at 3:30 p.m. Resident #29's current diagnoses included, but were not limited to, dementia Alzheimer's type, macular degeneration, hearing loss and diabetes. Resident #29 had a current, 1/28/14, physician's order for a mechanical soft diet</p> <p>Resident #29 had a current, 1/10/14, annual Minimum Data Set (MDS) assessment which indicated the resident spoke clearly, usually</p>	F000241	<p>The correction action accomplished for those residents affected by the deficient practice are: Activity assessments completed on the affected residents. Care plans updated on the residents to reflect current activity level. The menu board will be kept current each meal for specialized diets for all residents. Activities planned based the residents' desires and functional status. Other residents having the potential for this practice will be identified and the corrective action taken: All residents have updated activity assessments to reflect current activity needs. Care plans updated on the residents to reflect current activity levels. The menu board will be kept current each meal for specialized diets for all residents. Activities planned based the residents' desires and functional status. The systemic changes made to ensure that this deficient practice does not recur are: The activity assessment form was revised. Activity staff was in-serviced on March 6, 2014 individual and group activities. Dietary manager in-serviced dietary staff March 5, 2014 on</p>	03/13/2014			

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	<p>understood others, was usually understood by others, was dependent on staff assistance for mobility (purposeful movement from one location to another) and could make independent choices but needed some assistance in new situations.</p> <p>During a 2/6/14 Cafe Dining Room noon meal observation, Resident #29 was escorted into the cafe dining area and placed at his dining room table as if awaiting a meal. Resident #29 sat facing the dining room table from 11:30 a.m. to 12:00 p.m. (30 minutes) awaiting lunch. During this wait, Resident #29 was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 lunch meal observation, Resident #29 was offered a bacon lettuce and tomato sandwich, potato chips and a pickle for lunch as a meal choice. He selected this option. When his meal was served, he was given a ham salad sandwich and cheese puffs.</p>		<p>keeping menu board current for each meal. Resident Council will approve activity calendar at monthly meetings. All staff in-serviced on March 6, 2014 on interaction with residents during meal service. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Activity Director will monitor activities before noon and evening meals Monday through Friday for 6 months. Dietary manager will monitor menu boards Monday through Friday for 6 months. The Activity Director and Dietary manager will report outcomes to the monthly Quality Assurance Committee for 6 months and/or the interdisciplinary team deems necessary. Meal Manager on Duty will monitor interaction with residents, appropriate serving utensils and dishes, and menu boards daily for 1 month and report outcomes to the monthly interdisciplinary Assurance Committee for review to determine continue audit needs.</p>				

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	<p>No explanation or apology was offered to the resident when he was served a meal other than the one he had chosen.</p> <p>2.) Resident #16's record was reviewed on 2/6/13 at 3:34 p.m. Resident #16's current diagnoses included, but were not limited to, Parkinson's disease, depression and hypertension. Resident #16 had a current, 1/29/14, physician's order for a pureed diet with honey thickened liquids.</p> <p>Resident #16 had a current, 10/25/13, annual Minimum Data Set (MDS) assessment which indicated the resident had mumbled speech, usually understood others, was usually understood by others, rarely made choices, and was dependent on staff assistance for mobility (purposeful movement).</p> <p>During a 2/3/14 Cafe Dining Room meal observation, Resident #16 was escorted into the cafe dining area and placed at her dining room table as if awaiting a meal. Resident #16 sat facing the dining room table from 11:50 a.m. to 12:12 p.m. (22 minutes) awaiting lunch. During this wait, Resident #16 was offered a 1 to 2 minute personal activity. There</p>			
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	<p>was no audio or visual stimulation or diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 Cafe Dining Room meal observation, Resident #16 was escorted into the cafe dining area and placed at her dining room table as if awaiting a meal. Resident #16 sat facing the dining room table from 11:35 a.m. to 12:00 p.m. (25 minutes) awaiting lunch. During this wait Resident #16 was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 lunch meal observation, Resident #16 was offered a bacon lettuce and tomato sandwich, potato chips and a pickle for lunch as a meal choice. She selected this meal. When her meal was served, she was given a pureed ham salad sandwich and mashed potatoes. No explanation or apology</p>			

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	<p>was offered to the resident when the was served a meal other than the one she had chosen.</p> <p>3.) Resident #9's record was reviewed on 2/6/13 at 3:32 p.m. Resident #9's current diagnoses included, but were not limited to, Alzheimer's disease, debility and urinary retention. Resident #9 had a current, 1/29/14, physician's order for a a mechanical soft diet with ground meat.</p> <p>Resident #9 had a current, 11/27/13, quarterly Minimum Data Set (MDS) assessment which indicated the resident spoke clearly, usually understood others, was usually understood by others, needed assistance when making decisions in new situations and required staff assistance for mobility.</p> <p>During a 2/3/14 Cafe Dining Room meal observation, Resident #9 was escorted into the cafe dining area and placed at her dining room table as if awaiting a meal. Resident #9 sat facing the dining room table from 11:50 a.m. to 12:12 p.m. (22 minutes) awaiting lunch. During this wait, Resident #9 was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or</p>			

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	<p>diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 Cafe Dining Room meal observation, Resident #9 was escorted into the cafe dining area and placed at her dining room table as if awaiting a meal. Resident #9 sat facing the dining room table from 11:30 a.m. to 12:00 p.m. (30 minutes) awaiting lunch. During this wait, Resident #9 was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 lunch meal observation, Resident #9 was offered a bacon lettuce and tomato sandwich, potato chips and a pickle for lunch as a meal choice. She selected this option. When her meal was served, she was given a ham salad sandwich and cheese puffs. Resident #9 said "What is this? This is not what I thought I was having."</p>			

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	<p>Resident #9 was told what meal was on her tray, but was not offered an explanation or an apology.</p> <p>4.) Resident #B's record was reviewed on 2/6/13 at 9:39 a.m. Resident #B's current diagnoses included, but were not limited to, Parkinson's disease, depression and hypertension. Resident #B had a current, 1/29/14, physician's order for a pureed diet with honey thickened liquids.</p> <p>Resident #B had a current, 11/22/13, significant change Minimum Data Set (MDS) assessment which indicated the resident mumbled when he spoke, usually understood others, was usually understood by others, rarely or never made independent decisions and required staff assistance for mobility.</p> <p>During a 2/3/14 Cafe Dining Room meal observation, Resident #B was escorted into the cafe dining area and placed at his dining room table as if awaiting a meal. Resident #B sat facing the dining room table from 11:50 a.m. to 12:12 p.m. (22 minutes) awaiting lunch. During this wait, Resident #B was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or</p>						

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	<p>diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/3/14 Cafe Dining Room meal observation, Resident #B was escorted into the cafe dining area and placed at his dining room table as if awaiting a meal. Resident #B sat facing the dining room table from 11:35 a.m. to 12:00 p.m. (25 minutes) awaiting lunch. During this wait, Resident #B was offered a 1 to 2 minute personal activity. There was no audio or visual stimulation or diversionary materials offered. The resident did not engage in conversation with other residents. Other than the personal activity, the staff did not engage the resident in conversation.</p> <p>During a 2/6/14 lunch meal observation, Resident #B was offered a bacon lettuce and tomato sandwich, potato chips and a pickle for lunch as a meal choice. He selected this item. When his meal was served, he was given a pureed ham salad sandwich and mashed potatoes. No explanation or apology was offered to the resident when he</p>			

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	<p>was served a meal other than the one her had chosen.</p> <p>5.) During a 2/10/14, 10:00 a.m., interview, the Director of Nursing indicated, residents should not sit at the dining room table without activities or stimulation when awaiting a meal. The lunch meal was served in the Cafe Dining Room around 12:00 p.m. to 12:15 p.m. She did not know why nursing staff were bringing the residents in the dining room so early if no activity was scheduled. She needed to review that issue "We need to work toward making The Cafe a more pleasurable dining experience."</p> <p>6.) A current, undated, facility policy titled "Resident Rights, which was provided by the Social Services Director on 2/10/14 at 2:30 p.m. indicated the following:</p> <p>"Dignity: A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."</p> <p>3.1-3(t)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive plan of care was developed in regards to the use of an indwelling catheter. This deficient practice impacted 1 of 3 residents reviewed for catheter use. (Residents # 76). Findings include: The clinical record for Resident # 76 was reviewed on 2/6/14 at 10:23 a.m. Diagnoses for Resident # 76 included, but were not limited to,</p>	F000279	The correction action accomplished for those residents affected by the deficient practice are: There is no negative outcome for the resident. The resident medical record has been reviewed and a care plan updated. Other residents having the potential for this practice will be identified and the corrective action taken: All residents with catheters have had care plans audited, reviewed and updated as indicated. The systemic changes made to ensure that this deficient practice does not recur are: Care plans will be developed upon	03/13/2014	

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	<p>urosepsis, acute renal failure, chronic urinary tract infections, hypertension, alcoholic neuropathy, diabetes mellitus, and depression. During an observation on 2/3/14 at 2:30 p.m., Resident # 76 was observed to have an indwelling catheter in place.</p> <p>The Minimum Data Set (MDS) assessment, indicated Resident # 76 had moderate cognitive impairment.</p> <p>Resident # 76's comprehensive careplan did not include the use of an indwelling catheter.</p> <p>During an interview on 2/6/14 at 1:30 p.m., the Assistant Director of Nursing (ADON) was asked for the comprehensive care plan for an indwelling catheter for Resident # 76. The ADON indicated the facility did not have a current comprehensive care plan for Resident # 76's indwelling catheter.</p> <p>3.1-35(a)</p>		<p>admission and reviewed quarterly, and annually and upon significant changes. The nursing staff will be in-serviced on March 6, 2014 on reporting residents changes to the Director of Nursing/designee for care plan updates. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Director of Nursing/designee will audit resident with catheter care plans weekly and/or until compliance for 3 months or as determine by the monthly interdisciplinary Quality Assurance Committee.</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident, with an indwelling catheter, had a current order in place for an indwelling catheter, for 1 of 3 residents who were reviewed for catheter use (Resident # 76).</p> <p>Findings include:</p> <p>The clinical record for Resident # 76 was reviewed on 2/6/14 at 10:23 a.m. Diagnoses for Resident # 76 included, but were not limited to, urosepsis, acute renal failure, chronic urinary tract infections, hypertension, alcoholic neuropathy, diabetes mellitus, and depression.</p> <p>During an observation on 2/3/14 at 2:30 p.m., Resident # 76 was observed to have an indwelling</p>	F000315	<p>The correction action accomplished for those residents affected by the deficient practice are: The resident did not have a negative outcome. The physician order was obtained on February 7, 2014 after the error was discovered. The resident had been receiving catheter care since admission. Other residents having the potential for this practice will be identified and the corrective action taken: All residents with catheters medical records have been audited. All other residents had orders in the clinical chart. The systemic changes made to ensure that this deficient practice does not recur are: The 24 hour Admission Checklist form has been revised to include catheter and/or physician orders. The checklist will be done for the first 3 shifts of admission. The Director of Nursing/designee will monitor the forms post admission and for information as needed. The</p>	03/13/2014			

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	<p>catheter in place.</p> <p>The Minimum Data Set (MDS) assessment, indicated Resident # 76 had moderate cognitive impairment.</p> <p>Resident # 76's current physician orders, did not include the use of an indwelling catheter.</p> <p>During an interview on 2/6/14 at 1:30 p.m., the Assistant Director of Nursing (ADON) was asked for a current physician's order for an indwelling catheter for Resident # 76. The ADON indicated the facility did not have a current order for Resident # 76's indwelling catheter.</p> <p>During an interview on 2/7/14 at 2:30 p.m., the ADON produced a physician's order for an indwelling catheter. The physicians order had just been obtained and was dated 2/7/14.</p> <p>3.1-41(a)(2)</p>		<p>staffing will be in-serviced March 6, 2014 on the tool and following up with next 2 following shifts. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Director of Nursing/designee will audit residents with catheters medical records for physician orders for 3 months for compliance and/or as determine by the monthly interdisciplinary Quality Assurance Committee.</p>		

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F000323 SS=D	<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, record review, and interview, the facility failed to ensure a resident identified at risk for falls had interventions in place and/or had care provided in accordance with his plan of care to prevent falls for 1 of 4 residents reviewed for accidents. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 2/6/14 at 9:39 a.m. Diagnoses for the resident included, but were not limited to, history of multiple falls, dementia, and hypertension.</p> <p>During an observation in the cafe dining room on 2/3/14 from 11:51 a.m. to 12:12 p.m., Resident #B spent periods of time from 1 to 4 minutes in the room without staff present or in view of staff.</p> <p>During an observation in the cafe dining room on 2/6/14 from 11:35</p>	F000323	<p>The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The resident's interventions were reviewed and care plans were updated. Current interventions include: audio alarms for the chair and bed, low bed kept that position, recliner in lounge to rest, offer food and fluids, encourage activities, and socializing with others. The correction action accomplished for those residents affected by the deficient practice are: All residents have the potential to be at fall risk. Care plans are reviewed and updated when an event occurs. Interventions are determined based on individual needs and discussed in weekly fall committee meeting for recommendations and care planned as indicated. The systemic changes made to ensure that this deficient practice does not recur are: Therapy services are attending the weekly fall committee meeting for recommendations. Fall Committee Meets weekly and follows each resident event for at least 4 weeks after an event. Fall</p>	03/13/2014

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	<p>a.m. to 12:00 p.m., Resident #B spent periods of time from 1 to 4 minutes in the room without staff present or in view of staff.</p> <p>A health care plan problem, dated 10/4/12 and revised on 1/16/14, indicated Resident #B was a high risk for falls. One of the interventions for this problem was to keep the resident in view of the staff at all times when awake.</p> <p>A nurses note, dated 1/11/14, indicated Resident #B was found laying on the floor in the cafe after his alarm sounded.</p> <p>An incident report, dated 1/11/14, indicated Resident #B was found on his back in the cafe, and the alarm was sounding. The report indicated no witnesses were present.</p> <p>During an interview with the Director of Nursing on 2/11/14 at 1:21 p.m., she indicated the resident should have been kept in view of the staff while he was in the cafe.</p> <p>Review of the current undated facility procedure, titled "Fall Reporting Procedure," provided by the Assistant Director of Nursing on 2/10/14 at 8:39 a.m., included, but</p>		<p>assessments are done whenever an event occurs. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Fall Committee will report to the monthly interdisciplinary Quality Assurance Committee trends/patterns of the weekly meetings for further review and follow-up on an ongoing basis.</p> <p>The Director of Nursing/designee is responsible to monitor resident care services and needs on an ongoing basis.</p>		

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F000325 SS=D	<p>was not limited to,</p> <p>"...5. Interventions are put into place...."</p> <p>This Federal tag relates to Complaint # IN00143148.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 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 observation, interview and record review, the facility failed to monitor a resident with a 5% weight loss in 30 days for 1 of 3 residents reviewed for nutrition. (Resident #9)</p> <p>Findings include:</p> <p>Resident #9 was observed at lunch on 2/6/14 at 12:04 p.m. She was feeding herself one half of a ham salad sandwich. Her hands were very shaky. She had difficulty</p>	F000325	The correction action accomplished for those residents affected by the deficient practice are: The resident was assessed by the Registered Dietitian for nutritional needs and significant weight changes. The care plan was revised and updated. The dietitian reviewed meal service in larger rim bowls for the ease using eating utensils. Other residents having the potential for this practice will be identified and the corrective action taken: The Registered Dietitian will review all resident nutritional for risk and	03/13/2014

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	<p>holding the sandwich and was loosing the sandwich spread from squeezing the sandwich. She had a white handled spoon bent at a 90 degree angle. She picked up the spoon and attempted to eat her frozen lemon lush. The resident could not maneuver the spoon to fit into the bowl. She put the spoon down after two attempts and did not try again. The resident was removed from the cafe dining room at 12:30 p.m. She had made no attempt to eat the pudding she was served.</p> <p>Resident #9 was observed on 2/7/14 at 12:25 p.m., being removed from the cafe dining room. The resident indicated she had completed her lunch meal. Her pudding had not been touched.</p> <p>Resident #9's clinical record was reviewed on 2/6/14 at 9:51 a.m. The resident's diagnoses included, but were not limited to, debility, Parkinson's disease, Alzheimer's dementia, large hiatal hernia, and osteoporosis.</p> <p>The resident had 1/2/14, signed physician's orders for a mechanical soft diet, thin liquids in sipper cups only, high calorie puddings with</p>		<p>their update care plans as indicated. The Registered Dietitian will review those residents at risk weekly until no longer having signs/symptoms of weight changes. The systemic changes made to ensure that this deficient practice does not recur are: Registered Dietitian is attending the weekly Nutritional At Risk Committee meetings. Registered Dietitian will use the Point Click Care program as reference for weight changes. The dietary staff will be in-serviced on March 5, 2014 on serving utensil and size of food containers. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Director of Nursing/designee will review the weekly weight report for any significant changes and notify the Registered Dietitian for recommendations. Dietary Manager will review trends/patterns to the monthly interdisciplinary Quality Assurance Committee on an ongoing basis for recommendations.</p>		

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	<p>meals, and a house supplement of 120 cc's 3 times a day. The resident was to have all food in bowls and to have regular utensils with red built-up foam for increased independence with self feeding.</p> <p>Review of the resident's weights indicated the following: 11/7/13 153.8 pounds. 12/4/13 153.6 pounds. 01/3/14 145.8 pounds . This resulted in a 7.8 pound or 5.1% weight loss over 30 days.</p> <p>A weight change note, dated 1/9/14 at 3:36 p.m., indicated "Resident with noted weight loss. Resident has had an increase in UTI [urinary tract infection] lately. Appetite is fair. Resident will often stop eating when her tremors are bad and she is unable to feed herself. Sometimes will let staff feed her. Has HCHP [high calorie high protein] pudding ordered and house supplement tid [3 times a day.] Medical doctor and family aware."</p> <p>The Director of Nursing was interviewed on 2/6/14 at 3:45 p.m. She indicated the resident would benefit from having her sandwich cut into quarters and should be evaluated for using larger bowls to</p>			

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	<p>accommodate the bent spoon.</p> <p>During an interview with the Care Plan Co-coordinator on 2/10/14 at 10:55 a.m., she indicated the resident's high calorie pudding was calculated as part of her meal consumption and was not monitored individually for effectiveness. She indicated the CNA's tell her when the resident does not eat her pudding. She indicated she did not know the resident had not eaten her pudding at lunch on the two occasions. She indicated the resident was not identified and placed on the NAR [Nutritionally at Risk] program due to her being off work on the day of the meeting.</p> <p>During an interview with the Registered Dietician on 2/10/14 at 1:20 p.m., she indicated "I don't remember if I have looked at her for weight loss."</p> <p>3.1-46(a)(1)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>A.) Based on observation, interview and record review, the facility failed to ensure a resident who received anti-psychotic medication, had identified target behaviors, a method to monitor target behaviors, had indication for the use of the medication and had a dose reduction or statement of contraindication for 1 of 4 residents reviewed for the use of anti-psychotic medication (Resident #57).</p>	F000329	<p>The correction action accomplished for those residents affected by the deficient practice are: (A, Resident #57) A Psychoactive Medication Rationale Tool is being used to monitor psychoactive medications for signs, symptoms, behaviors and interventions. The tool will be used for interdisciplinary team review at the behaviors meetings. Any trends/patterns/suggestions will be referred to the psychiatrist. (B) Resident # 94 medical record has been reviewed and Tylenol has been decreased to 500 mg</p>	03/13/2014

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	<p>B.) Based on record review and interview, the facility failed to ensure medication orders were complete and dosage information was clear to ensure residents did not have the potential to exceed recommended maximum daily doses (Resident #94 and Resident #78) and failed to ensure bowel monitoring was completed so interventions to relieve constipation could be given for 2 of 5 residents reviewed for unnecessary medications. (Resident #78)</p> <p>Findings included:</p> <p>A. Resident #57's record was reviewed on 2/6/14 at 9:30 a.m. Resident #57's current diagnoses included, but were not limited to, dementia with delusions and agitation, hypertension, and sleep apnea. Resident #57 had a current, 4/11/13, physician's order for Risperdal (an anti-psychotic medication) 1 mg - take 1 tablet daily at bedtime.</p> <p>Resident #57's clinical record lacked, an identified target behavior which was being treated by the use of an anti-psychotic medication, a method to monitor target behaviors, documented psychotic/delusional</p>		<p>twice a day. Resident #78 medications have reviewed and Tylenol has been discontinued and increasing the Norco three times a day to address pain. (C) Resident #78 bowel program has been reviewed and care plan updated. Other residents having the potential for this practice will be identified and the corrective action taken: (A) A Psychoactive Medication Rationale Tool is being used to monitor psychoactive medications for signs, symptoms, behaviors and interventions. The tool will be used for interdisciplinary team review at the behaviors meetings. Any trends/patterns/suggestions will be referred to the psychiatrist. (B) Pharmacy Consultant will audit all resident medication records for recommended maximum daily does. Recommendations will be given to each attending physicians for appropriate orders. (C) List of residents without bowel movements within 3 days are reviewed by Director of Nursing/designee for bowel activity and interventions as needed. Follow up will be continued as needed until elimination occurs. The systemic changes made to ensure that this deficient practice does not recur are: (A)The Psychoactive Medication Rationale Tool will used for anyone on psychoactive Medications. All residents on</p>				

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	<p>behaviors in the past 6 months, an attempted dose reduction or statement of contraindication which included a risk benefit analysis and a "Psychoactive Medication Rationale" form.</p> <p>Resident #57 had a 7/24/13, pharmacy recommendation which indicated, "[Resident's name] was started on Risperdal in the hospital, likely for hospital psychosis. She does have a diagnoses of Dementia for which she is receiving Aricept [a dementia medication]. Your progress note lists 0.5 mg QHS [at bedtime] as the dose but her current dose is for 1 mg QHS. Could we reduce to 0.5 mg QHS?" The form had a check mark in the box next to disagree but did not contain a statement of contraindication with a risk benefit analysis.</p> <p>During a 2/10/14, 10:00 a.m. interview, the Director of Nursing and Social Services Director indicated Resident #57 did not have an identified target behavior for the use of Risperdal, a method to monitor said behavior or a statement of contraindication regarding reduction.</p> <p>A current, October 2000, facility</p>		<p>psychoactive medications will be reviewed by the Behavior Monitoring Committee with recommendations to the psychiatrist. Staff will be in-serviced on documenting resident behaviors on March 6, 2014 (B) Director of Nursing/designee will monitor all pharmacy recommendations and responses from physicians. Nursing staff will be in-serviced on March 6, 2014 on maximum of dose of Tylenol and Ultram per pharmacy recommendation standards. (C) Nursing staff will be in-serviced on March 6, 2014 on documentation of recording of bowel movements and interventions. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: (A) Behaviors Monitoring Meetings will be conducted weekly for 4 weeks, then every 2 weeks for 3 months, then monthly and as needed. The Behavior Monitoring Committee will give the monthly interdisciplinary Quality Assurance Committee trends/patterns, interventions and attempts to reduce psychoactive medications. (B) Pharmacy Consultant report will be reviewed at each month interdisciplinary Quality Assurance Committee. The Director of Nursing/designee will audit all new admissions medical records within 72 hours of admission for 6 months. Trends and patterns will reported</p>				

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	<p>policy titled "Monitoring of Residents on Psychoactive Drugs", which was provided by the Social Services Director on 2/10/14 at 2:30 p.m., indicated the following:</p> <p>" Psychoactive Medication Rationale- PMR [Psychoactive Medication Rationale forms] will be completed on all residents on psychotropic drugs upon admission and with the start of a new psychoactive drug every 30 days times 3 then quarterly and prn [as needed]."</p> <p>During a 2/11/14, 2:25 p.m., interview, the Social Services Director indicated Resident #57 had not had any PMR forms completed and the facility had not been completing PMR forms on any resident and this was an error.</p> <p>B.1. The clinical record for Resident #94 was reviewed on 2/7/14 at 9:54 a.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and paranoia, depression, fracture of hip, and pain.</p> <p>Review of the November 2013 and December 2013 Medication Administration Records indicated Resident #94 had the potential to</p>		<p>to the Quality Assurance Committee for 6 months. (C) The bowel activity log will be monitored in the Monday-Friday Daily Quality Assurance Meeting. The Director of Nursing/designee will report trends/patterns to the monthly interdisciplinary Quality Assurance Committee for 6 months or as necessary as determined by the interdisciplinary team.</p>		

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	<p>exceed the daily recommended doses for the following:</p> <p>a. Tylenol (a pain medication) 325 milligrams (mg) take 2 tablets (650 mg) by mouth every 4 hours as needed for pain or fever. The original date of this order was 8/28/13.</p> <p>b. Tylenol (a pain medication) 500 mg take 2 tablets (1000 mg) by mouth every 6 hours. The original date of this order was 11/23/13.</p> <p>c. Ultram (a pain medication) 50 mg take 1 tablet by mouth every 6 hours as needed for moderate pain. The original date of this order was 11/23/13.</p> <p>d. Ultram (a pain medication) 50 mg take 2 tablets by mouth every 6 hours as needed for severe pain. The original date of this order was 11/23/13.</p> <p>The resident had the potential to receive 7,900 mg of Tylenol and 600 mg of Ultram. The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mg in 24 hours and the maximum daily dose of Ultram should not exceed 300 mg</p>						

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	<p>in 24 hours for patients older than age 75.</p> <p>During an interview with the Director of Nursing on 2/10/14 at 1:33 p.m., additional information was requested related to the Tylenol and Ultram orders.</p> <p>The facility failed to provide any additional information as of exit on 2/11/14.</p> <p>B 2.) The clinical record for Resident #78 was reviewed on 2/7/14 at 12:43 p.m. Diagnoses for the resident included, but were not limited to, pain, dementia, Alzheimer's disease, and depression.</p> <p>Current physician's orders for Resident #78 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a pain medication) 325 milligrams (mg) take 2 tablets (650 mg) by mouth daily at noon for pain. The original date of this order was 2/5/13.</p> <p>b. Tylenol (a pain medication) 325 mg take 2 tablets (650 mg) by mouth at bedtime. The original date of this order was 2/5/13.</p>			

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	<p>c. Norco (Hydrocodone and Tylenol combination pain medication) 5-325 mg take 1 tablet by mouth twice daily. The original date of this order was 10/17/13.</p> <p>d. Tylenol (a pain medication) 325 mg take 2 tablets (650 mg) by mouth every 4 hours as needed for mild pain or temperature. The original date of this order was 1/23/12.</p> <p>e. Norco (Hydrocodone and Tylenol combination pain medication) 5-325 mg take 1 tablet by mouth every 6 hours as needed for pain. The original date of this order was 10/17/13.</p> <p>The resident had the potential to receive 7,150 mg of Tylenol. The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mg in 24 hours.</p> <p>During an interview with the Director of Nursing on 2/10/14 at 1:33 p.m., additional information was requested related to the Tylenol orders.</p> <p>The facility failed to provide any additional information as of exit on 2/11/14.</p>			

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	<p>The clinical record for Resident #78 was reviewed on 2/7/14 at 12:43 p.m. Diagnoses for the resident included, but were not limited to, pain, dementia, Alzheimer's disease, and depression.</p> <p>A quarterly, Minimum Data Set (MDS) assessment, dated 12/13/13, indicated Resident #78 was moderately cognitively impaired.</p> <p>A health care plan, dated 12/6/11, indicated Resident #78 has constipation. One of the goals for this problem was the resident would have a bowel movement at least every 3 days. Interventions for this problem included follow facility bowel protocol and monitor/document/report signs and symptoms of complications related to constipation.</p> <p>Current physician's orders for Resident #78 included, but were not limited to, the following orders:</p> <p>a. Miralax (a laxative) 17 Grams (1 capful) in 8 ounces of water and take by mouth daily as needed for constipation. The original date of this order was 9/7/12.</p>			

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	<p>b. Milk of Magnesia (a laxative) 30 milliliters (ml) by mouth daily as needed for constipation. The original date of this order is 11/10/11.</p> <p>Review of the last 30 days of bowel monitoring completed in Point Click Care (computerized record) indicated Resident #78 did not have a bowel movement from January 29 to February 4. A time period of 7 days without a recorded bowel movement.</p> <p>The nursing notes lacked any information related to assessments completed or any interventions having been given or tried during this time period.</p> <p>Review of the January and February 2014 Medication Administration Records indicated no as needed medications for constipation were given after January 19, 2014.</p> <p>During an interview with the Assistant Director of Nursing on 2/10/14 at 2:24 p.m., additional information was requested related to the bowel monitoring for Resident #78.</p> <p>During an interview with LPN #4 on</p>						

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	<p>2/11/14 at 2:10 p.m., she indicated no as needed medications for constipation had been given to Resident #78 in February 2014.</p> <p>During an interview with the Assistant Director of Nursing on 2/11/14 at 2:19 p.m., she indicated she had no additional documentation to provide related to constipation interventions for Resident #78 for this time period.</p> <p>Review of the current, undated facility policy, titled "BOWEL PROGRAM," provided by the Assistant Director of Nursing on 2/10/14 at 8:39 a.m., included, but was not limited to, the following:</p> <p>"BOWEL PROGRAM... 2nd Shift- If no BM x's 3 days administer laxative with 1st med pass. 3rd Shift- If no BM on 2nd Shift please follow up for your shift. If MOM (Milk of Magnesia) was given on 2nd shift with no results 3rd shift to follow with suppository. If the resident does not have a suppository order please get one. Small BM's do not count. If resident has a small BM a follow up still needs to be done...."</p>			

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F000371 SS=F	<p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was prepared and served under sanitary conditions regarding preparation of pureed foods and food handling at the point of service. This deficient practice had the potential to impact 61 of 61 residents who ate meals prepared in the facility kitchen and served by facility staff.</p> <p>Findings include:</p> <p>1.) During a 2/11/14, 1:00 p.m., interview, the Food Services Supervisor indicated when the annual survey began on 2/3/14 the facility had 61 residents who were all receiving meals which were cooked in the facility kitchen and served by facility staff.</p> <p>During a 2/3/14, 12:13 p.m. to 12:35 p.m., meal observation, CNA #2</p>	F000371	The correction action accomplished for those residents affected by the deficient practice are: There were no known negative resident outcomes for this finding. All staff has been in-service on food handling and serving practices. Other residents having the potential for this practice will be identified and the corrective action taken: All residents have the potential to be affected by this finding. All staff has been in-serviced on food handling and serving practices. The systemic changes made to ensure that this deficient practice does not recur are: Dietary staff was in-serviced on March 5, 2014 on food handling practices. All staff serving food in-serviced on March 6, 2014. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Manager on Duty for meals services will monitor staff serving meal trays daily all 3 meals days 5 times a week for 4 weeks, then all 3 meals a day 2	03/13/2014			

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	<p>picked up resident #12's bread and held it flat on the palm of her bare hand. She then put meat on top of the bread folded into a sandwich and handed it to Resident #12 with her bare hand. Resident #12 ate the sandwich. Later in the same meal CNA #2 removed one of Resident #12's tablemate's bread and butter from his tray. She picked up the bread and butter with her bare hand. She made a sandwich with the bread and butter using Resident #12's meat. She then served the sandwich made with the tablemate's bread to Resident #12. Resident #12 ate the second sandwich.</p> <p>2.) During a 2/6/14, 11:00 a.m., observation of the pureed process, Cook #3 pureed ham salad. She used a spatula to scrape down the sides of the blender. After using the spatula she placed it on the counter top. She did not place the spatula on a clean surface such as a plate or wax paper. She later used the same spatula to stir the pureed ham salad and place it in a pan. During an 2/6/14, 11:10 a.m. interview, Cook #3 indicated she should have placed the spatula on a clean surface for re-use.</p> <p>A current, 8/25/02, facility policy</p>		<p>times a week, then all 3 meals 1 time a week for 4 weeks. Audits will be submitted to the administrator for review. Administrator will report outcomes to the monthly interdisciplinary Quality Assurance Committee for review until the interdisciplinary team recommends to discontinue the audits. Dietary Manager food preparation practices daily 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. Dietary Manager will report to the monthly interdisciplinary Quality Assurance Committee meeting for 6 months.</p>				

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	<p>titled "Food Preparation, Handling and Service", which was provided by the Food Services Supervisor on 2/10/14 at 9:45 a.m., indicated the following: "4.) Food will be prepared with the least possible manual contact. Disposable gloves will be used as needed. Convenient and suitable utensils, such as forks, spoons, knives, tongs and scoops will be used in handling food items. ...6.) Handwashing will be stressed not only before work and after visiting the restrooms, but also at other times when the hands become contaminated."</p> <p>3.) During a dietary observation on 2/3/14 at 12:19 p.m., Staff #1 was observed serving an unknown resident her meal, just after touching another unknown resident's hair. Staff #1 was then observed touching an unknown residents bread while buttering it, then observed touching the hands of two additional unknown residents. At 12:24 p.m., Staff #1 was again observed passing a salad and coffee to an unknown resident, then observed stroking the hair of an additional resident. At 12:27 p.m., just prior to opening an ice cup for an unknown resident, Staff # 1 was observed touching her own hair. At 12:30 p.m., Staff #1 placed her hand on an unknown residents shoulder,</p>			

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F000428 SS=D	<p>before pushing another unknown resident out of the dining area. Through out the meal service, Staff #1 was never observed to have washed, or apply anti- bacterial gel.</p> <p>4.) A current, 8/25/02, facility policy titled "Food Preparation, Handling and Service", which was provided by the Food Services Supervisor on 2/10/14 at 9:45 a.m., indicated the following: "4.) Food will be prepared with the least possible manual contact. Disposable gloves will be used as needed. Convenient and suitable utensils, such as forks, spoons, knives, tongs and scoops will be used in handling food items. ...6.) Handwashing will be stressed not only before work and after visiting the restrooms, but also at other times when the hands become contaminated."</p> <p>3.1-21(a)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and</p>	F000428	The correction action	03/13/2014
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	<p>interview, the facility failed to ensure the consultant pharmacist identified medication orders with the potential to exceed the daily maximum dose for 2 of 5 residents reviewed for unnecessary medications. (Resident #94 and #78)</p> <p>Findings included:</p> <p>1.) The clinical record for Resident #94 was reviewed on 2/7/14 at 9:54 a.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and paranoia, depression, fracture of hip, and pain.</p> <p>Review of the November 2013 and December 2013 Medication Administration Records indicated Resident #94 had the potential to exceed the daily recommended doses for the following:</p> <p>a. Tylenol (a pain medication) 325 milligrams (mg) take 2 tablets (650 mg) by mouth every 4 hours as needed for pain or fever. The original date of this order was 8/28/13.</p> <p>b. Tylenol (a pain medication) 500 mg take 2 tablets (1000 mg) by mouth every 6 hours. The original</p>		<p>accomplished for those residents affected by the deficient practice are: Resident # 94 medical record has been reviewed and Tylenol has been decreased to 500mg twice a day. Resident #78 medications have reviewed and Tylenol has been discontinued and increasing the Norco three times a day to address pain. Both residents' care plans have been updated. Other residents having the potential for this practice will be identified and the corrective action taken: Pharmacy Consultant will audit all resident medication records for recommended maximum daily dose. Recommendations will be given to each attending physicians for appropriate order on March 5, 2014. The systemic changes made to ensure that this deficient practice does not recur are: Director of Nursing/designee will monitor all pharmacy recommendations and responses from physicians. Nursing staff will be in-serviced on March 6, 2014 on maximum of dose of Tylenol and Ultram per pharmacy recommendation standards and physician follow-up. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Pharmacy Consultant report will be reviewed at each month interdisciplinary Quality Assurance Committee. The Director of Nursing/designee will audit all Pharmacy Consultant</p>		

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	<p>date of this order was 11/23/13.</p> <p>c. Ultram (a pain medication) 50 mg take 1 tablet by mouth every 6 hours as needed for moderate pain. The original date of this order was 11/23/13.</p> <p>d. Ultram (a pain medication) 50 mg take 2 tablets by mouth every 6 hours as needed for severe pain. The original date of this order was 11/23/13.</p> <p>The resident had the potential to receive 7,900 mg of Tylenol and 600 mg of Ultram. The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mg in 24 hours and the maximum daily dose of Ultram should not exceed 300 mg in 24 hours for patients older than age 75.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 11/26/13, 12/20/13, 1/7/14 and 2/5/14. No recommendations were made related to the potential for exceeding the maximum recommended dose of Tylenol or Ultram.</p> <p>During an interview with the Director</p>		<p>recommendations and physician follow-up for 6 months. Trends and patterns will be reported to the interdisciplinary Quality Assurance Committee for 6 months.</p>				

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	<p>of Nursing on 2/10/14 at 1:33 p.m., additional information was requested related to pharmacy recommendations for Resident #94's Tylenol and Ultram orders.</p> <p>The facility failed to provide any additional information as of exit on 2/11/14.</p> <p>2.) The clinical record for Resident #78 was reviewed on 2/7/14 at 12:43 p.m. Diagnoses for the resident included, but were not limited to, pain, dementia, Alzheimer's disease, and depression.</p> <p>Current physician's orders for Resident #78 included, but were not limited to, the following orders:</p> <p>a. Tylenol (a pain medication) 325 milligrams (mg) take 2 tablets (650 mg) by mouth daily at noon for pain. The original date of this order was 2/5/13.</p> <p>b. Tylenol (a pain medication) 325 mg take 2 tablets (650 mg) by mouth at bedtime. The original date of this order was 2/5/13.</p> <p>c. Norco (Hydrocodone and Tylenol combination pain medication) 5-325</p>			

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	<p>mg take 1 tablet by mouth twice daily. The original date of this order was 10/17/13.</p> <p>d. Tylenol (a pain medication) 325 mg take 2 tablets (650 mg) by mouth every 4 hours as needed for mild pain or temperature. The original date of this order was 1/23/12.</p> <p>e. Norco (Hydrocodone and Tylenol combination pain medication) 5-325 mg take 1 tablet by mouth every 6 hours as needed for pain. The original date of this order was 10/17/13.</p> <p>The resident had the potential to receive 7,150 mg of Tylenol. The 2010 Nursing Drug Handbook indicated the maximum daily dose of Tylenol should not exceed 4000 mg in 24 hours.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 12/20/13, 1/7/14 and 2/5/14. No recommendations were made related to the potential for exceeding the maximum recommended dose of Tylenol or Norco.</p> <p>During an interview with the Assistant Director of Nursing on</p>			

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F000514 SS=D	<p>2/10/14 at 2:24 p.m., additional information was requested related to pharmacy recommendations for Resident #78's Tylenol and Norco orders.</p> <p>The facility failed to provide any additional information as of exit on 2/11/14.</p> <p>3.1-25(i)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure a resident's clinical record was complete and accurate in regards to hospice services for 1 of 1 resident reviewed for hospice services. (Resident #31)</p> <p>Findings include:</p>	F000514	The correction action accomplished for those residents affected by the deficient practice are: The resident passed away on February 25, 2014 with hospice services and care. The resident did not have a negative outcome from this finding. The hospice providers kept a separate binder due to the length of time of certified services for this resident.	03/13/2014	

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	<p>The clinical record for Resident #31 was reviewed on 2/6/14 at 2:39 p.m. Diagnoses for Resident #31 included, but were not limited to, end stage congestive heart failure, chronic kidney disease, urinary retention, hypertension, and diabetes.</p> <p>The most current hospice documentation in the resident's clinical chart was dated 10/23/13.</p> <p>During an interview with LPN #5 on 2/6/14 at 2:13 p.m., he indicated the hospice documentation is kept in the resident's clinical record under a divider marked "Hospice".</p> <p>During an interview with the Director of Nursing on 2/6/14 at 2:35 p.m., hospice documentation for Resident #31 was requested. The Director of Nursing stopped LPN #5 in the hall way and asked him where the hospice documentation was kept for Resident #31. LPN #5 indicated in the clinical record under a "Hospice" marked tab. The clinical record was shown to LPN #5 with the most current hospice documentation dated 10/23/13. He indicated he would call and request the information to be faxed to the facility.</p>		<p>The binder was located after the survey. The facility staff did secure the documentation the same day noticed it was not available. Other residents having the potential for this practice will be identified and the corrective action taken: All residents with hospice services are put in separate binders and located on the bottom shelf below the medical records at the nurse's stations. The systemic changes made to ensure that this deficient practice does not recur are: All hospice providers will use separate binders for the each residents' medical documentation. All staff in-serviced on location of binders at nurse's stations on March 6, 2014. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Medical Records Director will monitor hospice records location weekly to the interdisciplinary Quality Assurance Committee for months or as determined no longer necessary.</p>				

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	<p>During an interview with the Director of Nursing on 2/11/14 at 1:21 p.m., she indicated the hospice documentation for Resident #31 had been kept in separate binder with just the resident's initials on the outside of record. She further indicated staff was not aware of the separate binder containing the hospice documentation.</p> <p>3.1-50(a)(1)</p>			

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review, and interview, the facility failed to successfully implement a plan of action to address fall prevention, bowel monitoring and physician notification of laboratory results. (Resident #B, #78, and #94)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 2/6/14 at 9:39</p>	F000520	F 520 The correction action accomplished for those residents affected by the deficient practice are: Resident B's fall care plan and interventions were reviewed and updated. Current interventions include: audio alarms for the chair and bed, low bed kept that position, recliner in lounge to rest, offer food and fluids, encourage activities, and socializing with others. Resident 94 did not have a negative outcome. The physician orders have been reviewed and verified.	03/13/2014	

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	<p>a.m. Diagnoses for the resident included, but were not limited to, history of multiple falls, dementia, and hypertension.</p> <p>During an observation in the cafe dining room on 2/3/14 from 11:51 a.m. to 12:12 p.m., Resident #B spent periods of time from 1 to 4 minutes in length in the room without staff present or in view of staff.</p> <p>During an observation in the cafe dining room on 2/6/14 from 11:35 a.m. to 12:00 p.m., Resident #B spent periods of time from 1 to 4 minutes in length in the room without staff present or in view of staff.</p> <p>A health care plan problem, dated 10/4/12 and revised on 1/16/14, indicated Resident #B was a high risk for falls. One of the interventions for this problem was to keep the resident in view of the staff at all times when awake.</p> <p>An incident report, dated 1/11/14, indicated Resident #B was found on his back in the cafe, and the alarm was sounding. The report indicated no witnesses were present.</p> <p>2.) The clinical record for Resident #78 was reviewed on 2/7/14 at</p>		<p>Resident 78's medications have reviewed and Tylenol has been discontinued and increasing the Norco three times a day to address pain. Other residents having the potential for this practice will be identified and the corrective action taken: All residents with PT/INR orders have been reviewed and verified. No negative outcomes have been noted in the past 18 months. List of residents without bowel movements within 3 days are reviewed by Director of Nursing/designee for bowel activity and interventions as needed. Follow up will be continued as needed until elimination occurs. All residents have the potential to be at fall risk. Care plans are reviewed and updated when an event occurs. Interventions are determined based on individual needs and discussed in weekly fall committee meeting for recommendations. The systemic changes made to ensure that this deficient practice does not recur are: Therapy services are attending the weekly fall committee meeting for recommendations. Fall Committee Meets weekly and follows each resident event for at least 4 weeks after an event. Fall assessments are done whenever an event occurs. All new physician orders will be reviewed in the Daily Quality Assurance Meeting. Weekly printout of lab</p>				

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	<p>12:43 p.m. Diagnoses for the resident included, but were not limited to, pain, dementia, Alzheimer's disease, and depression.</p> <p>A health care plan, dated 12/6/11, indicated Resident #78 has constipation. One of the goals for this problem was the resident would have a bowel movement at least every 3 days. Interventions for this problem included follow facility bowel protocol and monitor/document/report signs and symptoms of complications related to constipation.</p> <p>Current physician's orders for Resident #78 included, but were not limited to, the following orders:</p> <p>a. Miralax (a laxative) 17 Grams (1 capful) in 8 ounces of water and take by mouth daily as needed for constipation. The original date of this order was 9/7/12.</p> <p>b. Milk of Magnesia (a laxative) 30 milliliters (ml) by mouth daily as needed for constipation. The original date of this order is 11/10/11.</p> <p>Review of the last 30 days of bowel</p>		<p>orders will be crossed checked with lab results. Nurses will be in-serviced on March 6, 2014 on following up with physician on all lab orders. Nursing staff will be in-serviced on March 6, 2014 on documentation of recording of bowel movements and interventions. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: Weekly printout of lab orders will be reviewed with lab results as they are received and follow up will done Monday-Friday with the Director of Nursing/designee for 6 months. Weekend abnormal lab results will be called to the Nurse On Call. The Director of Nursing will report audits to the monthly interdisciplinary Quality Assurance Committee for review for 6 months or as deemed by the interdisciplinary team. The bowel activity log will be monitored in the Monday-Friday Daily Quality Assurance Meeting. The Director of Nursing/designee will report trends/patterns to the monthly interdisciplinary Quality Assurance Committee for 6 months or as determined by the interdisciplinary team. Fall Committee will report to the monthly Quality Assurance Committee trends/patterns of the weekly meetings for further review and follow-up on an ongoing basis. The Director of Nursing/designee is responsible to monitor resident care services</p>	

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	<p>monitoring completed in Point Click Care (computerized record) indicated Resident #78 did not have a bowel movement from January 29 to February 4. A time period of 7 days without a recorded bowel movement.</p> <p>The nursing notes lacked any information related to assessments completed or any interventions having been given or tried during this time period.</p> <p>During an interview with LPN #4 on 2/11/14 at 2:10 p.m., she indicated no as needed medications for constipation had been given to Resident #78 in February 2014.</p> <p>During an interview with the Assistant Director of Nursing on 2/11/14 at 2:19 p.m., she indicated she had no additional documentation to provide related to constipation interventions for Resident #78 for this time period.</p> <p>3.) The clinical record for Resident #94 was reviewed on 2/7/14 at 9:54 a.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and paranoia, depression, fracture of hip, and pain.</p>		and needs on an ongoing basis.				

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	<p>The lab results completed on 12/9/13 and 1/8/14 were filed in the resident's clinical record. A nurses note dated 12/9/13 indicated PT/INR (prothrombin time/International Normalized Ratio) results were called to the physician and "awaiting return call from MD for any orders." A nurses note dated 12/12/13 indicated the physician's office returned the call and gave new orders based on lab result. A nurses note dated 1/8/14 indicated PT/INR results were called the physician and "Awaiting return phone call. 2nd Shift nurse notified." As of 2/11/14 at 1:16 p.m., no other documentation in nurses notes related to lab results.</p> <p>During an interview with the Director of Nursing on 2/11/14 at 1:21 p.m., she indicated the physician had not been notified timely of the PT/INR results on 12/9/13 or 1/8/14.</p> <p>4. During an interview with the Administrator on 2/11/14 at 2:37 p.m., she indicated during the daily morning meetings concerns related to falls, bowel monitoring, and physician notification were reviewed. When questioned regarding the concerns identified during the survey</p>			
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R000036	<p>process, she indicated the staff were behind in completing the reviews due to the weather.</p> <p>3.1-52(b)(2)</p> <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure a resident's physician was notified regarding a change in condition which could result in the need to alter care and treatment for 1 of 4 residents reviewed for physician notification in a sample of 7 (Resident #1).</p> <p>Findings include:</p> <p>Resident #R1's residential record was reviewed on 2/11/14 at 9:45 a.m. Resident #R1's current diagnoses included, but were not limited to, Alzheimer's disease and Parkinson's disease. The record</p>	R000036	The correction action accomplished for those residents affected by the deficient practice are: The medical record was reviewed and the penis has healed. Other residents having the potential for this practice will be identified and the corrective action taken: All male residents' medical records were reviewed and no other perineal areas that required physician notification or family action. The systemic changes made to ensure that this deficient practice does not recur are: Staff was in-serviced on male peri-care, dealing with residents with potential behaviors during personal care, family and physician notifications, and 24 hour communication tool on February 28, 2014. The	03/13/2014
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	<p>indicated the resident was dependent on staff assistance for activities of daily living, hygiene and toileting and rarely expressed his needs.</p> <p>Resident #R1 had a 1/27/14, 8:30 p.m., Nurse's Note which indicated "CNA called this QMA to shower room to look at resident's penis. The head of the resident's penis is red and swollen and had a lg [large] welt on the bottom of the head. The foreskin will not re-cover the head of the penis due to swelling. Resident c/o [complained off] 0 [zero or no] pain but grimaced when trying to pull foreskin back over the head of penis."</p> <p>The clinical record lacked any documentation of the resident's physician's being notified of the welt on the end of the penis from 1/27/14 to 1/30/14. The record lacked any documentation of care and treatment to the welt or monitoring for change in condition from 1/27/14 to 1/30/14.</p> <p>Resident #R1 had a 1/30/14, Nurse Practioner Progress Note which indicated she had seen the resident on this date for a number of health issues, included in the concerns</p>		<p>corrective actions will be monitored to ensure the deficient practices do not recur per the following: The 24 hour communication form will be the Unit Manager for daily review and follow-up as indicated. The Unit Manager will review trends/patterns with the Director of Nursing weekly for 4 weeks. The Director of Nursing will report the monthly Quality Assurance for 3 months or as recommended by the interdisciplinary team.</p>		

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	<p>was "penis is also red and swollen." The note indicated "Red/Swollen Penis: Bacitracin BID xs 1 wk [topical antibiotic two times daily for 1 week]."</p> <p>During a 2/11/13, 11:00 a.m., interview, the Residential Dementia Unit Manager indicated Resident #R1 had had this condition in the past, about a year ago. His physician should have been notified when the blister was first noted on 1/27/14. The Unit Manager indicated the facility had no verification of the physician's or his representative being notified before 1/30/14.</p> <p>A current, January 2006, facility policy titled, "Change in Resident's Condition or Status", which was provided by the Residential Dementia Unit Manager on 2/11/14 at 11:20 a.m., indicated the following:</p> <p>"Our facility shall promptly notify the resident, his or her physician's, Health care representative, and/or family of changes in the resident's condition and/or status."</p>			

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R000091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement its policy requiring physician notification of change in condition and failed to develop a policy regarding following treatment orders which resulted in a delay of treatment for 1 of 3 residents reviewed for treatment following a signification change in condition (Resident #R1).</p> <p>Findings include: 1.) Resident #R1's residential record was reviewed on 2/11/14 at 9:45 a.m. Resident #R1's current diagnoses include, Alzheimer's disease and Parkinson's disease. The record indicated the resident was dependent on staff assistance for activities of daily living, hygiene and toileting and rarely expressed his needs.</p>	R000091	<p>The correction action accomplished for those residents affected by the deficient practice are: The medical record was reviewed and the penis has healed. Other residents having the potential for this practice will be identified and the corrective action taken: All male residents' medical records were reviewed and no other perineal areas that required physician notification or family action.</p> <p>The systemic changes made to ensure that this deficient practice does not recur are: Treatment Policy has been developed and approved by the interdisciplinary Quality Assurance Committee. The Unit Manager will review daily 24 hour communication and follow-up on new orders, family and physician notification. Nursing staff was in-serviced on documentation on February 28, 2014 The corrective actions will be monitored to ensure the deficient practices do not recur</p>	03/13/2014			

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	<p>Resident #R1 had a 1/27/14, 8:30 p.m., Nurse's Note which indicated "CNA called this QMA to shower room to look at resident's penis. The head of the resident's penis is red and swollen and had a lg [large] welt on the bottom of the head. The foreskin will not re-cover the head of the penis due to swelling. Resident c/o [complained off] 0 [zero or no] pain but grimaced when trying to pull foreskin back over the head of penis."</p> <p>The clinical record lacked any documentation of the resident's physician's or resident's responsible party being notified of the welt on the end of the penis from 1/27/14 to 1/30/14. The record lacked any documentation of care and treatment to the welt or monitoring for change in condition of the swollen penis from 1/27/14 to 1/30/14.</p> <p>Resident #R1 had a 1/30/14, Nurse Practitioner Progress Note which indicated she had seen the resident on this date for a number of health issues, included in the concerns was "penis is also red and swollen." The note indicated "Red/Swollen Penis: Bacitracin BID xs 1 wk [topical</p>		per the following: The Unit Manager will review trends/patterns with the Director of Nursing weekly for 4 weeks. The Director of Nursing will report the monthly Quality Assurance for 3 months or as recommended by the interdisciplinary team.				

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	<p>antibiotic two times daily for 1 week]." The record lacked documentation of Resident #R1 receiving the topical antibiotic treatment to his penis from the time it was ordered on 1/30/14 until 2/6/14.</p> <p>Resident #R1 had a 2/3/14, 2:00 p.m., Nursing Note which indicated "This nurse in rm [room] to pull his foreskin. Lg [large] blister area noted to the underneath of penis at end. Called [Nurse Practioner]. Attempt to apply ice pack to swollen area of penis xs 10 min [for 10 minutes] prn [as needed]."</p> <p>Resident #R1 had a 2/4/14, 10:35 a.m., Nursing Note which indicated the ice packs were not helping and the Nurse Practitioner wanted the resident to see an Urologist.</p> <p>Resident #R1 had a, 2/6/14, Urologist report which indicated the resident had received service that day to return the foreskin to it's proper position. The Urologist wrote orders to apply Bacitracin to the foreskin each day and do not retract foreskin for one week.</p> <p>Resident #R1's clinical record, medication and treatment records</p>			

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	<p>indicated the resident had Bacitracin applied for the first time on 2/6/14, even though it had been ordered by the Nurse Practitioner on 1/30/14.</p> <p>During a 2/11/14, 11:00 a.m., interview, the Residential Dementia Unit Manager indicated Resident #R1 had had this condition in the past, about 1 year prior. His physician and family should have been notified when the blister was first noted on 1/27/14. Bacitracin should have been applied beginning 1/30/14 when the Nurse Practitioner ordered it. The Unit Manager indicated the facility had no verification of the doctor and family being notified before 1/30/14 and the facility had no documentation of treatment beginning prior to 2/6/14.</p> <p>A current, January 2006, facility policy titled, "Change in Resident's Condition or Status", which was provided by the Residential Dementia Unit Manager on 2/11/14 at 11:20 a.m., indicated the following:</p> <p>"Our facility shall promptly notify the resident, his or her physician's, health care representative, and/or family of changes in the resident's condition and/or status."</p>			

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	During an interview with the Dementia Unit Manager on 2/11/14 at 11:20 a.m., the manager indicated the facility did not have a policy for following medication and treatment orders.			
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