

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/25/2015
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NAME OF PROVIDER OR SUPPLIER  COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00165298.</p> <p>Complaint IN00165298 Substantiated, Federal/State deficiency related to the allegations is cited at F441.</p> <p>Survey Dates: 2/17, 2/18, 2/19, 2/20, 2/23, 2/24, 2/25/2015</p> <p>Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870</p> <p>Survey Team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN Christine Fodrea, RN</p> <p>Census Bed Type: SNF/NF: 108 Total: 108</p> <p>Census Payor Type: Medicare: 16 Medicaid: 66</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 155 SS=D Bldg. 00	<p>Other: 26 Total: 108</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 4, 2015 by Randy Fry RN.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>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.</p> <p>Based on interview and record review the facility failed to follow their policy on Cardiopulmonary Resuscitation (CPR) and failed to immediately provide CPR to a resident with a full code status</p>	F 155	<p>1. Resident #73 no longer resides in the facility. Facility conducted immediate education on CPR/Code Blue/Rapid Response policy. 2. Staff to beeducated by Director of Staff Development on March 17, 2015. All residents have the potential to beaffected.</p>	03/27/2015			

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	<p>(Resident #73).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, hypertension, depression, anxiety state, and general pain.</p> <p>Resident #73 was admitted to the facility on 11/13/14.</p> <p>A facility Options for Healthcare for Resident #73, dated 11/13/14, indicated he wanted cardiopulmonary resuscitation if he was not breathing or his heart stopped.</p> <p>A physician's order for Resident #73, dated 11/14/14, indicated Full Cardiopulmonary Resuscitation (CPR).</p> <p>Resident #73 was hospitalized from 11/20/14 through 11/24/14 related to decreased level of consciousness.</p> <p>A facility Options for Healthcare for Resident #73, dated 11/24/14, indicated he wanted cardiopulmonary resuscitation if he was not breathing or his heart stopped.</p>		<p>Facility reviewed residents Code Status to ensure accuracy. 3. DON or designee to monitor and assess Code Blue to ensure facility compliance with CPR/Code Blue/Rapid Response policy. 4. Facility will implement mock Code Blue on all three shifts quarterly for at least six months and until compliant with facility policy. Results will be forwarded to the Admin/designee and be reviewed monthly in QA. 5. Facility will becompliant by March 27, 2015</p>		

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	<p>A Nurses Notes for Resident #73, dated 11/30/14 at 2:00 a.m., indicated he complained of pain and was medicated.</p> <p>A Nurses Notes for Resident #73, dated 11/30/14 at 4:16 a.m., indicated at approximately 3:10 a.m., a Certified Nursing Assistant (CNA) reported the resident was unresponsive. The note also indicated the nurse went to assess the resident and found no respirations or heart rate. At 3:16 a.m., the note indicated the nurse called a code blue and began CPR after confirming the code status. Staff members called 911. The note further indicated nurses continued the CPR with no heart rate noted. At approximately 3:19 a.m., a faint heart rate was noted and the nurse continued to assess. The note indicated the resident then had no heart rate or respirations and the nurses continued CPR until the Medics arrived. The resident still had no heart rate. The medics continued the CPR protocol for approximately 20 minutes. The time of death was called at approximately 3:51 a.m.</p> <p>A Prehospital Care Report Summary for Resident #73 from a local ambulance service, dated 11/30/14, indicated the call was received at 3:24 a.m., they were dispatched at 3:25 a.m., and arrived at the facility at 3:28 a.m. The report also</p>			

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	<p>indicated breath sounds were absent in his left and right lungs. The report further indicated "Staff stated that around 3 AM Pt (patient) was acting normal and was given oxycodone for pain. Staff left the room for a little bit and returned to find pt pulseless and apneic (not breathing). They attached the AED (automatic external defibrillator) w/no shock advised and began chest compressions and used BVM (bag valve mask) at 15 L (liter) to ventilate. Upon arrival staff was no longer doing chest compressions as they stated they got pulses back. Checked carotid and absent... Started CPR. Pt naked and had insulin pump between his legs still hooked up but not turned on. Staff stated he was a full code. Continued CPR and BVM at 15 L. Continued efforts for 20 min. (Hospital name) contacted and per medical control, permission was given to cease efforts." Resident #73 was pronounced dead at 3:39 a.m.</p> <p>A Nurses Note for Resident #73, dated 11/30/14 as a late entry for 3:20 a.m., indicated the writer responded to call of Code Blue over the PA system and immediately came to the Rehabilitation unit with AED to Room 505 to assist. The note also indicated the writer assisted with finding equipment and assessment as needed.</p>			

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	<p>A Nurses Notes for Resident #73, dated 12/2/14 at 3:45 p.m. as an addendum for 11/30/14, indicated the resident had IV (intravenous) ATB (antibiotic) hung at 11:08 p.m. The note also indicated at that time he was A&amp;O (alert and oriented) x (times) 3 with no s/s (signs/symptoms) of distress. The note further indicated the writer went back after IV administration to flush the PICC at approximately 11:50 p.m. At that time the resident was A &amp; O x 3 with no s/s of distress. The resident requested pain medication at approximately 1:50 a.m. The note indicated the writer followed up for effectiveness of the pain medication at 2:35 a.m. The resident was in bed with eyes closed, respirations appeared unlabored with a rate of 16 resp (respirations) per min ( minute). At approximately 3:10 a.m. the call light was activated. The CNA answered the light, looked around the curtain and noticed the resident had no respirations. The note also indicated at that time the CNA reported to the nurse. The note further indicated an assessment took place and it was determined the resident had no respirations or heart rate and CPR was given. The AED was applied and the AED stated "no shock advised." The note indicated shortly after the Paramedics arrived and began their code</p>			

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	<p>protocol.</p> <p>The Consulting DON #1 was interviewed on 2/23/15 at 10:05 p.m. During the interview she indicated facility staff knew which residents were full code by a green dot on the outside spine of their clinical records and by a green dot next to the resident's name by their room door.</p> <p>The Staff Developmental Coordinator was interviewed on 2/23/15 at 2:40 p.m. During the interview she indicated she would expect an immediate response from the nurse when notified by a CNA of a resident being unresponsive.</p> <p>A facility care plan for Resident #73, with a start date of 11/17/14, indicated the focus area of resident desires CPR be initiated in the event of cardiac arrest. Interventions to the focus included, but were not limited to, in the event of cardiac arrest, CPR will be initiated and continued until EMS arrival to take over compressions, and/or physician gives order to stop compression.</p> <p>A current facility policy "Cardiopulmonary Resuscitation (CPR), dated 2006 and provided by the Consulting DON #1 on 2/23/15 at 2:45 p.m., indicated "...To ventilate and establish circulation on a resident with</p>			

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F 156 SS=E Bldg. 00	<p>absence of respirations and pulse...Date and exact time condition change was observed...Vital signs or absence of vital signs...Exact time CPR was started...Exact time paramedics were notified...Exact time paramedics arrived...If there are signs of circulation, but no signs of breathing, continue to give rescue breaths until help arrives or until the resident starts breathing on his or her own...."</p> <p>3.1-38(f)</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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</p>			

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	<p>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.</p> <p>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.</p> <p>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;</p> <p>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.</p> <p>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</p>			

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	<p>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure the Notice of Medicare Non-Coverage was signed and provided to 4 of 4 residents reviewed for the completion of the Notice. (Resident #158, Resident #162, Resident #116 and Resident #186)</p> <p>Findings include:</p> <p>A review of the Notice of Medicare Non-Coverage for 3 Residents (#158, #162 and #116) which were provided by the Administrator on 2-19-2015 at 12:03 p.m., indicated the following:</p> <p>-The skilled therapy services for Resident #158 had an end date of 6-1-2014 written</p>	F 156	<p>1. Residents number #158, 162, 116 and 186 no longer reside in the facility. The facility will ensure that Notice of Medicare Non Coverage (NOMNC) will be signed by either the Resident or Responsible Party. 2. Social Services educated by Executive Director on February 25, 2015. All residents receiving skilled services have the potential to be affected. 3. Executive Director/Designee will randomly audit NOMNC three times/week for 1 month, weekly for one month and then monthly for 4 months to ensure facility is compliant. 4. Results will be forwarded to the QA committee monthly for 6 months by the Executive Director and reviewed with the Medical Director</p>	03/27/2015

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	<p>on the form. The signature line had "Resident verbalized understanding" with Social Service #14's signature below and dated "5-30-16" [sic].</p> <p>-The skilled therapy services for Resident #162 had an end date of 11-13-14 written on the form. The signature line had "Family notified via phone" with Social Service #14's signature below and dated "11-11-14.</p> <p>A review of the Social Progress Notes for Resident #162 dated 11-11-14 and provided by Receptionist #20 on 2-24-2015 at 8:33 a.m., did not indicate what family was notified, when the family was notified and that the Notice was mailed to the family.</p> <p>-The skilled therapy services for Resident #116 had an end date of 12-27-2014 written on the form. The signature line had "Res (Resident) verbalized understanding" with Social Service #14's signature below and dated "12-24-2014".</p> <p>An additional Notice of Medicare Non-Coverage for Resident #186 was provided by Social Services #5 on 2-23-2015 at 4:39 p.m. and indicated the following:</p> <p>-The skilled therapy services for Resident</p>		<p>quarterly. 5. Facility will becompliant by March 27, 2015</p>	

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	<p>#186 had an end date of 10-16-2014 written on the form. The signature line had "Residents [sic] family member verbalized understanding" with Social Service #14's signature below and dated 10-13-2014.</p> <p>A review of the Social Progress Notes for Resident #186 and provided by Receptionist #20 on 2-23-2015 at 4:43 p.m., did not indicate any discussion with a family member regarding the Notice of Medicare Non-Coverage and did not indicate a form had been mailed to the family member.</p> <p>An interview with Social Service #14 on 2-24-2015 at 9:06 a.m., indicated the following:</p> <ul style="list-style-type: none"> <li>-For residents receiving therapy/skilled services, the Notice of Medicare Non-Coverage was explained to the resident.</li> <li>- If the resident was able to sign, Social Service #14 indicated she would have the resident sign the form as long as the BIMS (Brief Interview for Mental Status, to determine cognitive status) was greater than 12 (a BIMS 13-15 would indicate a resident was cognitively intact).</li> <li>- If the family was present, Social Service #14 indicated she would have the family</li> </ul>			

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	<p>sign the form.</p> <p>- Social Services #14 indicated the Notice of Medicare Non-Coverage would be placed in the resident's chart.</p> <p>-Social Service #14 indicated if the resident was unable to understand the notice, the family would be called. The phone call would be made and the Notice of Medicare Non-Coverage would be explained. The family would be mailed a copy only if no one was able to be reached.</p> <p>-Social Service #14 indicated the information on contacting the family would be recorded on the back of the Notice of Medicare Non-Coverage.</p> <p>An interview with Social Service #14 on 2-24-2015 at 11:30 a.m., indicated the following:</p> <p>-For Resident #158 (deemed alert and oriented by the social worker with a BIMS of 15/15 on 5-14-2014), Social Service #14 indicated she did not have a form with her when she discussed the Notice of Medicare Non-Coverage and the Social Worker indicated she just placed "resident verbalized understanding" with the date of "5-30-2016" [sic] on the form at a later</p>			
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	<p>time.</p> <p>-For Resident #162 (BIMS 11/15 on 11-13-2014, with a score of 8-12 indicating a resident was moderately impaired cognitively), Social Service #14 indicated the resident's family member was present when the Notice of Medicare Non-Coverage was discussed and the family member was not the POA (Power of Attorney). Social Service #14 indicated she contacted another family member via phone and did not send the family member a completed Notice.</p> <p>- For Resident #116 (BIMS of 15/15 as of 14 day MDS-Minimum Data Set, dated 12-23-2014), Social Service #14 indicated she did not have a form at the time she talked to the resident about her skilled therapy ending. Social Service #14 indicated the resident went out to the hospital and she was unable to get a form signed. Social Service #14 indicated she just filled out the Notice of Medicare Non-Coverage and put "Res verbalized understanding" on the signature line and dated it "12-24-2014".</p> <p>For Resident #186 (BIMS of 15/15 on the admission MDS dated 9-12-2014), Social Service #14 indicated she placed a note on the back of the Notice of Medicare</p>			

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	<p>Non-Coverage that the Resident's "family member verbalized understanding" as the resident kept deferring to her family member. Social Service #14 indicated she didn't have a Notice with her at the time so she just filled it in later.</p> <p>-Further interview indicated Social Service #14 did not give any of the residents a copy of the Notice of Medicare Non-Coverage and indicated she was not aware she was required to have the resident or representative sign the form.</p> <p>A policy "Medicare Notice of Non-Coverage" revised on 8-1-2010 and provided by Social Service #14 at 10:16 a.m., indicated the purpose was "...to inform the Medicare beneficiary or representative of the...discontinuation of Part A/Part B Medicare benefits..." The policy did not indicate when to inform residents, how to inform residents or their representatives or the signature requirements.</p> <p>A review of the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 provided by Social Service #14 on 2-25-2015 at 8:30 a.m. indicated the following:</p> <p>"...When to Deliver the NOMNC...A</p>			

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	<p>Medicare provider...must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing...rehabilitation...at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily..."</p> <p>"...Provider Delivery of the NOMNC...The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed..."</p> <p>"...Notice Delivery to Representatives...CMS (Center for Medicare and Medicaid Services) requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person</p>			

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F 157 SS=D Bldg. 00	<p>acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.</p> <p>The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date..."</p> <p>3.1-4(f)(3)</p> <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</p>			

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	<p>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 interview and record review the facility failed to notify the physician of continuing elevated blood sugars for 1 resident (Resident #73) of 3 residents reviewed for diabetes mellitus.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus and chronic kidney disease.</p> <p>Resident #73 was admitted to the facility on 11/13/14.</p> <p>A physician's order for Resident #73, dated 11/13/14, indicated Humalog 100 unit/ml (milliliter) subcutaneous cartridge. The order also indicated the resident had an implanted insulin pump, with a rate currently at 0.8 units/hr (hour).</p> <p>A physician's order for Resident #73,</p>	F 157	<p>1. Resident #73 no longer resides in the facility. The facility will audit all IDDM residents to ensure adequate documentation of notification of Blood sugars outside of parameters. 2. All residents have the potential to be affected. Staff was in-serviced by the Director of Staff Development on hypo/hyperglycemia, insulin pumps and documentation on February 24, 2015. No other residents were found to be affected by the deficiency. 3. Daily review of blood sugar documentation by DON/designee to ensure MD notification for five times/week for 1 month, then three times/week for 1 month and then weekly for 3 months. 4. Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will be compliant by March 27, 2015</p>	03/27/2015

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	<p>dated 11/14/14, indicated fingerstick (blood sugar) QID (four times a day) every day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The order also indicated the following sliding scale: if blood sugar &lt;150 mg/dl (milligrams per deciliter) = no coverage; 150-200 mg/dl = 2 units; 201-250 mg/dl = 4 units; 251-300 mg/dl = 6 units; 301-350 mg/dl = 8 units; 351-400 mg/dl = 10 units; and if &lt;50 mg/dl or &gt;400 mg/dl call MD.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 15, 2014 through November 19, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/15/14, his 6:00 a.m. blood sugar reading was 170 mg/dl.</li> <li>- On 11/15/14, his 8:00 p.m. blood sugar reading was 150 mg/dl.</li> <li>- On 11/16/14, his 6:00 a.m. blood sugar reading was 329 mg/dl.</li> <li>- On 11/16/14, his 11:00 a.m. blood sugar reading was 180 mg/dl.</li> <li>- On 11/16/14, his 8:00 p.m. blood sugar reading was 215 mg/dl.</li> <li>- On 11/17/14, his 6:00 a.m. blood sugar reading was 164 mg/dl.</li> </ul>			

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	<p>- On 11/17/14, his 4:00 p.m. blood sugar reading was 409 mg/dl.</p> <p>- On 11/17/14, his 8:00 p.m. blood sugar reading was 238 mg/dl.</p> <p>- On 11/18/14, his 6:00 a.m. blood sugar reading was 235 mg/dl.</p> <p>- On 11/18/14, his 11:00 a.m. blood sugar reading was 454 mg/dl.</p> <p>- On 11/18/14, his 4:00 p.m. blood sugar reading was 600 mg/dl.</p> <p>- On 11/18/14, his 8:00 p.m. blood sugar reading was 400 mg/dl.</p> <p>- On 11/19/14, his 11:00 a.m. blood sugar reading was 345 mg/dl.</p> <p>- On 11/19/14, his 4:00 p.m. blood sugar reading was 400 mg/dl.</p> <p>Review of the Nurses Notes for Resident #73, dated 11/13/14 through 11/19/14, did not indicate his physician had been notified of any blood sugars &gt;400 mg/dl, or his continuing elevated blood sugars.</p> <p>On 11/20/14, he was admitted to the local hospital secondary to altered level of consciousness.</p>			

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	<p>The hospital History and Physical for Resident #73, dated 11/20/14, indicated he was a poorly-controlled Type 1 diabetic. The History and Physical also indicated his blood sugars were significantly elevated over the last couple of days.</p> <p>Resident #73 was re-admitted to the facility on 11/24/14.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 25, 2014 through November 29, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/25/14, his 6:00 a.m. blood sugar reading was 204 mg/dl.</li> <li>- On 11/25/14, his 4:00 p.m. blood sugar reading was 176 mg/dl.</li> <li>- On 11/25/14, his 8:00 p.m. blood sugar reading was 176 mg/dl.</li> <li>- On 11/26/14, his 6:00 a.m. blood sugar reading was 514 mg/dl.</li> <li>- On 11/26/14, his 11:00 a.m. blood sugar reading was 206 mg/dl.</li> <li>- On 11/26/14, his 4:00 p.m. blood sugar reading was 251 mg/dl.</li> </ul>			

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	<ul style="list-style-type: none"> <li>- On 11/26/14, his 8:00 p.m. blood sugar reading was 455 mg/dl.</li> <li>- On 11/27/14, his 11:00 a.m. blood sugar reading was 164 mg/dl.</li> <li>- On 11/27/14, his 4:00 p.m. blood sugar reading was 251 mg/dl.</li> <li>- On 11/27/14, his 8:00 p.m. blood sugar reading was 217 mg/dl.</li> <li>- On 11/28/14, his 6:00 a.m. blood sugar reading was 400 mg/dl.</li> <li>- On 11/28/14, his 4:00 p.m. blood sugar reading was 179 mg/dl.</li> <li>- On 11/28/14, his 8:00 p.m. blood sugar reading was 301 mg/dl.</li> <li>- On 11/29/14, his 6:00 a.m. blood sugar reading was 507 mg/dl.</li> <li>- On 11/29/14, his 11:00 a.m. blood sugar reading was 487 mg/dl.</li> <li>- On 11/29/14, his 4:00 p.m. blood sugar reading was 443 mg/dl.</li> <li>- On 11/29/14, his 8:00 p.m. blood sugar reading was 349 mg/dl.</li> </ul>			

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	<p>Review of the Nurses Notes for Resident #73, dated 11/24/14 through 11/29/14, did not indicate his physician had been notified of any blood sugars &gt;400 mg/dl, or his continuing elevated blood sugars.</p> <p>A facility care plan for Resident #73, dated 11/20/14, indicated the problem area of diabetes mellitus or hypo/hyperglycemia. Interventions to the problem included, but were not limited to, fingerstick blood monitoring and Hgb A1C (blood test for diabetes mellitus) as directed, notify physician if blood sugar is above or below the following range: 60-100 mg/dl, assess for signs/symptoms of hyper/hypoglycemia, and medications as ordered.</p> <p>LPN #6 was interviewed on 2/20/15 at 2:12 p.m. During the interview she indicated physician notifications for residents would be documented in the Nurses Notes.</p> <p>The Consulting DON #1 was interviewed on 2/23/15 at 9:50 a.m. During the interview she indicated correspondence between the facility and a physician concerning elevated blood sugars would be documented in the Nurses Notes or on the the SBAR (Situation Background Assessment Request/RP Notification/Response report.</p>			

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	<p>The Consulting DON #1 was interviewed on 2/24/15 at 8:44 p.m. During the interview she indicated she was not able to locate any documentation on physician notification of the elevated blood sugars of Resident #73. She also indicated nurses were to document blood sugars and insulin given on the MAR and document physician notification in the nurses notes.</p> <p>The Consulting DON #1 was interviewed on 2/24/15 at 3:20 p.m. During the interview she indicated she would expect nursing staff to contact the physician of a resident who showed a pattern for elevated blood sugars.</p> <p>A current facility policy "Blood Sugar Monitoring", dated 2006 and provided by the Consulting Nurse on 2/23/15 at 11:18 a.m., indicated "...To monitor blood glucose level...If blood glucose level is above or below normal range, document the time the physician was notified...."</p> <p>A current facility policy "Managing Change of Condition", updated 2011 and provided by the Consulting Nurse on 2/24/15 at 12:55 p.m., indicated "...To appropriately assess, document, and communicate changes of condition (COC) to the primary care provider...."</p>			

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F 174 SS=D Bldg. 00	<p>3.1-5(a)(2)</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on observation, interview and record review the facility failed to replace a mouse to a laptop computer for 1 resident (Resident #9) which was misplaced during a room change.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #9 on 2/20/15 at 9:34 a.m., indicated the following: diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, chronic pain, heart failure, and chronic kidney disease.</p> <p>Resident #9 was interviewed on 2/17/15 at 2:26 p.m. During the interview he indicated he was missing 4 slacks and 3 shirts. He also indicated he was missing the mouse to his laptop computer. He further indicated these items came up missing when his belongings were moved from room 214P to room 110B. Resident #9 also indicated he was not too</p>	F 174	<p>1. Resident #9 mouse was replaced immediately and the inventory sheet was completed. The facility audited resident charts to ensure inventory sheets were completed. 2. All residents have the potential to be affected. Staff were in-serviced by the Director of Staff Development on completing inventory sheets on March 17, 2015. No other residents were found to be affected by the deficiency. 3. Health Information Manager/Designee to audit new admission within 72 hours to ensure Inventory sheet is completed. Executive Director will also audit Angel Care rounds. Audits will be conducted three times/week for 1 month, one time/week for 1 month and then monthly for 3 months. 4. Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will becompliant by March 27, 2015</p>	03/27/2015

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	<p>concerned about the missing articles of clothing since he had more in his closet, but he would like to have the mouse to his laptop computer back. He further indicated he reported the missing items to the facility.</p> <p>A Minimum Data Set assessment for Resident #9, dated 1/12/15, indicated a score of 15 out of 15 on the Brief Interview for Mental Status, indicated he was cognitively intact.</p> <p>An Inventory of Personal Effects for Resident #9 could not be located in his clinical record.</p> <p>A piece of paper in the clinical record for Resident #9, dated 10/19/14 and signed by the Activity Director, indicated "(resident's name) mother brought in a laptop computer. Cannot locate inventory sheet to list it."</p> <p>LPN #4 was interviewed on 2/24/15 at 8:30 a.m. During the interview she indicated she could not locate an Inventory of Personal Effects for Resident #9. She also indicated staff who helped Resident #9 move into the facility would have been responsible to complete the Inventory of Personal Effects.</p>			

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F 223 SS=D Bldg. 00	<p>A current undated facility policy "Your Rights As A Nursing Home Resident", provided by the Staff Development Coordinator on 2/23/15 at 12:25 p.m., indicated "...Reasonable security of clothing and personal property. The nursing home must have a program to reduce theft and loss and maintain an inventory of your clothing and other personal property...."</p> <p>3.1-3(f)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review the facility failed to ensure a resident was not abused for 1 of 3 Residents reviewed for abuse. (Resident #71)</p> <p>Findings include:</p> <p>Review of the ISDH (Indiana State Department of Health) Incident Report Form, provided by the Administrator on 2/19/15 at 2:30 p.m., indicated the</p>	F 223	<p>1. Resident #71 still resides in the facility. The employee was terminated. 2. All residents have the potential to be affected. Staff was in-serviced by Executive Director immediately on abuse prevention, intervention and reporting policy on January 18, 2015. Additional education was provided by the Director of Staff Development to staff on February 3, 2015. The facility continues to do annual and as needed education with staff on abuse</p>	03/27/2015

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	<p>following:</p> <p>"...Initial Report Date: 1/18/15, incident occurred on 1/17/15 at 7:00 p.m.....involved: Resident #71...Diagnosis: Generalized Pain, Dementia with behavioral disturbances, Depression Disorder, Hypothyroidism, Hypertension....Staff involved: CNA #18...Description of Incident: During morning walk through, resident appeared to have discoloration of her upper extremities of unknown origin....Type if Injury:...Discoloration of upper extremities...Immediate Action Taken: Staff member who cared for resident on second shift was suspended pending investigation....Family and physician notified....care plan updated....Preventive measures taken: Social Services to follow up with resident. Also other residents will be interviewed to see if there are any concerns with care from CNAs from the night before. Other staff are being interviewed as well...."</p> <p>"...Follow up Report Date: 1/22/15....FOLLOW-UP: Pain assessment completed, resident had no complications of discomfort related to discoloration. Through the investigation, it was found that Resident #71, a severely demented resident, was able to recall three different occasions that a young</p>		<p>prevention. 3. SSD/designee to interview three residents/week for 1 month, interview three residents monthly for 5 months to ensure there are no concerns with any forms of abuse. Any concerns will be immediately brought to the Executive Director's attention and reported immediately. 4. Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will be compliant by March 27, 2015</p>				

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	<p>man got into an altercation. Witnesses substantiated accusation. Employee is terminated and this allegation of abuse is substantiated. Psych NP (Nurse Practitioner) evaluated resident on Monday, 1/19 and Social Services continue to follow up with resident as well. X-ray ordered and results are negative. Discoloration is improving and resident has no complaints of pain. Resident is no showing any signs and symptoms of distress...."</p> <p>Review of the clinical record for Resident #71's on 1/23/15 at 2:00 p.m. indicated the following diagnoses included, but were not limited to osteoporosis, dementia with behavioral disturbances, anxiety disorder, diabetes mellitus, hypothyroidism, anemia, hypertension, esophageal reflux and osteoarthritis.</p> <p>-Review of the MDS (Minimum Data Set) assessment dated 1/8/15 indicated a BIMS (Brief Interview for Mental Status) score was 2 which indicated severe cognition impairment.</p> <p>-Review of the Resident #71's nurse's notes on 2/20/15 at 2:10 p.m., indicated the following:</p> <p>-1/18/15, 9 p.m., "...resident was yelling out, she wanted to get up, resident got up</p>			

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	<p>for supper. No c/o (complaints of) pain or yelling, resident did mention before supper she wanted up because she feels lonely. No other issues during shift...."</p> <p>-1/19/15, 3:30 a.m., "...Res (Resident) resting quietly on bed with eyes closed this shift, No evidence of any psychosocial distress. Bruising remains to BUE (bilateral upper extremities)...."</p> <p>-1/19/15, 11:30 p.m., "Res. had no changes in behaviors or moods due to suspected abuse...."</p> <p>-1/20/15, 3:30 a.m., "...Res resting in bed at this time. No signs of moods or behaviors tonight...."</p> <p>-1/23/15, 9:10 p.m., "...Res. had no s/s (signs and symptoms) of changes in mood or behaviors this shift...."</p> <p>-1/24/15, 10:30 a.m., "...Res. Alert and oriented. No change in moods/behaviors this shift...."</p> <p>-1/25/15, 11 a.m., "...A&amp;O (alert and oriented) x 3, No negative behaviors or moods this shift...."</p> <p>-1/27/15, 2 a.m., "...Resting quietly with eyes clsd (closed), resp (respirations) are norm (normal). No behaviors or moods</p>			

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	<p>have been noted...."</p> <p>-1/27/15, 11 p.m., "...Res. alert and oriented x 3 (to person, place and time). Resident screamed and yelled at CNA's while changing her and getting res. up for dinner. While in bed res. pleasant...."</p> <p>-1/30/15, 11 p.m., "...Res. alert and oriented x 3. No moods or behaviors this shift...."</p> <p>-2/1/15 10 p.m., "...Res had no moods or behaviors this shift. Will cont (continue) to monitor...."</p> <p>-2/2/15, 11:00 p.m., "...Res was combative towards aide when getting up for supper. Once up res was fine, no moods or behaviors...."</p> <p>Review of Resident #71's Skin Condition Reports on 2/20/15 at 2:15 p.m., indicated the following:</p> <p>-1/20/15 at 2:30 p.m., indicated, "...weekly inspection...bruising noted to bilateral hands and forearms...."</p> <p>-1/27/15 at 3:00 p.m., indicated, "...weekly inspection...non-pressure, nothing recorded, clear inspection bony prominence's...."</p>			

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	<p>Review of Resident #71's Social Progress Notes on 2/24/15 at 4:48 p.m., indicated the following:</p> <p>- On 1/19/15, "...Writer follow up w (with)/resident regarding alleged abuse, for 1/17/15. Resident stated that she has not had any concerns since (1/17/15) incident. Resident stated that she was doing well today and that she was just resting. Resident was pleasant to writer during conversation and thanked writer for stopping by to see the resident. SS(social services) to f/u (follow up) w/resident and provide services as needed...."</p> <p>-On 1/20/15, "...F/U w/ res. regarding alleged abuse report. Res reported that she was doing well and that she had no concerns...."</p> <p>-On 1/21/15, "...Res stated that she has no concerns and no issues with her care...."</p> <p>Review of Resident #71's MARS (Medication Administration Record Sheet) on 2/25/15 at 9:50 a.m. indicated Resident received Tylenol Extra Strength 500 mg 3 times a day routinely. The MARS also indicated the highest level of pain recorded from 1/17/15 to 1/25/15 was zero. Lorazepam (for anxiety) 0.5 mg BID (2 times a day) as needed for anxiety was given as on 1/17/15 at 4:15</p>			

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	<p>p.m., 1/24/15 at 1:45 p.m., 1/25/15 at 8:56 a.m., and 1/28/15 at 2:42 p.m...."</p> <p>Review of the facility's investigation provided by the Administrator on 2/24/15 at 3:00 p.m., of alleged abuse indicated CNA's interviewed and indicated abuse was substantiated and CNA #18 was terminated. Summary of investigative finding indicated, "...Through investigation of other residents and assessing Resident #71, the facility substantiated abuse and will terminate the employee.</p> <p>Interview with the Administrator on 2/24/15 at 4:20 p.m., indicated the facility staff was in-serviced regarding types of abuse, ensuring safety of residents, reporting abuse immediately to nurse/supervisor and call the executive director.</p> <p>Review of the facility's policy on 2/24/15 at 1:30 p.m., provided by the Consultant DON #2, titled, "Abuse Prevention, Interventions, Investigation and Crime Reporting Policy, with revised date of December 2012 indicated the following, "...every resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment and involuntary seclusion...Any form of mistreatment of resident....It is the</p>			

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F 225 SS=D Bldg. 00	<p>responsibility of employee to promptly report to the facility administrator, local ombudsman, or local law enforcement agency and to Stat Licensing and Certification immediately...any incident of suspected or alleged neglect or resident abuse...including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner....To protect the physical and emotional well-being and personal possessions of every resident...."</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>			

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	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>A. Based on interview and record review the facility failed to report the presence of syringes with an unknown substance found in the bed of 1 resident (Resident #73) following his death.</p> <p>B. Based on interview and record review, the facility failed to investigate and report immediately to the state agencies the potential allegations of neglect and misappropriation of property for 1 of 3 residents indicated as reported to the Administrator. (Resident #170)</p>	F 225	<p>1. Resident #73 no longer residents in the facility and Resident #170 were reported on February 20, 2015. Facility immediately turned over syringes to the Police Department. 2. All residents have the potential to be affected. Staff were in-serviced by the Director of Staff Development on March 17, 2015 on notifying SSD or Executive Director of any missing items. No other residents were found to be affected by the deficiency at this time. 3. Executive Director updated and reviewed Angel Rounds with facility staff to</p>	03/27/2015

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	<p>Findings include:</p> <p>A. Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, hypertension, depression, anxiety state, and generalized pain.</p> <p>A hospital History and Physical for Resident #73, dated 11/20/14, indicated he was brought to the Emergency Room (ER) secondary to altered level of consciousness. The History and Physical also indicated "There was some concern among the ER staff that he had someone bring in some drugs and inject them into his PICC (peripherally inserted central catheter) line at the nursing facility."</p> <p>A hospital Consultation report for Resident #73, dated 11/21/14, indicated "there was question to whether or not his girlfriend was also bringing in extra pain medicines into the nursing home where he was staying and if this is also contributing to his decreased level of consciousness."</p> <p>A Prehospital Care Report Summary for Resident #73 from a local ambulance service, dated 11/30/14, indicated "...Pt</p>		<p>include asking if there are any missing items. Angel Care Rounds to be turned into the Executive Director three times/week for 1 month, weekly for 1 month and then monthly ongoing. 4 Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will be compliant by March 27, 2015</p>		

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	<p>(patient) was at home getting antibiotics but girlfriend was found to be injecting an unknown substance through IV (intravenous) port...."</p> <p>Nurses Notes for Resident #73, dated 11/30/14, indicated he was pronounced dead by Medics at 3:51 a.m. The note also indicated at the time staff were cleaning up the resident before releasing his body to the funeral home, the writer found two syringes with an unknown substance in them.</p> <p>A Prehospital Care Report Summary for Resident #73 from the local ambulance service, dated 11/30/14, indicated he received Epi (treats life-threatening allergic reactions) and Narcan (pain medication antagonist) during their attempts at resuscitation.</p> <p>The Administrator was interviewed on 2/20/15 at 9:25 a.m. During the interview he indicated the facility was aware of the hospital's concern of Resident #73's girlfriend bringing him additional pain medications. He also indicated he called the Coroner's office to have the syringes picked up and have the contents analyzed.</p> <p>The Administrator was interviewed on 2/20/15 at 10:28 a.m. During the</p>			

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	<p>interview he indicated he did not think the syringes found in the bed of Resident #73 were an unusual occurrence since they looked like the syringes used to flush his PICC line.</p> <p>Paramedics from the local ambulance service were interviewed on 2/20/15 at 10:40 a.m. During the interview they indicated the syringes they used were labeled.</p> <p>A current facility policy "Reportable Incidents Policy", revised on 1/15/13 and provided by the Consulting DON #2, indicated "...To ensure that reportable incidents are recorded and monitored to facility compliance with state and federal laws...All incidents reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services...Reportable Incidents...Unusual Death...death of a resident that is unusual... any... suspicious death which has been reported to the coroner...."</p> <p>B. An interview with Resident #170 on 2/18/15 at 10:11 a.m., indicated a nurse neglected him by ignoring him. He indicated his family member had reported this and indicated this nurse was moved to another unit at the facility. He could</p>				

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	<p>not remember the date and indicated it happened a couple of months ago. During the interview at 10:26 a.m., Resident #170 indicated he was missing his wallet with \$600 dollars, his drivers license, social security card, insurance cards and credit cards. He indicated his family member had given him the money to pay for transportation to several medical appointments. He indicated it happened about 2 months ago. He indicated he had changed his clothes and had taken his wallet out and put it on the bedside table. Before he got the wallet put back in his pocket the facility Doctor came in to see him and he indicated several people were in and out of his room before he found the wallet was missing. He indicated he reported the missing wallet to LPN #4 and Social Service (SS) #5. Resident #170 indicated the Administrator and SS #5 had checked with him about the missing wallet and checked to see what had been replaced. He indicated he did not think the police were notified.</p> <p>Review of the clinical record for Resident #170 on 2/19/15 at 3:00 p.m., indicated the following: diagnoses included, but were not limited to, pain in joint of pelvic region and thigh, benign neoplasm of prostate, colostomy, diabetes mellitus, hyperlipidemia, anemia, hypertension,</p>			

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	<p>COPD (chronic obstructive pulmonary disease), inguinal hernia, pain of joint shoulder, muscular wasting disuse atrophy, anxiety, mild cognitive impairment, glaucoma, constipation chronic kidney disease.</p> <p>Review of the MDS (Minimum Data Set) assessment dated 1/23/15 indicated a BIMS (Brief Interview for Mental Status) score was 15 which indicated cognition was intact. The MDS assessment also indicated Resident #170 required extensive assist of 1 person for dressing, total dependence of 1 person for toileting and required physical help of 1 person for part of bathing. The MDS also indicated Resident 170's balance moving from seated to standing position and moving from surface to surface, like chair to wheelchair, was not steady, but was able to stabilize himself without human assistance.</p> <p>An interview on 2/20/15 at 11:00 a.m. through 11:20 a.m. with Resident 170's POA (Power of Attorney), indicated she had reported to Social Services(SS) #5 on January 10th, LPN #26 was not being nice to her parents. She indicated LPN #26 asked her if she stayed all of the time. The POA indicated she reported to SS #5 that LPN #26 did not take her fathers blood pressure (B/P) or check his</p>			

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	<p>blood sugar (BS). The POA indicated Resident #170 refused to take his medications until his blood pressure and blood sugars were checked. She further indicated LPN #26 took the medications and left the room and indicated Resident #170 did not receive his medications or his breathing treatment until later that afternoon from another nurse. The POA indicated LPN # 26 was rude and hateful. She indicated SS #5 said he would report the incident to the Administrator. She indicated LPN #26 did not care for her parents. She indicated the nurse was moved to another unit. She indicated the Administrator had not asked her about Nurse #26's care of her parents or why she requested Nurse #26 not provide care for them. She indicated when she tried to talk to the Administrator, he had told her he was investigating the incident and already knew what had happened. She indicated he did not take a statement of the incident from her. The POA indicated Resident #170 had a missing wallet. She indicated she had given him \$500 to pay for transportation to and from the appointments. She indicated she did not know how much money was left and indicated she had stopped his credit cards and had taken him to get a new social security card. She indicated the driver's license was not replaced yet. She indicated the facility notified the</p>			

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	<p>laundry staff of missing wallet but she did not know why since she does the laundry. She indicated it had been a few months since it came up missing at the end of November or in December 2014.</p> <p>An interview with the Administrator on 2/20/15 at 11:55 a.m., indicated he was not aware of the complaint by the family member or resident of neglect. He indicated the family member had reported LPN #26 and Resident #170 did not get along and felt it was a personality conflict between LPN #26 and the Resident. The Administrator indicated LPN# 26 was moved off the 200 Hall. The Administrator also indicated he was not aware the resident's B/P or BS was not taken and his medications were not given. He indicated he would report the incident to ISDH and do an investigation regarding the incident. The Administrator also indicated he was aware the resident's wallet was missing but indicated he was not aware there was a large sum of money missing. He indicated he had followed up with the resident and indicated he knew his Social Security card was replaced and indicated the daughter took care of canceling credit cards. The Administrator indicated when he talked with the resident about the missing wallet Resident #170 did not tell him there was \$600 dollars missing. The</p>			

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	<p>Administrator indicated the wallet had been missing for a few months. The Administrator indicated he had offered the Resident a lock box, but the resident declined. The Administrator indicated he would report the missing wallet and money to ISDH (Indiana State Department of Health) and begin the investigation and report to the police.</p> <p>A review on 2/20/15 at 2:30 p.m. of the facility's reportable incidents to ISDH (Indiana State Department of Health) provided by the Corporate DON indicated the alleged incident of neglect and the alleged missing wallet and large sum of money was not reported to the required State Agencies.</p> <p>An interview on 2/20/15 at 1:25 p.m., with the Administrator indicated LPN #26 was informed she was suspended during the investigation and she would not be working today or over the weekend until the investigation was completed.</p> <p>An interview on 2/20/15 at 2:40 p.m. with the Administrator indicated the incident of the missing wallet and money was reported to the police. He indicated the facility was informed Resident #170 would need to report the missing wallet and money to the police department. The</p>			

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	<p>Administrator indicated the resident had made a report the to the Police Department and indicated they gave the resident an investigation number assigned to the case.</p> <p>Review of the ISDH Health Care Quality and Regulatory Commission Incident Report Form on 2/20/15 at 2:40 p.m., indicated the 2 incidents were reported on 2/20/15 at 2: 29 p.m., the fax verification also indicated the reports were faxed to the Ombudsman and Adult Protective Services.</p> <p>An interview with the Administrator on 2/23/15 at 1:00 p.m. indicated investigation of both incidents was still ongoing. He indicated staff have been interviewed and indicated residents were interviewed regarding concerns about care, not receiving their medication or missing personal items.</p> <p>An interview with the Administrator on 2/24/15 at 3:00 p.m., indicated the investigation was complete for neglect and was unsubstantiated, indicated medications were given and there was no documentation of refused medication. He further indicated there were no concerns about care provided by LPN #26. He indicated the investigation will be completed tomorrow for the missing</p>			

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	<p>money and wallet. He indicated SS #5 had documentation reported by the POA.</p> <p>An interview with SS # 5 on 2/25/15 at 9:00 a.m., indicated he had a written statement as reported to him by the POA regarding a request to not let LPN #26 provide care for Resident #170.</p> <p>On 2/25/15 at 9:05 a.m., Review of SS #5's undated written statement indicated, "...On November 15th, 2014 as I was Manager on Duty, I was standing at the desk in the main lobby. POA approached me regarding the nurse that was assigned to her parents room. POA advised me that she would like to have the nurse switched off of their room and she furthermore stated that she and the nurse do not see eye to eye...During my conversation with POA and LPN #26 there was no mention of neglect of care...POA mentioned to me the personality conflict that she and LPN #26 had and never once mentioned that she felt LPN #26 was providing inadequate care to her parents...I moved LPN #26 off of the residents room...without any further issues of concerns...."</p> <p>An interview on 2/25/15 at 9:15 p.m., with SS #5 indicated this information was not documented in the resident's clinical records and he indicated he had</p>			

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	<p>typed the written statement yesterday. He indicated he had reported the incident to the Administrator by text and it was not documented in the clinical record.</p> <p>An interview on 2/25/15 at 2:00 p.m. with the Administrator, indicated he had spoken with Resident #170 this afternoon. He indicated he was satisfied with the investigation that was done for his wallet. He indicated the resident now has a lock box in his room with a key and indicated the resident was aware about the lock box in the front office and the availability of the banking services at the facility.</p> <p>Review of the facility's policy on 2/24/15 at 1:30 p.m., provided by the Consultant DON #2, titled, "Abuse Prevention, Interventions, Investigation and Crime Reporting Policy, with a revised date of December 2012 indicated the following, "...every resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment and involuntary seclusion...Any form of mistreatment of resident....It is the responsibility of employee to promptly report to the facility administrator, local ombudsman, or local law enforcement agency and to State Licensing and Certification immediately...any incident of suspected or alleged neglect or</p>			

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F 226 SS=D Bldg. 00	<p>resident abuse...including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner....To protect the physical and emotional well-being and personal possessions of every resident...."</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>A. Based on interview and record review the facility failed to implement and follow their policy on reporting to the appropriate state agency the presence of syringes with an unknown substance found in the bed of 1 resident (Resident #73) following his death.</p> <p>B. Based on interview and record review, the facility failed to implement their Abuse Prevention, Intervention, Investigation and Crime Reporting</p>	F 226	<p>1. Resident #73 no longer residents in the facility and Resident #170 were reported on February 20, 2015. Facility immediately turned over syringes to the Police Department. 2. All residents have the potential to be affected. Staff were in-serviced by the Director of Staff Development on March 17, 2015 on notifying SSD or Executive Director of any missing items. No other residents were found to be affected by the deficiency at this time. 3. Executive Director updated and reviewed Angel</p>	03/27/2015	

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	<p>Policy, at the time of the incidents, to investigate and report immediately to the state agency the potential allegations of neglect and misappropriation of property for 1 of 3 residents indicated as reported to the Administrator. (Resident #170)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, hypertension, depression, anxiety state, and generalized pain.</p> <p>A hospital History and Physical for Resident #73, dated 11/20/14, indicated he was brought to the Emergency Room (ER) secondary to altered level of consciousness. The History and Physical also indicated "There was some concern among the ER staff that he had someone bring in some drugs and inject them into his PICC (peripherally inserted central catheter) line at the nursing facility."</p> <p>A hospital Consultation report for Resident #73, dated 11/21/14, indicated "there was question to whether or not his girlfriend was also bringing in extra pain medicines into the nursing home where he was staying and if this is also</p>				<p>Rounds with facility staff to include asking if there are any missing items. Angel Care Rounds to be turned into the Executive Director three times/week for 1 month, weekly for 1 month and then ongoing.</p> <p>4. Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will be compliant by March 27, 2015</p>		

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	<p>contributing to his decreased level of consciousness." The report also indicated "At this time, we are going to continue non-narcotic treatment."</p> <p>Nurses Notes for Resident #73, dated 11/30/14, indicated he was pronounced dead by Medics at 3:51 a.m. The note also indicated at the time staff were cleaning up the resident before releasing his body to the funeral home, the writer found two syringes with an unknown substance in them.</p> <p>A Prehospital Care Report Summary for Resident #73 from a local ambulance service, dated 11/30/14, indicated "Pt (patient) was at home getting antibiotics but girlfriend was found to be injecting an unknown substance through IV (intravenous) port.</p> <p>The Administrator was interviewed on 2/20/15 at 9:25 a.m. During the interview he indicated the facility was aware of the hospital's concern of Resident #73's girlfriend bringing him additional pain medications. He also indicated he called the Coroner's office to have the syringes picked up and have the contents analyzed.</p> <p>The Administrator was interviewed on 2/20/15 at 10:28 a.m. During the</p>			

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	<p>interview he indicated he did not think the syringes found in the bed of Resident #73 were an unusual occurrence since they looked like the syringes used to flush his PICC line.</p> <p>A current facility policy "Reportable Incidents Policy", revised on 1/15/13 and provided by the Consulting DON #2, indicated "...To ensure that reportable incidents are recorded and monitored to facility compliance with state and federal laws...All incidents reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services...Reportable Incidents...Unusual Death...death of a resident that is unusual... any...suspicious death which has been reported to the coroner...."</p> <p>B. An interview with Resident #170 on 2/18/15 at 10:11 a.m., indicated a nurse neglected him by ignoring him. He indicated his family member had reported this and indicated this nurse was moved to another unit at the facility. He could not remember the date and indicated it happened a couple of months ago. During the interview at 10:26 a.m., Resident #170 indicated he was missing his wallet with \$600 dollars, his drivers license, social security card, insurance</p>			

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	<p>cards and credit cards. He indicated his family member had given him the money to pay for transportation to several medical appointments. He indicated it happened about 2 months ago. He indicated he had changed his clothes and had taken his wallet out and put it on the bedside table. Before he got the wallet put back in his pocket the facility Doctor came in to see him and he indicated several people were in and out of his room before he found the wallet was missing. He indicated he reported the missing wallet to LPN #4 and Social Service (SS) #5. Resident #170 indicated the Administrator and SS #5 had checked with him about the missing wallet and checked to see what had been replaced. He indicated he did not think the police were notified.</p> <p>Review of the clinical record for Resident #170 on 2/19/15 at 3:00 p.m., indicated the following: diagnoses included, but were not limited to, pain in joint of pelvic region and thigh, benign neoplasm of prostate, colostomy, diabetes mellitus, hyperlipidemia, anemia, hypertension, COPD (chronic obstructive pulmonary disease), inguinal hernia, pain of joint shoulder, muscular wasting disuse atrophy, anxiety, mild cognitive impairment, glaucoma, constipation chronic kidney disease.</p>			

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	<p>Review of the MDS (Minimum Data Set) assessment dated 1/23/15 indicated a BIMS (Brief Interview for Mental Status) score was 15 which indicated cognition was intact. The MDS assessment also indicated Resident #170 required extensive assist of 1 person for dressing, total dependence of 1 person for toileting and required physical help of 1 person for part of bathing. The MDS also indicated Resident 170's balance moving from seated to standing position and moving from surface to surface, like chair to wheelchair, was not steady, but was able to stabilize himself without human assistance.</p> <p>An interview on 2/20/15 at 11:00 a.m. through 11:20 a.m. with Resident 170's POA (Power of Attorney), indicated she had reported to Social Services(SS) #5 on January 10th, LPN #26 was not being nice to her parents. She indicated LPN #26 asked her if she stayed all of the time. The POA indicated she reported to SS #5 that LPN #26 did not take her fathers blood pressure (B/P) or check his blood sugar (BS). The POA indicated Resident #170 refused to take his medications until his blood pressure and blood sugars were checked. She further indicated LPN #26 took the medications and left the room and indicated Resident</p>			

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	#170 did not receive his medications or his breathing treatment until later that afternoon from another nurse. The POA indicated LPN # 26 was rude and hateful. She indicated SS #5 said he would report the incident to the Administrator. She indicated LPN #26 did not care for her parents, and was moved to another unit. She indicated the Administrator had not asked her about LPN #26's care of her parents or why she requested Nurse #26 not provide care for them. She indicated when she tried to talk to the Administrator, he had told her he was investigating the incident and already knew what had happened. She indicated he did not take a statement of the incident from her. The POA indicated Resident #170 had a missing wallet. She indicated she had given him \$500 to pay for transportation to and from the appointments. She indicated she did not know how much money was left and indicated she had stopped his credit cards and had taken him to get a new social security card. She indicated the driver's license was not replaced yet. She indicated the facility notified the laundry staff of the missing wallet but she did not know why since she does the laundry. She indicated it had been a few months since it came up missing at the end of November or in December 2014.			

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	An interview with the Administrator on 2/20/15 at 11:55 a.m., indicated he was not aware of the complaint by the family member or resident of neglect. He indicated the family member had reported LPN #26 and Resident #170 did not get along and felt it was a personality conflict between LPN #26 and the Resident. The Administrator indicated # 26 was moved off the 200 Hall. The Administrator also indicated he was not aware the resident's B/P or BS were not taken and his medications were not given. He indicated he would report the incident to ISDH and do an investigation regarding the incident. The Administrator also indicated he was aware the resident's wallet was missing but indicated he was not aware there was a large sum of money missing. He indicated he had followed up with the Resident and indicated he knew his Social Security card was replaced and indicated the daughter took care of canceling credit cards. The Administrator indicated when he talked with the Resident about the missing wallet Resident #170 did not tell him there was \$600 dollars missing. The Administrator indicated the wallet had been missing for a few months. The Administrator indicated he had offered the Resident a lock box, but the resident declined. The Administrator indicated he would report the missing wallet and			

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	<p>money to ISDH and begin the investigation and report to the police.</p> <p>A review on 2/20/15 at 2:30 p.m. of the facility's reportable incidents to ISDH (Indiana State Department of Health) provided by the Corporate DON indicated the alleged incident of neglect and the alleged missing wallet and large sum of money was not reported to the required State Agencies.</p> <p>An interview on 2/20/15 at 1:25 p.m., with the Administrator indicated LPN #26 was informed she was suspended during the investigation and she would not be working today or over the weekend until the investigation was completed.</p> <p>An interview on 2/20/15 at 2:40 p.m. with the Administrator indicated the incident of the missing wallet and money was reported to the police. He indicated the facility was informed Resident #170 would need to report the missing wallet and money to the police department. The Administrator indicated the resident had made a report the to the Police Department and indicated they gave the resident an investigation number assigned to the case.</p> <p>Review of the ISDH Health Care Quality</p>			

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	<p>and Regulatory Commission Incident Report Form on 2/20/15 at 2:40 p.m., indicated the 2 incidents were reported on 2/20/15 at 2: 29 p.m., the fax verification also indicated the reports were faxed to the Ombudsman and Adult Protective Services.</p> <p>An interview with Administrator on 2/23/15 at 1:00 p.m. indicated investigation of both incidents is still ongoing. He indicated staff have been interviewed and indicated residents were interviewed regarding concerns about care, not receiving their medication or missing personal items.</p> <p>An interview with the Administrator on 2/24/15 at 3:00 p.m., indicated the investigation was complete for neglect and was unsubstantiated, medications were given and there was no documentation of refused medication. He further indicated there were no concerns about care provided by LPN #26. He indicated the investigation will be completed tomorrow for the missing money and wallet. He indicated SS #5 had documentation reported by the POA.</p> <p>An interview with SS # 5 on 2/25/15 at 9:00 a.m., indicated he had a written statement as reported to him by the POA regarding request to not let LPN #26</p>			

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	<p>provide care for Resident #170.</p> <p>On 2/25/15 at 9:05 a.m., Review of SS #5's undated written statement indicated, "...On November 15th, 2014 as I was Manager on Duty, I was standing at the desk in the main lobby. POA approached me regarding the nurse that was assigned to her parents room. POA advised me that she would like to have the nurse switched off of their room and she furthermore stated that she and the nurse do not see eye to eye...During my conversation with POA and LPN #26 there was no mention of neglect of care...POA mentioned to me the personality conflict that she and LPN #26 had and never once mentioned that she felt LPN #26 was providing inadequate care to her parents...I moved LPN #26 off of the residents room...without any further issues of concerns...."</p> <p>An interview on 2/25/15 at 9:15 p.m., with SS #5 indicated this information was not documented in the resident's clinical records and he indicated he had typed the written statement yesterday. He indicated he had reported the incident to the Administrator by text and it was not documented in the clinical record.</p> <p>An interview on 2/25/15 at 2:00 p.m. with the Administrator, indicated he had</p>			

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	<p>spoken with Resident #170 this afternoon. He indicated he was satisfied with the investigation that was done for his wallet. He indicated the resident now has a lock box in his room with a key and indicated the resident was aware about the lock box in the front office and the availability of the banking services at the facility.</p> <p>Review of the facility's policy on 2/24/15 at 1:30 p.m., provided by the Consultant DON #2, titled, "Abuse Prevention, Interventions, Investigation and Crime Reporting Policy, with a revised date of December 2012 indicated the following, "...every resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment and involuntary seclusion...Any form of mistreatment of resident...It is the responsibility of employee to promptly report to the facility administrator, local ombudsman, or local law enforcement agency and to State Licensing and Certification immediately...any incident of suspected or alleged neglect or resident abuse...including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner....To protect the physical and emotional well-being and personal possessions of every resident...."</p>			

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F 241 SS=D Bldg. 00	<p>This deficiency was cited on the annual recertification survey on 1/30/14, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-29(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 provide 1 resident (Resident #9) with a television with a full picture screen after being transferred from a private room to a double room.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #9 on 2/20/15 at 9:34 a.m., indicated the following: diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, chronic pain, heart failure, and chronic kidney disease.</p> <p>Resident #9 was interviewed on 2/17/15 at 2:30 p.m. During the interview he</p>	F 241	<p>1. Resident #9 was provided a flat screen TV immediately. 2. All residents have the potential to be affected. Facility to incorporate an additional question with Angel Rounds to ask residents whether or not they are experiencing any issues after their room move. 3. Executive Director updated and reviewed Angel Rounds with facility staff to include asking if there are any concerns after their room move. Angel Care Rounds to be turned into the Executive Director three times/week for 1 month, weekly for 1 month and then ongoing 4. Results will be forwarded to the QA committee monthly for 6 months and reviewed with the Medical Director quarterly. 5. Facility will be compliant by March 27, 2015</p>	03/27/2015	

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	<p>indicated he had been moved from a private room in the facility to his current double room because the carpet in his previous room was being cleaned. He also indicated his previous room had a flat screen television attached to the wall. His current room had an older television with only a partial picture. He further indicated he spent a great deal of time in his room watching television and the longer the television was on, the smaller the picture became. He also indicated he had to turn the television off for awhile to let it cool down when the picture got so small he couldn't see it. When queried, he indicated he spoke to facility maintenance about the television and was informed he would have to provide his own television if he wanted a better picture. Resident #9 further indicated he was a loner and did not wish to participate in activities with other residents. He also indicated watching his television and spending time on his computer were his sources of enjoyment.</p> <p>During the interview with Resident #9, the television was on in his room. The top third of the screen was black. There was only a picture on the lower 2/3's of the screen.</p> <p>A Minimum Data Set assessment for Resident #9, dated 1/12/15, indicated a</p>			

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	<p>score of 15 out of 15 on the Brief Interview for Mental Status, indicated he was cognitively intact.</p> <p>A Social Progress Notes for Resident #9, dated 11/26/14, indicated the Admissions Director spoke with the resident about a room move due to cleaning the carpets in his current room. The note also indicated the resident signed the room move sheet for the move to happen on 11/26/14.</p> <p>An Intrafacility Room Transfer Notification for Resident #9, dated 11/26/14, indicated he was being moved from room 214P to 110B due to carpets being cleaned.</p> <p>During an observation of Room 214P, a flat screen television was observed attached to the wall.</p> <p>An Activities Progress Notes for Resident #9, dated 11/12/14, indicated "he stated that he's very content using his laptop computer and watching TV in his spare time."</p> <p>Social Service #5, was interviewed on 2/23/15 at 11:50 a.m. During the interview he indicated Resident #9 had been moved from 214P to his current room so the floors could be cleaned. He also indicated there had been plans to</p>			

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F 272 SS=D Bldg. 00	<p>move him back to his former room, but that had not been done. He further indicated the facility did not provide televisions in "those" rooms. When queried, he indicated certain rooms in the facility were based on a certain payor source.</p> <p>A current undated facility policy "Your Rights As A Nursing Home Resident", provided by the Staff Development Coordinator on 2/23/15 at 12:25 p.m., indicated "...You have the right to be treated with respect and dignity in recognition of your individuality and preferences. You have the right to quality care and treatment that is fair and free from discrimination...."</p> <p>3.1-3(t)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>			

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	<p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) was accurate for a continence decline since admission for 1 of 2 residents reviewed for a continence decline.                      (Resident #14)</p> <p>Findings include:</p> <p>Resident #14's record was reviewed on</p>	F 272	<p>1. Resident #14 still resides in the facility and a Continence Maintenance Plan was developed. 2. All residents have the potential to be affected. Continence care plans reviewed to ensure accuracy. Education provided by the Director of Staff Development to CNAs/nurses regarding voiding patterns of dialysis patients. 3. DON/designee to review all dialysis patients to ensure</p>	03/27/2015

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	<p>2-19-2015 at 11:25 a.m. and indicated diagnoses including but not limited to chronic renal failure, hypertension and on dialysis.</p> <p>A review of the 30, 60, and 90 day cognition assessment completed on 11-14-2014, 12-12-2014 and 1-13-2015 by Social Services #14 indicated the Resident #42 had a BIMS (Brief Interview for Mental Status) of 15/15, which indicated the resident was cognitively intact.</p> <p>A review of the Bowel and Bladder Assessment and Management form column dated 10-17-2014 and provided by Receptionist #20 on 2-23-2015 at 3:56 p.m., indicated Resident #14 scored a "12" on the assessment. (Score 7-14 indicated the resident was a candidate for prompted toileting). On 10-24-2014 a note was entered on the form by RN #11, "res (resident) is continent of Bowel &amp; Bladder.....""</p> <p>A review of the Bowel and Bladder Assessment and Management form column dated 1-13-2015 indicated a score of "9" and a note entered by RN #11 "Resident is Freq (frequently) incont (incontinent) of B/B (Bowel/Bladder)...on a prompted toileting plan...able to ask staff for</p>		<p>continence status is consistent and accurate with MDS and Care Plan assessment. 4. Residents' continence status will be reviewed quarterly thru IDT rounds. Findings will be brought to QA committee to be reviewed monthly and until substantial compliance is met. 5. Facility will becompliant by March 27, 2015</p>		

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	<p>assistance, as well...."</p> <p>A review of the MDS assessments indicated the following: -Admission MDS dated 10-24-2014, bladder assessment was "always continent." -14 day MDS dated 10-31-2014, the 30 day MDS dated 11-14-2014 and the 60 day MDS dated 12-12-2014 indicated the bladder assessment was "occasional incontinence (less than 7 episodes of incontinence)." -2 quarterly MDS assessments dated 1-13-2015 and 1-25-2015 indicated the bladder assessment was "frequently incontinent (7 or more episodes of urinary incontinence but at least one episode of continent voiding)...."</p> <p>An interview with LPN #8 on 2-24-2015 at 9:15 a.m., indicated the CNAs taking care of Resident #14 indicated the resident did not urinate.</p> <p>An interview with RN MDS #2 on 2-24-2014 at 9:45 a.m., indicated the look back period for Resident #14 for the last MDS was 1-19-2015 through 1-24-2015. The RN indicated the Resident ADL (Activities of Daily Living) documentation was used to determine the frequency of incontinence.</p>			

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	<p>A review of the the look back period on Resident #14's ADL records dated 1-19-2015 through 1-24-2015 and provided by Receptionist #20 on 2-20-2015 at 10:23 a.m., indicated 3 incontinent episodes documented.</p> <p>An interview with CNA #12 on 2-24-2015 at 9:50 a.m., indicated on day shift the aides change halls every 2 weeks and since she had been taking care of Resident #14, the CNA indicated the resident did not urinate and has had no incontinence episodes.</p> <p>An interview with RN #7 DSD (Director of Staff Development) on 2-24-2015 at 10:05 a.m., indicated at admission, residents have a Bowel and Bladder Assessment completed and a 3 day voiding pattern is completed by the CNA. A 3 day voiding pattern assessment for Resident #14 was not provided.</p> <p>An interview with RN MDS #11 on 2-24-2015 at 10:30 a.m., indicated a care plan was not in the record for urinary incontinence and a continence maintenance plan was developed today. RN MDS #11 indicated she talked with the aide, the nurse and the resident and all indicated the resident was continent of urine. Further interview with RN MDS #11 indicated she was not sure how to</p>			

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	<p>interpret the Medicare/HMO skilled Documentation by nursing staff on the Bowel and Bladder Status. She further indicated the information for the MDS was based on the aide documentation which was all they had to go by.</p> <p>A review of the Medicare/HMO (Health Maintenance Organization) Skilled Documentation Flow Sheet indicated the following codes for documentation were as follows:                      "C = Continent"                      "I = Incontinent"                      B = Episodes of Both Occur"                      -On 1-25-2015 Bladder = C                      -On 1-24-2015 Bladder = C                      -On 1-23-2015 Bladder = C                      -On 1-22-2015 Bladder = C                      -On 1-21-2015 Bladder = B                      -On 1-19-2015 Bladder = B                      -On 1-18-2015 Bladder = no void                      -On 1-17-2015 Bladder = B                      -On 1-16-2015 Bladder = B                      -On 1-14-2015 Bladder = B                      -On 1-13-2015 Bladder = no void                      -On 1-12-2015 Bladder = no void                      -On 1-11-2015 Bladder = no void                      -On 1-9-2015 Bladder = no void                      -On 1-8-2015 Bladder = no void                      -On 1-7-2015 Bladder = no void                      -On 1-6-2015 Bladder = no void                      -On 1-5-2015 Bladder = no entry                      -On 1-4-2015 Bladder = no void</p>			

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F 279 SS=D	<p>-On 1-3-2015 Bladder = C -On 1-2-2015 Bladder = C -On 1-1-2015 Bladder = C</p> <p>An interview with RN #10 on 2-24-2015 at 11:25 a.m., indicated on the skilled documentation for bowel and bladder, the "B" under Bladder meant the resident went to the toilet and had bladder incontinence during the shift.</p> <p>An interview with RN MDS #11 on 2-24-2015 at 11:29 a.m., indicated "documentation for the bowel and bladder status was confusing" after reviewing the nursing documentation for the resident on the Medicare/HMO Skilled Documentation Flow sheet.</p> <p>A policy "Managing Change of Condition" dated October 2011 and provided by the Consulting DON #2 on 2-24-2015 at 1:29 p.m., indicated the objective was "...to appropriately assess, document and communicate changes of condition to the primary care provider...to provide treatment and services to address changes in accordance with resident needs...."</p> <p>3.1-31(c)(4)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE</p>				

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Bldg. 00	<p><b>PLANS</b></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 care plan for urinary incontinence/continence was implemented for 1 of 2 residents who were reviewed for urinary continence decline since admission. (Resident #14)</p> <p>Findings include:</p> <p>Resident #14's record was reviewed on 2-19-2015 at 11:25 a.m. and indicated diagnoses including but not limited to chronic renal failure, hypertension and on dialysis.</p>	F 279	<p>1. Resident #14 still resides in the facility and a Continence Maintenance Plan was developed. 2. All residents have the potential to be affected. Audit completed for incontinent residents. 3. DON/designee to review dialysis patients to ensure continence status is consistent and accurate with MDS and Care Plan assessment. Reeducation will be provided to the MDS department on the RAI Process. 4. Residents' continence status will be reviewed quarterly thru IDT and results will be forwarded to the QA Committee. 5. Facility will becompliant by March 27, 2015</p>	03/27/2015	

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	<p>A review of the 30, 60, and 90 day cognition assessment completed on 11-14-2014, 12-12-2014 and 1-13-2015 by Social Services #14 indicated the Resident #42 had a BIMS (Brief Interview for Mental Status) of 15/15, which indicated the resident was cognitively intact.</p> <p>A review of the Bowel and Bladder Assessment and Management form column dated 10-17-2014 and provided by Receptionist #20 on 2-23-2015 at 3:56 p.m., indicated Resident #14 scored a "12" on the assessment. (Score 7-14 indicated the resident was a candidate for prompted toileting). On 10-24-2014 a note was entered on the form by RN #11, "res (resident) is continent of Bowel &amp; Bladder.....""</p> <p>A review of the Bowel and Bladder Assessment and Management form column dated 1-13-2015 indicated a score of "9" and a note entered by RN #11 "Resident is Freq (frequently) incont (incontinent) of B/B (Bowel/Bladder)...on a prompted toileting plan...able to ask staff for assistance, as well...."</p> <p>A review of the MDS assessments indicated the following: -Admission MDS dated 10-24-2014,</p>			

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	<p>bladder assessment was "always continent."</p> <p>-14 day MDS dated 10-31-2014, the 30 day MDS dated 11-14-2014 and the 60 day MDS dated 12-12-2014 indicated the bladder assessment was "occasional incontinence (less than 7 episodes of incontinence)."</p> <p>-2 quarterly MDS assessments dated 1-13-2015 and 1-25-2015 indicated the bladder was "frequently incontinent (7 or more episodes of urinary incontinence but at least one episode of continent voiding)...."</p> <p>A review of Resident #14's care plans indicated there was not a care plan for bladder incontinence.</p> <p>An interview with RN MDS #2 on 2-24-2014 at 9:45 a.m., indicated the look back period for Resident #14 for the last MDS was 1-19-2015 through 1-24-2015. The RN indicated the Resident ADL (Activities of Daily Living) documentation was used to determine the frequency of incontinence. Further interview with RN MDS #2 indicated Resident #14 should have an incontinence care plan.</p> <p>An interview with RN #7 DSD (Director of Staff Development) on 2-24-2015 at 10:05 a.m., indicated at admission,</p>			

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	<p>residents have a Bowel and Bladder Assessment completed and a 3 day voiding pattern is completed by the CNA. A 3 day voiding pattern assessment for Resident #14 was not provided.</p> <p>An interview with RN MDS #11 on 2-24-2015 at 10:30 a.m., indicated a care plan was not in the record for urinary incontinence and a continence maintenance plan was developed today. RN MDS #11 indicated she talked with the aide, the nurse and the resident and all indicated the resident was continent of urine. Further interview with RN MDS #11 indicated she was not sure how to interpret the Medicare/HMO skilled Documentation by nursing staff on the Bowel and Bladder Status. She further indicated the information for the MDS was based on the aide documentation which was all they had to go by.</p> <p>A policy "Managing Change of Condition" dated October 2011 and provided by the Consulting DON #2 on 2-24-2015 at 1:29 p.m., indicated "...care plans should be reviewed, revised, and resolved per facility policy...."</p> <p>This deficiency was cited on the annual recertification survey on January 30, 2014 and the facility failed to implement a plan</p>			

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F 282 SS=E Bldg. 00	<p>of correction to correct the deficiency.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on interview and record review the facility failed to follow physician orders for sliding scale insulin for 1 resident (Resident #73) of 3 residents reviewed for diabetes mellitus.</p> <p>B. Based on interview and record review the facility failed to follow physician orders to monitor fluid intake for 1 of 3 resident's reviewed for hydration. (Resident # 144)</p> <p>C. Based on observation, interview and record review, the facility failed to ensure fluid intakes were monitored and documented for a dialysis resident with a physician ordered fluid restriction for 1 of 1 dialysis resident reviewed. (Resident #14)</p> <p>D. Based on observation, interview and record review, the facility failed to ensure</p>	F 282	<p>1. Res #248 on February 23, 2015 had PT/INR done with no changes in Coumadin dose. Orders entered for follow up PT/INR to continue to monitor. Res #51 had INR results, which is what the nurse practitioner uses to dose Coumadin. Res #144 no longer resides in the facility, facility will review all physician orders five times/week and will ensure proper documentation in place for every resident Res #14 still resides in the facility and facility to monitor fluid intake 2. All residents have the potential to be affected. In-service on March 17, 2015 for all licensed nursing staff on hypo/hyperglycemia, SBAR,Blood sugar parameters, documentation and insulin pumps. 3. DON/designee to weekly review IDDM residents to ensure documentation of sliding scale insulin. Orders to be reviewed five times/week to ensure correct implementation and procedure followed in</p>	03/27/2015

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	<p>physician orders were followed for PT/INR (Prothrombin Time/International Normalized Ratio-a blood test to measuring clotting time) for 2 of 2 residents reviewed for Coumadin and monitoring PT/INR orders. (Resident #248 and Resident #51)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and anxiety state.</p> <p>Resident #73 was admitted to the facility on 11/13/14.</p> <p>A physician's order for Resident #73, dated 11/13/14, indicated Humalog 100 unit/ml (milliliter) subcutaneous cartridge. The order also indicated the resident had an implanted insulin pump, with the rate currently 0.8 units/hr (hour).</p> <p>A physician's order for Resident #73, dated 11/14/14, indicated fingerstick (blood sugar) QID (four times a day) every day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The order also indicated the following sliding scale: if blood sugar &lt;150 mg/dl (milligrams per</p>		<p>Sigmacare for insulin, supplements, fluid restriction and PT/INR. 4. Residents on supplements will be audited to ensure clinical monitoring enabled for nurses to document intake percentage or amount. Residents on fluid restriction will be audited to ensure orders are correct with attached clinical monitoring to accurately document fluids. Nurse Practitioner will order INR only unless otherwise indicated as that is how she doses Coumadin. Findings will be brought to QA committee monthly and continue until substantial compliance. 5. Facility will be compliant by March 27, 201</p>	

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	<p>deciliter) = no coverage; 150-200 mg/dl = 2 units; 201-250 mg/dl = 4 units; 251-300 mg/dl = 6 units; 301-350 mg/dl = 8 units; 351-400 mg/dl = 10 units; and if &lt;50 mg/dl or &gt;400 mg/dl call MD.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 15, 2014 through November 29, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/15/14, his 6:00 a.m. blood sugar reading was 170 mg/dl (milligrams per deciliter). There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/15/14, his 8:00 p.m. blood sugar reading was 150 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 6:00 a.m. blood sugar reading was 329 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 11:00 a.m. blood sugar reading was 180 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 8:00 p.m. blood sugar reading was 215 mg/dl. There was no documentation any insulin was given per</li> </ul>			

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	<p>sliding scale.</p> <p>- On 11/17/14, his 6:00 a.m. blood sugar reading was 164 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/17/14, his 4:00 p.m. blood sugar reading was 409 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/17/14, his 8:00 p.m. blood sugar reading was 238 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 6:00 a.m. blood sugar reading was 235 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 11:00 a.m. blood sugar reading was 454 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 4:00 p.m. blood sugar reading was 600 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 8:00 p.m. blood sugar reading was 400 mg/dl. There was no</p>			

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	<p>documentation any insulin was given per sliding scale.</p> <p>- On 11/19/14, his 11:00 a.m. blood sugar reading was 345 mg/dl. Documentation indicated he was given 25 units of insulin instead of the 8 units of insulin ordered per sliding scale.</p> <p>- On 11/19/14, his 4:00 p.m. blood sugar reading was 400 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/25/14, his 6:00 a.m. blood sugar reading was 204 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/25/14, his 4:00 p.m. blood sugar reading was 176 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/25/14, his 8:00 p.m. blood sugar reading was 176 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/26/14, his 6:00 a.m. blood sugar reading was 514 mg/dl. There was no documentation any insulin was given per sliding scale.</p>			

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	<p>- On 11/26/14, his 11:00 a.m. blood sugar reading was 206 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/26/14, his 4:00 p.m. blood sugar reading was 251 mg/dl. Documentation indicated he was given 12 units of insulin instead of 6 units of insulin ordered per sliding scale.</p> <p>- On 11/26/14, his 8:00 p.m. blood sugar reading was 455 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/27/14, his 11:00 a.m. blood sugar reading was 164 mg/dl. Documentation indicated he was given 3.3 units of insulin instead of 2 units of insulin ordered per sliding scale.</p> <p>- On 11/27/14, his 4:00 p.m. blood sugar reading was 251 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/27/14, his 8:00 p.m. blood sugar reading was 217 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 6:00 a.m. blood sugar reading was 400 mg/dl. There was no</p>			

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	<p>documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 4:00 p.m. blood sugar reading was 179 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 8:00 p.m. blood sugar reading was 301 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/29/14, his 6:00 a.m. blood sugar reading was 507 mg/dl. Documentation indicated he was given 16 units of insulin. The documentation did not indicate the physician was notified due to the blood sugar greater than 400 mg/dl and an order for insulin was received.</p> <p>- On 11/29/14, his 11:00 a.m. blood sugar reading was 487 mg/dl. Documentation indicated he was given 14 units of insulin. The documentation did not indicate the physician was notified due to the blood sugar greater than 400 mg/dl and an order for insulin was received.</p> <p>- On 11/29/14, his 4:00 p.m. blood sugar reading was 443 mg/dl. There was no documentation any insulin was given per sliding scale.</p>			

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	<p>- On 11/29/14, his 8:00 p.m. blood sugar reading was 349 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>LPN #4 was interviewed on 2/23/15 at 11:02 a.m. During the interview she indicated blood sugars and insulin given were documented on the MAR.</p> <p>The Consulting DON #2 was interviewed on 2/25/15 at 9:58 a.m. During the interview she indicated physician orders were to be followed.</p> <p>B. Review of the clinical record for Resident #144 on 2/24/15 at 10:30 a.m., indicated the following: diagnoses included, but were not limited to, senile dementia, diabetes mellitus, anemia, depressive disorder, hypertension, atrial fibrillation, CHF(congestive heart failure) , esophageal reflux, UTI (urinary tract infection).</p> <p>-Review of the MDS (Minimum Data Set) assessment dated 2/2/15 indicated a BIMS (Brief Interview for Mental Status) score was 4 which indicated severe cognition impairment. The MDS assessment also indicated Resident #144 required extensive assist of 1 person to eat.</p>			

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	<p>-The Change of Condition SBAR-Mental Status dated 1/21/15 at 4:50 p.m., indicated, "...Lethargy or drowsiness, unable to squeeze hands, increased weakness, unable to move arms...notified NP (Nurse Practitioner) and new order given to transfer to ER (Emergency Room) if family chooses...family notified...requested resident to be sent for evaluation..."</p> <p>-A hand written physician's order for Resident #144, dated 1/28/15, indicated, "...1. Please make sure patient will be hydrated and on a schedule of frequently asked about thirst. Hydration should be monitored also because of her cardiac condition...."</p> <p>-The Hospital H&amp;P (History and Physical) was faxed to the facility on 2/24/15 at 12:17 p.m., with an admission date of 1/21/15 and indicated, "...Impression: UTI, sepsis with elevated white blood cell count, altered mental status, dehydration....admit to Med-Surg (Medical/Surgical) floor and will continue IV Levaquin (antibiotic), IV (intravenous) fluids will be given...."</p> <p>-The Nursing Admission Assessment dated 1/26/15 at 6:25 p.m., indicated, "...No recent history of nutrition, hydration or weight issue..."</p>			

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	<p>-The Interdisciplinary Assessment and Progress Notes, dated 1/27/15, indicated, "...Re-admission Review...Skin intact...Resident has CHF...has edema...WT (weight loss) expected d/t (due to) dx (diagnoses): regular diet.</p> <p>-The Nutrition Screening and Assessment dated, 12/12/14, indicated, "...Fluid Needs (ml): 2044 - 2190..."</p> <p>-The laboratory reports indicated the following: -On 12/8/14, the BUN (Blood Urea Nitrogen) (a blood test indicating how the kidneys and liver are functioning) was 17 mg/dl (milligram per deciliter) and in normal reference range of 7-18 mg/dl. The Creatinine (a blood test to measure kidney function) was 1.1 mg/dl and in normal reference range of 0.6 - 1.3 mg/dl -On 1/6/15, the BUN was 21 mg/dl (H) (high) and the Creatinine was 1.1 mg/dl. -On 1/11/15, the BUN was 26 mg/dl (H) and the Creatinine was 1.2 mg/dl and the Urinalysis was negative. -On 1/17/15, the BUN was 28 mg/dl (H) and the Creatinine was 1.1 mg/dl. -On 2/10/15, the BUN was 31 (H) and the Creatinine was 1.1 mg/dl</p> <p>An interview on 2/24/15 at 2:05 p.m., with RN #22, indicated Resident #144's</p>			

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	<p>meal consumption was documented for the meal on the record. She indicated they do not keep a strict I &amp; O (fluid intake and output) for Resident #144. The nurse indicated the Resident takes a supplement and indicated the amount of supplement taken should be documented on the electronic MARS. The nurse indicated staff are to encourage and ask the resident if she was thirsty, she indicated the nurse will give a 120 ml (milliliter) drink of water when medications are given. She indicated the offered fluids were not documented and also indicated the resident had lab work done to monitor for dehydration.</p> <p>An interview on 2/24/15 at 2:06 p.m., with QMA #21 indicated Resident #144's supplement was documented on the MARS. She further indicated the amount of the supplement was not documented. She indicated the supplement was documented if it was given or refused.</p> <p>An interview on 2/24/15 at 4:20 p.m., with LPN #16 indicated she had not seen the hand written Physician's Telephone Order for Resident #144, dated on 1/28/15. She indicated there was not an electronic Physician's order to indicate, "...1. Please make sure patient will be hydrated and on a schedule of frequently asked about thirst. Hydration should be</p>			

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	<p>monitored also because of her cardiac condition...." LPN #16 indicated she could not determine if the hand written order had been processed. She further indicated the times and the amounts of fluids were not documented. She also indicated she could not determine how much of the supplement Resident #144 had taken on the electronic MARS (Medication Administration Record Sheet). She indicated the amount of the supplement should have been documented on the electronic MARS.</p> <p>An interview on 2/25/15 at 9:25 a.m. with the Consultant DON (Director of Nursing) #1, indicated Resident #144 was not on strict I &amp; O because it was not ordered by the physician. She indicated the Resident's hydration was assessed weekly with the skin assessment. She indicated the facility did not have a policy for monitoring hydration and indicated they use the policy for I &amp; O.</p> <p>An interview on 2/25/15 at 10:53 a.m., with the Consulting DON #2 indicated when pointing to the hand written physician order dated 1/28/15 about monitoring hydration and thirst, indicated these things are "kinda" of being implemented already. They monitor the number of times residents void and report to the NP</p>			

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	<p>An interview with the Facility's NP (Nurse Practitioner) on 2/25/15 at 10:53 a.m., indicated, with Resident 144's UTI and sepsis, dehydration would be normal. The NP further indicated the resident's dehydration resolved due to her lab work not indicating she was dehydrated. The NP further indicated the Resident had stage 1 kidney disease and did not have any other signs or symptoms of dehydration other than her elevated BUN and that could be due to other issues.</p> <p>An interview with the CDM (Certified Dietary Manager) on 2/25/15 at 11:15 a.m., indicated the Residents who eat in the East Hall Dining Room and Bed and Breakfast (Memory Unit) were served pre-poured beverages. She indicated the residents receive 1 large glass of milk (240 ml), 1 large glass of water (240 ml) and 1 small glass of juice (120 ml) for breakfast. She also indicated for lunch and dinner the residents received 1 large glass of water (240 ml), 1 small glass of milk(120 ml), and 1 small glass of juice (120 ml). Total fluid intake from meals was 1440 ml.</p> <p>Review of the Resident #144's Meal Card provided by the CDM on 2/25/15 at 11:20 a.m., indicated no fluids were listed on the cards.</p>			

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	<p>Review of the current facility policy, titled, Intake and Output (I &amp; O), dated 2008, provided by the Consultant DON #1, on 2/25/15 at 9:30 a.m., indicated, "...It is the policy of this facility to monitor intake and output and accurately document when it is determined that monitoring is necessary to evaluate hydration status...or to assist in the assessing and managing fluid needs....Potential residents may include (but not limited to): a. Admissions or re-admissions to establish baseline patterns (72 hours)...b. Residents who are determined to be at risk for dehydration....c. Resident exhibiting poor consumption or refusals of food and/or fluids...."</p> <p>C. An observation of Resident #14's room on 2-19-2015 at 11:30 a.m., indicated an opened 12 pack of Pepsi with 7 cans inside.</p> <p>During an interview with Resident #14 on 2-19-2015 at 3:55 p.m., the Resident indicated he was "not really" on a fluid restriction. A 12 pack container of Pepsi was observed on the floor with seven 12 ounce cans in the box.</p> <p>An observation of Resident #14 in the main dining room on 2-19-2015 at 11:35 a.m., indicated the resident had a cup of</p>			

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	<p>coffee and a small bowl of soup for lunch.</p> <p>An observation of Resident #14's lunch dishes on 2-19-2015 at 12:30 p.m., indicated the coffee cup was empty, the soup bowl had a little left in the bottom and there was a small water glass with a little water left in the bottom.</p> <p>An observation of Resident #14's room on 2-20-2015 at 8:41 a.m., indicated 6 cans of Pepsi were left in the 12 pack container.</p> <p>An observation in the main dining room on 2-20-2015 at 11:38 a.m., indicated Resident #14 was having a cup of coffee. Further observation at 12:00 p.m., indicated Resident #14's coffee cup was empty.</p> <p>An observation of Resident #14's room on 2-23-2015 at 8:56 a.m., indicated an unopened 12 pack of Pepsi was in the room and there were 4 cans of Pepsi left in the opened 12 pack.</p> <p>Resident #14's record was reviewed on 2-19-2015 at 11:25 a.m. and indicated diagnoses including but not limited to chronic renal failure, hypertension and on dialysis.</p>			

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	<p>A review of the physician's orders provided by LPN Unit Manager #4 on 2-20-2015 at 8:50 a.m., indicated an order dated 11-5-2014 for a fluid restriction of 1500 ml (milliliters) total per 24 hrs (hours) as follows: Dietary Department 840 ml on meal trays (breakfast 360 ml, lunch 240 ml, dinner 240 ml) Nursing Department 660 ml (days 350 ml, PM's 200 ml, Noc (night) 110 ml)</p> <p>A review of Resident #14's MAR (Medication Administration Record) for February 2015 indicated the fluid restriction order (as written above) was electronically signed by the nurse on duty for the following shift times: 4:00 a.m. - 6:00 a.m. 12:00 p.m. - 2:00 p.m. 8:00 p.m. - 10:00 p.m.</p> <p>A review of the Nutrition and Screening Assessment completed by the CDM on 10-17-2014 indicated Resident #14 was on a 1200 ml fluid restriction.</p> <p>A review of the Nutritional Progress Notes completed by the RD (Registered Dietitian) on 11-7-2014 indicated Resident #14's fluid restriction was changed to 1500 ml.</p> <p>A review of the Nutrition Care Plan dated</p>			

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	<p>10-20-2014 indicated Resident #14 was on a fluid restriction.</p> <p>A review of the Dialysis Care Plan dated 10-24-2015 indicated Resident #14 was on a fluid restriction of 1500 cc (cubic centimeters which is the same as milliliters) total in 24 hours with dietary providing 840 cc's and nursing providing 660 cc's.</p> <p>A review of the Nurse Aide Assignment Sheet for the West unit dated 2-20-2015 and provided by LPN Unit Manager #4 on 2-20-2015 at 10:15 a.m., indicated Resident #14 was on a fluid restriction.</p> <p>An interview with LPN #8 on 2-20-2015 at 8:40 a.m., indicated she did not monitor the fluid intake for the Resident #14. Further interview with the LPN #8 indicated she did not know if the resident was on a fluid restriction.</p> <p>An interview with the CDM (Certified Dietary Manager) on 2-20-2015 at 8:48 a.m., indicated the nurses track and document the fluid intakes in the resident's records. Further interview with the CDM on 2-20-2015 at 11:34 a.m., indicated the dishes used in the main dining room held the following amounts of fluids, the coffee cup 240 cc, the small glass 120 cc and the small soup bowl 180</p>			

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	<p>cc.</p> <p>An interview with LPN Unit Manager #4 on 2-20-2015 at 10:17 a.m., indicated the nurse signed off on the MAR with their initials to indicate Resident #14 was on a fluid restriction.</p> <p>An interview with the DSD (Director of Staff Development) RN #7 on 2-20-2015 at 10:34 a.m., indicated for Resident #14 the clinical monitoring tool was not attached to the fluid restriction order which did not prompt the nurse to enter the fluid intake amounts into the MAR.</p> <p>An interview with LPN Unit Manager #4 on 2-20-2015 at 10:38 a.m., indicated the clinical monitoring tool was added to the fluid restriction order for the Resident #14. Further interview with LPN Unit Manager #4 indicated the nurse and the aide should have been recording fluid amounts on the supplemental ADL (Activities of Daily Living) record. A review of the supplemental ADL record for February 2015 indicated fluid amounts were not recorded. Additional review of the supplemental ADL records for Resident #14 for January 2015, December and November 2014 indicated fluid amounts were not recorded.</p> <p>An interview with LPN Unit Manager #4</p>			

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	<p>on 2-20-2015 at 10:46 a.m., indicated the meal consumption included the fluids on the ADL record. Further interview with the LPN indicated for a resident on a fluid restriction, the fluid intakes should have been recorded separately.</p> <p>A current policy "Hemodialysis Care" dated September 2007 and provided by the DSD RN #7 on 2-20-2015 at 11:34 a.m., indicated "...This facility has direct responsibility for the care of the resident, including customary standard of care provided by the facility and the following resident assessment and dialysis management processes including...providing and monitoring fluid restrictions when order by the physician...."</p> <p>A current policy "Fluid Restriction" dated August 2014 and provided the DSD RN #7 on 2-20-2015 at 11:34 a.m., indicated the "...basic responsibility...nursing, activity and dietary staff...fluid restrictions will be followed per physician order and monitored by nursing staff for resident compliance...Procedure...nursing records the fluids on the Intake &amp; Output Record ...every shift and calculates the 24 hour totals...."</p> <p>D.1. An observation of Resident #248 on</p>			

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	<p>2-17-2015 at 2:27 p.m., indicated the resident had a bruise on his right hand by his thumb and index finger, on top of his right hand and by his right elbow. During an interview at the same time, Resident #248 indicated he bumped himself.</p> <p>An observation and interview with Resident #248 on 2-23-2015 at 9:40 a.m., indicated a quarter sized purplish area on the resident's right forearm was new. Resident #248 indicated anytime he bumps his skin, he gets bruising.</p> <p>A review of Resident #248's record began on 2-20-2015 at 2:41 p.m. and indicated diagnoses included but were not limited to, lumbago, diabetes and atrial fibrillation.</p> <p>A review of the Physician's Orders printed on 2-23-2015 at 9:10 a.m. and provided by LPN Unit Manager #9 on 2-23-2015 at 9:22 a.m., indicated orders for Coumadin 6 mg (milligrams) by oral route daily with no further orders for the next PT/INR.</p> <p>A review on 2-23-2015 at 9:25 a.m. of the Anticoagulant Administration and Billing Record for February 2015 indicated the following: -on 2-14-2015 (no time), the note</p>			

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	<p>indicated to continue the same dose Coumadin 8.5 mg daily and to recheck PT/INR in 3 days on 2-17-2015.</p> <p>-on 2-17-2015 at 11:00 a.m., the note indicated the INR was 3.5 and to hold Coumadin on 2-17-2015. An order to recheck the PT/INR on 2-18-2015 was received.</p> <p>-on 2-18-2015 at 9:30 a.m., the note indicated the INR was 2.4, the coumadin was held on 2-17-2015, and Coumadin 6 mg was to be given daily with the next PT/INR on 2-21-2015.</p> <p>-no further PT/INRs were recorded as of 2-23-2015 at 9:25 a.m.</p> <p>A review of the February 2015 MAR (Medication Administration Record) provided by the LPN Unit Manager #9 on 2-23-2015 at 9:37 a.m., indicated the Coumadin 6 mg was documented as administered on 2-18, 2-19, 2-20, 2-21 and 2-22-2015; The last PT/INR order was dated 2-18-2015.</p> <p>A review of the Medicare/HMO Skilled Documentation Flow Sheet indicated an entry on 2-18-2015 "...Coumadin 6 mg po (by mouth) qd (everyday) recheck PT/INR 2/21/2015 res (resident) notified...."</p> <p>An interview with LPN #13 on 2-23-2015 at 9:20 a.m., indicated there</p>			

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	<p>had not been a PT/INR for Resident #248 done since 2-18-2015. LPN #13 indicated the Coumadin dose was reduced from 8.5 mg (milligrams) daily to 6 mg daily. The LPN indicated once the PT/INR results are known, the NP (Nurse Practitioner) would be notified of the results. The results and orders received would be entered into the PT/INR book and also would be entered into the computer. Further interview with the nurse indicated there were no orders in the computer for the next PT/INR.</p> <p>An interview with LPN Unit Manager #9 on 2-23-2015 at 9:23 a.m., indicated she was unsure of a tracking system to ensure the PT/INR orders were entered into the computer after the new orders were received.</p> <p>A current policy "Anticoagulant Therapy" dated September 2010 and provided by the Consulting DON (Director of Nursing) #1 on 2-23-2015 at 10:51 a.m. indicated the purpose was "...to monitor anticoagulant therapy so that therapeutic drug parameters are maintained..." and the procedure indicated "...obtain orders for therapeutic lab monitoring from the physician...lab frequencies...should be included...transcribed...for anticoagulant therapy on the MAR...administer</p>			

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	<p>anticoagulant in accordance with physician's orders...monitor for signs and symptoms of adverse drug effects, including, but not limited to, ...excessive bruising...."</p> <p>D.2. On 2/20/15 at 8:30 a.m. the clinical record for Resident #51 was reviewed. At the time, the January 2015 MAR (Medication Administration Record) was reviewed. This record included, but was not limited to, the following: a physician order with a start date of 1/15/15 indicated "PT (prothrombin time)/INR (international ratio) on 1-15-15." The result on 1/15/15 for the PT/INR was documented on this form as a hash mark in the location the PT was to be documented and the result of 4.7 in the location of the INR result. These results were compared to the "Anticoagulant Administration and Billing Record" also dated January 2015. This log indicated an INR result of 4.7 and was blank for a PT result. Documentation was lacking of a PT result.</p> <p>On 2/20/15 at 8:30 a.m. the January 2015 MAR also indicated a physician order for a PT/INR for 1/22/15. The MAR had documented result of 1 for the PT and 2.2 for the INR result. The Anticoagulant Administration and Billing Record only had documented on 1/22/15 an INR result of 2.2. Documentation was lacking of a</p>			

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	<p>PT result.</p> <p>On 2/20/15 at 8:30 a.m. the February MAR was reviewed. A physician order dated 2/11/15 indicated a PT/INR was to be completed on 2/18/15. The documented result for 2/18/15 was a PT of 1 and an INR of 2.6. The Anticoagulant Administration and Billing Record for 2/18/15 only had a documented INR result of 2.6. Documentation was lacking of a PT result.</p> <p>On 2/20/15 at 10:13 a.m. LPN #8 was interviewed. She indicated she was familiar with how to perform the PT/INR tests for this resident and had done so in the past. She indicated she used the facility provided hand held machine to obtain the PT/INR results. She indicated the procedure involved, but was not limited to, obtaining a blood sample on a test strip and inserting the test strip into the machine to obtain the result. At the time, the February 2015 Anticoagulant Administration and Billing Record was reviewed with LPN #8. She indicated the reason the resident only had a documented INR result of 2.6 on 2/18/15 was "because sometimes the machine doesn't always read the PT." She indicated this was the reason on 2/18/15 documentation was lacking of a PT</p>			

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	<p>result. At the time, the MAR for February 2015 was also reviewed. LPN #8 indicated on the computer there was a location to document the PT/INR results. At the time, LPN #8 reviewed the PT/INR entry for 2/18/15. The slot for the PT had a "1" documented. LPN #8 indicated "1" was not really the PT result but the computer required she "put something in there" so she "just put a 1 in there." LPN #8 indicated there were several other times the machine only gave her an INR result, 1/15/15 and 1/22/15. LPN #8 indicated "that just happens sometimes."</p> <p>On 2/20/15 at 10:30 a.m. the Unit Manager #19 was interviewed. She indicated " the machine we use sometimes doesn't give us the PT, it only gives the INR. The NP (Nurse Practitioner) only wants the INR."</p> <p>On 2/20/15 at 2:10 p.m. LPN #8 was interviewed. She demonstrated the use of the machine they use to obtain the PT/INR results. She indicated she was aware of the blue button on the side of the machine that shows about the PT (seconds) result but said sometimes the machine only shows the INR result on this resident. LPN #8 indicated she doesn't know why.</p>			

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F 309 SS=D	<p>On 2/24/15 at 2 25 p.m. the West Unit Manager was interviewed. The Unit Manager indicated the facility notified the physician of all PT/INR results. She indicated the PT/INR order to be done on 1/15 had a INR result of 4.7 and documentation was lacking of a PT. She indicated she thinks the INR was to be between 2-3. The UM provided documentation the NP (Nurse Practitioner) was notified of this result and a repeat PT/INR was ordered for 1/16/15 and both results obtained. At the time, the Unit Manager indicated she was aware the facility machine they use to obtain PT/INR results did not always provide a result for the PT value. At the time, she was made aware LPN #8 had documented a "1" on the MAR when the machine didn't provide her with a PT result. The Unit Manager indicated if the machine didn't give a PT result and only an INR result, she "would put zero instead of a 1."</p> <p>This deficiency was cited on the annual recertification survey on January 30, 2014 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-35(g)(2)</p>				
	483.25 PROVIDE CARE/SERVICES FOR				

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Bldg. 00	<p><b>HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to monitor and address the continuing elevated blood sugars for 1 resident (Resident #73) of 3 residents reviewed for diabetes mellitus.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, and chronic kidney disease.</p> <p>Resident #73 was admitted to the facility on 11/13/14.</p> <p>A physician's order for Resident #73, dated 11/13/14, indicated Humalog 100 unit/ml (milliliter) subcutaneous cartridge. The order also indicated the resident had an implanted insulin pump, with a rate currently 0.8 units/hr (hour).</p> <p>A physician's order for Resident #73, dated 11/14/14, indicated fingerstick</p>	F 309	<p>1. Resident #73 no longer resides in the facility. 2. All residents have the potential to be affected. In-service provided by the Director of Staff Development to licensed nurses on hypo/hyperglycemia, insulin pumps, documentation and notification of changes. 3. DON/designee to audit IDDM residents to ensure adequate documentation of notification of Blood Sugars outside of parameters. 4. DON/Designee to review five times/week for MD notification. Audit through Sigmacare to ensure coverage given appropriately per MD order weekly. Results will be reviewed in QA committee monthly until substantial compliance noted. 5. Facility will be compliant by March 27, 2015</p>	03/27/2015

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	<p>(blood sugar) QID (four times a day) every day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The order also indicated the following sliding scale: if blood sugar &lt;150 mg/dl (milligrams per deciliter) = no coverage; 150-200 mg/dl = 2 units; 201-250 mg/dl = 4 units; 251-300 mg/dl = 6 units; 301-350 mg/dl = 8 units; 351-400 mg/dl = 10 units; and if &lt;50 mg/dl or &gt;400 mg/dl call MD.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 15, 2014 through November 19, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/15/14, his 6:00 a.m. blood sugar reading was 170 mg/dl.</li> <li>- On 11/15/14, his 8:00 p.m. blood sugar reading was 150 mg/dl.</li> <li>- On 11/16/14, his 6:00 a.m. blood sugar reading was 329 mg/dl.</li> <li>- On 11/16/14, his 11:00 a.m. blood sugar reading was 180 mg/dl.</li> <li>- On 11/16/14, his 8:00 p.m. blood sugar reading was 215 mg/dl.</li> <li>- On 11/17/14, his 6:00 a.m. blood sugar reading was 164 mg/dl.</li> </ul>			

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	<p>- On 11/17/14, his 4:00 p.m. blood sugar reading was 409 mg/dl.</p> <p>- On 11/17/14, his 8:00 p.m. blood sugar reading was 238 mg/dl.</p> <p>- On 11/18/14, his 6:00 a.m. blood sugar reading was 235 mg/dl.</p> <p>- On 11/18/14, his 11:00 a.m. blood sugar reading was 454 mg/dl.</p> <p>- On 11/18/14, his 4:00 p.m. blood sugar reading was 600 mg/dl.</p> <p>- On 11/18/14, his 8:00 p.m. blood sugar reading was 400 mg/dl.</p> <p>- On 11/19/14, his 11:00 a.m. blood sugar reading was 345 mg/dl.</p> <p>- On 11/19/14, his 4:00 p.m. blood sugar reading was 400 mg/dl.</p> <p>Review of the Nurses Notes for Resident #73, dated 11/13/14 through 11/19/14, did not indicate his physician had been notified of any blood sugars &gt;400 mg/dl, or his continuing elevated blood sugars.</p> <p>On 11/20/14, he was admitted to the local hospital secondary to altered level of consciousness.</p>			

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	<p>The hospital History and Physical for Resident #73, dated 11/20/14, indicated he was a poorly-controlled Type 1 diabetic. The History and Physical also indicated his blood sugars were significantly elevated over the last couple of days.</p> <p>Resident #73 was re-admitted to the facility on 11/24/14.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 25, 2014 through November 29, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/25/14, his 6:00 a.m. blood sugar reading was 204 mg/dl.</li> <li>- On 11/25/14, his 4:00 p.m. blood sugar reading was 176 mg/dl.</li> <li>- On 11/25/14, his 8:00 p.m. blood sugar reading was 176 mg/dl.</li> <li>- On 11/26/14, his 6:00 a.m. blood sugar reading was 514 mg/dl.</li> <li>- On 11/26/14, his 11:00 a.m. blood sugar reading was 206 mg/dl.</li> <li>- On 11/26/14, his 4:00 p.m. blood sugar reading was 251 mg/dl.</li> </ul>			

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	<ul style="list-style-type: none"> <li>- On 11/26/14, his 8:00 p.m. blood sugar reading was 455 mg/dl.</li> <li>- On 11/27/14, his 11:00 a.m. blood sugar reading was 164 mg/dl.</li> <li>- On 11/27/14, his 4:00 p.m. blood sugar reading was 251 mg/dl.</li> <li>- On 11/27/14, his 8:00 p.m. blood sugar reading was 217 mg/dl.</li> <li>- On 11/28/14, his 6:00 a.m. blood sugar reading was 400 mg/dl.</li> <li>- On 11/28/14, his 4:00 p.m. blood sugar reading was 179 mg/dl.</li> <li>- On 11/28/14, his 8:00 p.m. blood sugar reading was 301 mg/dl.</li> <li>- On 11/29/14, his 6:00 a.m. blood sugar reading was 507 mg/dl.</li> <li>- On 11/29/14, his 11:00 a.m. blood sugar reading was 487 mg/dl.</li> <li>- On 11/29/14, his 4:00 p.m. blood sugar reading was 443 mg/dl.</li> <li>- On 11/29/14, his 8:00 p.m. blood sugar reading was 349 mg/dl.</li> </ul> <p>Review of the Nurses Notes for Resident</p>			

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	<p>#73, dated 11/24/14 through 11/29/14, did not indicate his physician had been notified of any blood sugars &gt;400 mg/dl, or his continuing elevated blood sugars.</p> <p>A facility care plan for Resident #73, dated 11/20/14, indicated the problem area of diabetes mellitus or hypo/hyperglycemia. Interventions to the problem included, but were not limited to, fingerstick blood monitoring and Hgb A1C (blood test for diabetes mellitus) as directed, notify the physician if blood sugar is above or below the following range: 60-100 mg/dl, assess for signs/symptoms of hyper/hypoglycemia, and medications as ordered.</p> <p>LPN #6 was interviewed on 2/20/15 at 2:12 p.m. During the interview she indicated physician notifications for residents would be documented in the Nurses Notes.</p> <p>The Consulting DON #1 was interviewed on 2/23/15 at 9:50 a.m. During the interview she indicated correspondence between the facility and a physician concerning elevated blood sugars would be documented in the Nurses Notes or on the the SBAR (Situation Background Assessment Request/RP Notification/Response report.</p>			

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	<p>The Consulting DON #1 was interviewed on 2/24/15 at 8:44 p.m. During the interview she indicated she was not able to locate any documentation on physician notification of the elevated blood sugars of Resident #73.</p> <p>The Consulting DON #1 was interviewed on 2/24/15 at 3:20 p.m. During the interview she indicated she would expect nursing staff to contact the physician of a resident who showed a pattern for elevated blood sugars.</p> <p>A current facility policy "Blood Sugar Monitoring", dated 2006 and provided by the Consulting Nurse on 2/23/15 at 11:18 a.m., indicated "...To monitor blood glucose level...If blood glucose level is above or below normal range, document the time the physician was notified...."</p> <p>A current facility policy "Managing Change of Condition", updated 2011 and provided by the Consulting Nurse on 2/24/15 at 12:55 p.m., indicated "...To appropriately assess, document, and communicate changes of condition (COC) to the primary care provider...."</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p>			

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F 323 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to provide supervision during showers for 2 of 5 Residents reviewed for accidents. (Residents # 170 and #40)</p> <p>Findings include:</p> <p>1. An interview with Resident #170 on 2/18/15 at 10:53 a.m., indicated a CNA had taken him to the shower and indicated he needed shampoo to wash his hair so the CNA left him in the shower with the water running to get him the shampoo. He indicated the CNA never returned and he was in the shower for about 30 minutes before another CNA found him in the shower room. He indicated the CNA had to leave the</p>	F 323	<p>1. Resident's #110 and #40 still reside in the facility. Unit Manager stayed with the resident until CNA returned to the shower room. 2. All residents have the potential to be affected. 3. Education provided to all direct care staff by Director of Staff Development on resident safety and never leaving residents unattended in shower room. Also staff educated on March 17, 2015 on utilizing call lights to gain assistance. 4. DON/Designee to monitor shower rooms on all three shifts one time/week for 2 months to ensure compliance and then monthly ongoing until compliant Results will be forwarded to the QA committee on a monthly basis 5. Facility will be compliant by March 27, 2015</p>	03/27/2015	

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	<p>building with another resident.</p> <p>Review of the clinical record for Resident #170 on 2/19/15 at 3:00 p.m., indicated the following: diagnoses included, but were not limited to, pain in joint of pelvic region and thigh, benign neoplasm of prostate, colostomy, diabetes mellitus, hyperlipemia, anemia, hypertension, COPD (chronic obstructive pulmonary disease), inguinal hernia, pain of joint shoulder, muscular wasting disuse atrophy, anxiety, mild cognitive impairment, glaucoma, constipation chronic kidney disease.</p> <p>-Review of the MDS (Minimum Data Set) assessment dated 1/23/15 indicated a BIMS (Brief Interview for Mental Status) score was 15 which indicated cognition is intact. The MDS assessment also indicated Resident #170 required extensive assist of 1 person for dressing, total dependence of 1 person for toileting and required physical help of 1 person for part of bathing. The MDS also indicated Resident 170's balance moving from seated to standing position and moving from surface to surface, like chair to wheelchair, was not steady, but was able to stabilize himself without human assistance.</p> <p>An interview on 2/23/15 at 1:50 p.m.</p>			

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	<p>with CNA #23 indicated a non-alert resident should not be left alone in the shower.</p> <p>An interview on 2/23/14 at 2:05 p.m., with CNA #12 indicated if a personal care item is forgotten the call light should be used for another staff to get the needed item. She indicated a confused resident should never be left alone in the shower. She indicated she would inform the nurse and other staff if she has to be away from the unit.</p> <p>An interview on 2/23/15 at 2:20 p.m., with LPN #8, indicated if staff have to leave the unit for any length of time, the other staff on the unit were notified of their absence so care for the residents is covered. She indicated Resident #170 had complained the staff left him in the shower over a month ago. She indicated CNA #12 had to leave the floor when Resident 170 was her resident. LPN #8 indicated the Unit Manager and the nurses were aware CNA #12 had left. She indicated another CNA was assigned to finish his shower and indicated he was not alone for very long.</p> <p>An interview on 2/23/15 at 9:20 a.m. with Resident #170 indicated he was left alone in the shower for 30 to 40 minutes before another CNA came into assist</p>				

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	<p>him. He indicated there was not a call light cord to pull in his shower stall, he indicated there was a call light cord beside the toilet. He indicated he kept the warm water running in the shower to stay warm. He indicated it happened a few weeks ago but could not say what day it happened.</p> <p>An interview on 2/23/15 at 9:48 a.m., with CNA #12 indicated she had left Resident #170 in the shower. She indicated he was independent in showering but liked to have supervision while he was in the shower. She indicated there is a call light pull cord in the shower stall, but not the one he likes to use.</p> <p>An observation on 2/25/15 at 9:05 a.m., of the West Hall shower room with LPN #4 indicated the shower stall on the left had a call light pull cord near the shower curtain. The shower stall on the right did not have a call light pull cord.</p> <p>An interview on 2/25/15 at 9:05 a.m., with LPN #4, indicated a resident should never be left alone in the shower room.. She indicated even if the resident was independent and wanted the shower curtain pulled for privacy, the staff should remain in the shower room while the resident showered.</p>			

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	<p>2. During an observation on 2/25/15 at 9:25 a.m. with LPN # 16 of the 400 Hall shower room the following was observed:</p> <ul style="list-style-type: none"> <li>-LPN #16 knocked on the shower room door that was locked with a coded touch key pad. There was no answer when the LPN knocked on the door.</li> <li>-LPN #16 unlocked the door and opened slightly and asked if anyone was here, and there was no answer.</li> <li>-The curtains were pulled shut on both of the shower stalls. Called out again and started to open the curtain and startled a male resident in the right shower stall.</li> <li>-There was no staff with the resident in the shower room.</li> </ul> <p>An interview with LPN #16 indicated she was surprised by the Resident being in the shower stall. She indicated it was Resident #40 in the shower stall and indicated he should not have been alone in the shower room.</p> <p>Review of the clinical record for Resident #40 on 2/25/15 at 10:10 a.m., indicated the following: diagnoses included, but were not limited to, history of falls, difficulty walking, muscular wasting, insomnia, hypothyroidism, esophageal reflux, adult failure to thrive, depressive disorder, contracture of shoulder,</p>			

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	<p>hypertension, hypertrophy of prostate.</p> <p>-Review of the MDS (Minimum Data Set) assessment dated 1/14/15 indicated a BIMS (Brief Interview for Mental Status) score was 07 which indicated moderate cognitive impairment. The MDS assessment also indicated Resident #40 required physical help of 1 person for part of bathing and required limited assistance of 1 person for dressing. The MDS also indicated Resident 40's balance moving from seated to standing position and moving from surface to surface, like chair to wheelchair, was not steady, but was able to stabilize himself without human assistance.</p> <p>-Review of SBAR (Situation Background Assessment Recommendation) dated 2/7/15 at 1:00 p.m., indicated an unwitnessed fall. Family member reported his shoulder hurt him. The NP was notified and the NP ordered an x-ray of the Left shoulder and also ordered Tramadol (pain medication) 50 mg (milligrams) PRN (as needed) every 4 hours x 10 days....neuro's started..."</p> <p>-Review of the Fall Risk Assessment indicated Resident #40 was at High Risk for Falls.</p> <p>-Review of the care plans indicated the</p>			

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F 371 SS=E Bldg. 00	<p>following: "...Fall Risk Care Plan Interventions:...observe for unsteady gait and balance...provide verbal safety cues...pressure sensor pad in bed..."</p> <p>Review of the Facility's current procedure provided by the Consultant DON #2 on 2/25/15 at 1:00 p.m., titled, Bath, Shower, dated 2006, indicated, "...Procedure: Never leave the resident alone in the shower room..."</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-45(a)(2)</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</p> <p>Based on observation, interview and record review the facility staff failed to wash their hands appropriately for the recommended amount of time and after touching a soiled object, and failed to use a paper towel as a barrier when turning</p>	F 371	<p>1. The oven on Bed and Breakfast was cleaned immediately. Staff was educated by RegisteredDietician/Nutritional Services Manager immediately on proper food handling techniques and the proper hand washing techniques. 2. All residents havethe potential to be affected.</p>	03/27/2015

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	<p>off the water faucet. The facility also failed to ensure food was protected from contamination and the temperature of milk was taken at each meal potentially affecting 102 of 108 residents who received food prepared by the facility kitchen.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 2/19/15 in the Bed and Breakfast dining room, the following was observed:</p> <ul style="list-style-type: none"> <li>- At 10:54 a.m., Certified Nursing Assistant (CNA) #1 was observed to wash his hands for the recommended amount of time. He was observed to turn off the water faucet with his bare hands, not using a paper towel as a barrier.</li> <li>- At 10:57 a.m., CNA #1 was observed to use a tissue to wipe the runny nose of a male resident seated at a dining room table. He was then observed to lather his hands for 13 seconds prior to rinsing. He was observed to turn off the water faucet with his bare hands, not using a paper towel as a barrier.</li> <li>- At 10:59 a.m., CNA #1 was observed to obtain a set of keys and unlock the refrigerator so the Certified Dietary Manager (CDM) could place a tray</li> </ul>		<p>3. CNA educated on hand washing and Infection Control by the Director of Staff Development. Other staff to be educated on hand washing, safe food handling practices, and temping milk when it comes out of the cooler. Housekeeping supervisor/designee to monitor the oven being cleaned weekly.</p> <p>4. Audits to be conducted by the Dietary Manager or designee for three times/week for 1 month, weekly for 1 month and then monthly to ensure compliance. Results will be discussed at the QA committee and continue until compliant. 5. Facility will becompliant by March 27, 2015</p>				

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	<p>containing covered desserts into the refrigerator. He then was observed to re-lock the refrigerator and pull up a chair to visit with residents seated at a dining table.</p> <p>- At 11:13 a.m., CNA #1 was observed to lather his hands for 15 seconds prior to rinsing. He was then observed to pass meal trays to residents.</p> <p>- During a sanitation check of the kitchenette in the Bed and Breakfast, the oven was observed to be extremely dirty with dried spills and food debris.</p> <p>2. During an observation of the lunch meal on 2/20/15 in the facility kitchen, the following was observed:</p> <p>- At 10:45 a.m., an open cart containing containers of juice and milk was observed on ice in an open bin.</p> <p>- At 10:53 a.m., Assistant Dietary #2 was observed to take the temperature of the pureed meat. While taking the temperature, the thermometer was observed to drop into the steam table pan of the pureed meat. Assistant Dietary #2 was observed to pick the thermometer out the pureed meat with her bare fingers touching the pureed meat. She then was observed to wash the pureed food from</p>			

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	<p>her fingers, lathering her hands for 9 seconds prior to rinsing. She was not observed to inform the CDM about touching the pureed meat with her fingers and did not discard the pureed meat she had touched. She then was observed to start dishing plates of pureed food, including the pureed meat, for the Bed and Breakfast.</p> <p>- At 11:00 a.m., Assistant Dietary #2 was observed to open cabinets and retrieve serving utensils to be used on the tray line. She was then observed to start dishing hall meal trays. She was not observed to wash her hands.</p> <p>- During the observation, temperatures were taken of the hot food, but the temperature of the milk was not taken prior to service.</p> <p>- At 11:07 a.m., Dietary #3 was observed to lather his hands for 8 seconds prior to rinsing.</p> <p>- At 11:10 a.m., Assistant Dietary #2 was observed to wipe her hands on her apron and put her hand into her apron pocket. She then was observed to resume dishing lunch plates for residents eating on the east and west ends of the facility. The pureed meat which had been touched by her bare fingers continued to be served.</p>			

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	<p>- At 11:11 a.m., the open cart containing the containers of juice and milk on ice in an open bin were taken to the dining room for service to the residents. The temperature of the milk was not taken prior to leaving the facility kitchen.</p> <p>- At 11:26 a.m., Assistant Dietary #2 was observed to lather her hands for 7 seconds prior to rinsing. She then was observed to start meal service for the main dining room.</p> <p>The Administrator was interviewed on 2/20/15 at 8:51 a.m. During the interview he indicated the oven in the Bed and Breakfast kitchenette was used 3-4 times per month, depending on how often a baking activity was scheduled for the residents.</p> <p>The CDM was interviewed on 2/24/15 at 9:36 a.m. During the interview she indicated staff were to lather their hands out of the water for 20 seconds prior to rinsing and were to use a paper towel as a barrier to turn off the water faucet. She also indicated staff should have used tongs to retrieve the thermometer from the pureed meat. She further indicated the pureed meat should have been discarded and fresh pureed meat prepared. She also indicated the</p>			

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	<p>temperature of milk should be taken at every meal and the temperature recorded in the temperature log. She further indicated Dietary was not responsible for cleaning the oven in the Bed and Breakfast.</p> <p>The Administrator was interviewed on 2/24/15 at 10:10 a.m. During the interview he indicated housekeeping was responsible for cleaning the oven in the Bed and Breakfast. A copy of the cleaning schedule for the oven in the Bed and Breakfast was requested.</p> <p>Review of the Food Temperature Logs for the facility kitchen, indicated the following:</p> <ul style="list-style-type: none"> <li>- 2/2/15 - The temperature of the milk was not recorded for the lunch meal</li> <li>- 2/3/15 - The temperature of the milk was not recorded for the breakfast meal and the lunch meal.</li> <li>- 2/4/15 - The temperature of the milk was not recorded for the lunch meal.</li> <li>- 2/5/15 -The temperature of the milk was not recorded for the lunch meal.</li> <li>- 2/6/15 - The temperature of the milk was not recorded for the breakfast meal</li> </ul>			

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	<p>and the lunch meal.</p> <p>- 2/9/15 - The temperature of the milk was not recorded for the lunch meal.</p> <p>- 2/10/15 - The temperature of the milk was not recorded for the breakfast meal and the lunch meal.</p> <p>- 2/11/15 - The temperature of the milk was not recorded for the lunch meal.</p> <p>- 2/12/15 - The temperature of the milk was not recorded for the breakfast meal and the lunch meal.</p> <p>- 2/13/15 - The temperature of the milk was not recorded for the lunch meal.</p> <p>- 2/14/15 - The temperature of the milk was not recorded for the breakfast meal and the lunch meal.</p> <p>- 2/15/15 - The temperature of the milk was not recorded for the breakfast meal and the lunch meal.</p> <p>- 2/16/15 - The temperature of the milk was not recorded for the lunch meal and the dinner meal.</p> <p>- 2/17/15 - The temperature of the milk was not recorded for the lunch meal.</p>			

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	<p>- 2/19/15 - The temperature of the milk was not recorded for the lunch meal.</p> <p>- 2/20/15 - The temperature of the milk was not recorded for the breakfast meal, the lunch meal, and the dinner meal.</p> <p>- 2/23/15 - The temperature of the milk was not recorded for the lunch meal.</p> <p>A current facility policy "Hand Washing Techniques", with an effective date of 2/09 and provided by the CDM on 2/24/15 at 10:00 a.m., indicated "....Proper sanitation techniques are used to avoid food-borne illness and cross-contamination in the food and dining services department...Proper hand washing technique is accomplished at all times to prevent the spread of infection...1. Hand washing is to be done: when hands are visibly soiled...Before and after resident contact...After contact with soiled or contaminated articles...After contact with an object or source where there is a concentration of microorganisms, such as mucous membranes...3. Rub hands together using friction for 20 seconds...Turn water off using a dry paper...."</p> <p>A current facility policy "Safe Food Temperatures:, with an effective date of 2/09 and provided by the CDM on</p>			

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F 431 SS=E Bldg. 00	<p>2/24/15 at 10:00 a.m., indicated "...Food temperatures are maintained at acceptable levels during food storage, preparation, holding, service, delivery, cooling, and reheating...Cold food will be held at 41 degrees F (Fahrenheit) or lower during meals service (on the tray line)...All tray line food temperatures are checked and recorded on the food temperature log...."</p> <p>The Administrator was interviewed on 2/25/15 at 11:30 a.m. During the interview he indicated the facility did not have a cleaning schedule for the oven in the Bed and Breakfast.</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS 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</p>				

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	<p>periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure over the counter (OTC) medications, topical treatments and unlabeled white powder substances were properly labeled and medication storage rooms were maintained in a clean manner. The facility failed to further ensure medication and treatment carts were maintained clean for 1 of 3 medication rooms and 3 of 5 treatment carts and 5 of 7 medication carts.</p>	F 431	<p>1. OTC medications have been labeled with the MD name, all med rooms/refrigerators have been cleaned and the medications were sent back immediately. All Hydrogel and thickener are labeled. 2. All residents have the potential to be affected. 3. Licensed staff educated by the Director of Staff Development on OTC labeling, drug storage, date opened, and thickener labeled appropriately. Med Rooms and treatment carts are on a cleaning schedule and monitored by DON/designee. 4.</p>	03/27/2015

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	<p>Findings include:</p> <p>1. On 2/19/15 at 9:20 a.m. the 300 hall medication cart was observed with LPN #24. The following was observed: an over the counter bottle (OTC) of Niacin 500 mg, 250 capsules, was observed with no physician name on the bottle.</p> <p>On 2/19/15 at 9:50 a.m. the medication cart was observed on the dementia unit with LPN #28. The following OTC medications were observed with no physician name: Zinc 25 mg, 250 tablets; Mega B-50 100 capsules; Super C 500 Complex 250 capsules; Vitamin D3 1000 International Units (IU) 250 capsules; cod liver oil 1000 mg 250 capsules; CQ-10 120 mg. The following OTC medications were observed in the over flow area of the medication cart with no physician name: CQ -10 100 mg; Selenium 200 mcg; Zinc 25 mg; vitamin D3 2000 IU; Cod Liver Oil 390 mg; and Multivitamins.</p> <p>2. On 2/19/15 at 10 a.m. the treatment cart was observed on the 300 hall unit with the Unit Manager. An opened tube of Hydrogel was observed in the cart with no resident name to identify the resident it belonged to.</p>		<p>Audits to be completed weekly for one month and then monthly for 2 months by DON/designee and discussed at the QA committee and continue until substantial compliance achieved. 5. Facility will becompliant by March 27, 2015</p>	

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	<p>3. On 2/19/15 at 10:15 a.m. the medication room on the 300 Hall Unit was toured with the Unit Manager. On the floor in the medication room was a large plastic tote with a banana box placed inside the tote. Inside the tote was observed to be various medications including pills. At the time, the unit manager was interviewed. She indicated the medications placed in the tote were medications which had been discontinued or medications of residents that had expired or been discharged. She indicated the pharmacy comes to the facility nightly and they are to take the medications back to the pharmacy. At the time, the floor of the medication room was observed to have an accumulation of dust, dirt and paper fragments throughout, with a concentrated accumulation observed in the corners of the room and along the edges. When a hand was wiped across the floor, the accumulation of dust and dirt was visible on the hand. At the time, the refrigerator was observed. Shelves in the refrigerator were observed to have an accumulation of dried spills and dust. The two storage drawers located near the bottom of the refrigerator were observed to also have a visible accumulation of dust, dirt and dried spills inside of them.</p>			

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	<p>On 2/19/15 at 2:46 p.m. the Unit Manager of the 300 unit provided a list of the medications which were observed in the tote on the floor, which she indicated should have been returned to the pharmacy within 7 days of being discontinued. The list of medications included, but was not limited to, the following: 30 Mucinex tablets which had been discontinued on 2/11/15; a bottle of Miralax and Potassium tablets, which had been discontinued on 2/8/15; the following medications had been discontinued on 2/9/15: 25 tablets of Lisinopril; 9 tablets of Lasix; 51 tablets of potassium chloride; 25 tabs of Occuvite; 25 tablets of Vitamin D; 25 tablets of Provastatin; 55 tablets of Zolofit; 26 tablets of Donepezil; 26 tabs of Coumadin; 25 tablets of Aspirin; 26 tabs of Metoprolol; bottle of Chloraseptic was discontinued on 1/27/15; bottle of Miralax was discontinued on 1/12/15 and a tube of Ben Gay was discontinued on 10/29/14. The Unit Manager indicated when medications are discontinued, the medication is scanned with a hand held scanner and this enables the pharmacy to know the facility is wasting the medication and/or returning the medication. The Unit Manager indicated the pharmacy indicated to the facility they "were a month behind." The unit manager indicated the following</p>			

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	<p>medications in this tote had been scanned previously on 2/8/15.</p> <p>On 2/20/15 at 8:20 a.m. accompanied by the unit manager, the med room on the 300 unit was observed with the same observations made on 2/19/15 of the dirty floor as well as the dirty interior of the medication refrigerator. On 2/20/15 at 8:20 a.m. the Unit Manager was interviewed. She indicated she thought night shift cleaned the med room once a week. She wasn't sure how often the floor was cleaned. The banana box full of medications was gone.</p> <p>On 2/20/15 at 9:27 a.m. the Administrator was interviewed regarding the dates of the most recent visits the pharmacy made to the facility. At the time he provided the copies of the "Monthly Survey of Medication Room/Cart Inspection Report." The Monthly Survey Reports included, but were not limited to the following: "Medication room is clean, orderly...Med cart is clean, orderly...treatment cart is clean, orderly...refrigerator is clean...Over the counter...meds are labeled properly..." The Administrator provided the most recent copy of the pharmacy report dated 1/9/15 for the Rehab (rehabilitation) unit; 1/30/15 for the West (300 hall) unit; and 1/22/15 for the East unit. All three of the</p>			

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	<p>above monthly survey medication room/cart inspection reports indicated the medication rooms, medication carts, treatment carts were clean and orderly and the refrigerator was clean and/or over the counter medications were labeled properly.</p> <p>On 2/25/15 at 1:30 p.m. the Consulting DON (Director of Nursing) was interviewed. She indicated the facility did not have a current policy and procedure to address cleaning procedures for the medication rooms, medication and treatment carts. She also indicated the facility did not have current cleaning schedules for the medication and treatment carts and the medication rooms.</p> <p>On 2/25/15 at 3:20 p.m. the Interim DON was interviewed. She indicated after a resident is discharged or a resident expires and a medication is discontinued, the medication should be returned to the pharmacy within 7 days. 4. During an observation of the West Wing's Medication Room with LPN (Licensed Practical Nurse) #4 on 2/19/15 at 9:45 a.m., an opened 30 oz. (ounce) bottle of Pro-Stat Sugar Free AWC (Advanced Wound Healing), (a protein supplement), with a expiration date of 17/Oct/14 was observed. The bottle of Pro-Stat Sugar Free AWC was on the shelf with other</p>						

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	<p>un-opened nutritional supplements. The opened bottle was not labeled with a resident's name or an opened date.</p> <p>An interview with LPN #4 on 2/19/15 at 9:50 a.m., indicated the Pro-Stat needed to be thrown away. She indicated the bottle should have been labeled with an opened date. She also indicated she was not sure if the Pro-stat had expired in 2014 or 2017 by the way the expiration was dated. She discarded the bottle in the bin to be thrown away.</p> <p>5. During an observation of the 200 Hall's Treatment cart with RN # 17 on 2/19/15 at 10:00 a.m. to 10:40 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>-3 opened tubes of Betamethasone DP 0.05% Cream (a steroid cream for inflammation of the skin) were not labeled with opened date</li> <li>-One opened tube of Nystatin Ointment (an antifungal antibiotic for the skin) 100,000 units, 30 gm (gram) was not labeled with an opened date</li> <li>-One opened bottle of Nystop (an antifungal antibiotic powder for skin) 100,000 unit/Gm Powder was not labeled with an opened date</li> </ul>			

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	<p>-2 opened tubes of Zinc Oxide (skin protectant) 20% Ointment were not labeled with an opened date.</p> <p>-One opened bottle of [Name] Baby Shampoo 1.5 oz was not labeled with an opened date, the bottle did not have an expiration date.</p> <p>-2 opened tubes of Voltaren Gel (nonsteroidal anti-inflammatory for skin) 1% 100 gm were not labeled with an opened date.</p> <p>-3 opened tubes of Muscle Rub Extra Strength 3 oz., were not labeled with opened dates.</p> <p>-1 opened tube of Mupirocin (an antibacterial for the skin) 2% Ointment, was not labeled with an opened date.</p> <p>-1 opened tube of Carrasyn Hydrogel Wound Dressing (to maintain moisture in wound) 30 gm was not labeled with a Resident's name or an opened date.</p> <p>- 1 opened tube of Santyl (for debridement of wounds) Ointment 30 gm, was not labeled with an opened date.</p> <p>-1 opened tube of Trizaicin (for pain) 0.025% Cream 60 gm, was not labeled with an opened date.</p>			

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	<p>-A large plastic zip lock bag labeled with a Resident's name was full of treatment supplies which included but not limited to the following:</p> <p>-1 opened tube of Triamcinolone acetonide (topical steroid) cream USP 0.1%, 80 gm was not labeled with an opened date</p> <p>-1 opened tube of Nystatin Triamcinolone (combination of antifungal and corticosteroid for the skin) Cream was not labeled with an opened date.</p> <p>-1 opened tube of Nystatin (antifungal treatment for the skin) Ointment 100,000 units 30 gm (1.1 oz) was not labeled with an opened date.</p> <p>-1 opened tube of Santyl (for debridement of wounds) Ointment was not labeled with a Resident's name or an opened date and was in a plastic bag labeled Nystatin 100,00 Units.</p> <p>An interview with RN # 17 on 2/19/15 at 10:20 a.m., during observation of the 200 Hall Treatment Cart, indicated the tube of Santyl should have been labeled with the Resident's name and an opened date, and she also indicated the Santyl should not have been stored in a bag labeled</p>			

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	<p>Nystatin.</p> <p>-1 opened tube of Mupirocin Ointment (an antibacterial for the skin) was not labeled with an opened date.</p> <p>-1 opened tube of Nystatin Cream (an antifungal antibiotic for the skin) 15 gm was not labeled with a Resident's name or an opened date. The tube of Nystatin in a plastic bag with a prescription label for Mupirocin Ointment.</p> <p>-1 opened 8 oz. spray bottle of All In One Perineal Lotion with Odor Control (cleansing lotion) was not labeled with a Resident's name or an opened date.</p> <p>-2 opened 8 oz. spray bottles of Skin Integrity Wound Cleanser (wound cleaner) was not labeled with a Resident's name or an opened date.</p> <p>- 2 opened tubes of Honey Wound Gel (wound treatment) 1.5 oz were not labeled with a Resident's name or an opened date.</p> <p>An interview with RN #17 on 2/19/14 at 10:25 a.m., during observation of 200 Hall Medication Cart, indicated there were only 2 Resident on the 200 Hall that use the Wound Cleaner and indicated she knew which one to use for each of them.</p>			

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	<p>She further indicated another nurse would not know who the spray bottles belonged too and indicated the bottles should be labeled with the Resident's name and an opened date.</p> <p>An interview with RN # 17 on 2/19/15 at 10:30 a.m., during observation of the 200 Hall Treatment cart, indicated the treatment creams, ointments and powders were kept in large plastic zip bags with the resident's name written on the bag. She further indicated there were several residents who receive treatments on the West Unit and indicated the treatment tubes and bottles should be labeled with a resident's name and an opened date. She indicated most of the treatments were not labeled with an opened date in the Treatment carts on the West Unit.</p> <p>An interview with LPN #4 on 2/19/15 at 10:40 p.m., indicated the treatments should be labeled with opened dates. She indicated it is the responsibility of all of the nurses to make sure the treatments were labeled with the resident's name and the opened date. She indicated the pharmacy writes the expiration date on the tube or bottle and the prescription label and indicated the pharmacy checks the medication and treatment carts monthly.</p>			

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	<p>6. During an observation of the 200 Hall's Medication cart with LPN #8 on 2/19/15 at 10:40 a.m. to 1:55 a.m., the following was observed:</p> <p>-1 blue plastic storage container with a clear lid contained an un-identified white powder substance was not labeled with a date or the contents of the container.</p> <p>An interview with LPN #8, during observation of the 200 Hall Medication cart, indicated the white powder was a thickener. She indicated she took the container to dietary and had the container re-filled when she runs out. She also indicated the container was cleaned by dietary staff before they re-fill the container with thickener.</p> <p>7. An observation with RN #10 of the Rehabilitation Medication Cart #2 on 2-19-2015 at 9:27 a.m., indicated the following:</p> <p>-The bottom of the top drawer was not clean and had staining and grit on the bottom of the drawer.</p> <p>-The second drawer had loose grit in the back edges of the cart.</p> <p>-A clear plastic container with a blue screw on lid, had a white granulated</p>			

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	<p>powder inside and was unlabeled.</p> <p>An interview with the RN #10 on 2-19-2015 at 9:30 a.m., indicated the container with the blue lid with the white granulated powder was thickener and it was replaced every week. Further interview with RN #10 indicated she cleans the medication cart as she sees things that need cleaned and at least weekly.</p> <p>8. An observation with RN #10 of the Rehabilitation Treatment cart on 2-19-2015 at 9:37 a.m., indicated the following:</p> <ul style="list-style-type: none"> <li>- A partially used tube of skin integrity hydrogel was in the top drawer and there was not a label affixed to the tube.</li> <li>- An interview with the RN #10 on 2-19-2015 at 9:38 a.m., indicated she did not know which resident the tube belonged.</li> <li>- An interview with the LPN Unit Manager #9 on 2-19-2015 at 9:39 a.m., indicated if the tube of hydrogel was used for a resident--it would be labeled...she indicated she did not know why the tube was there.</li> <li>-An observation of the 2nd drawer</li> </ul>			

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	<p>indicated a pink/red sticky substance in the bottom of the drawer.</p> <p>-An interview with RN #10 and the LPN Unit Manager #9 on 2/19-2015 at 9:40 a.m., indicated the treatment cart was cleaned weekly.</p> <p>9. An observation of the Rehabilitation Medication Cart #1 with LPN #13 on 2-19-2015 at 9:45 a.m., indicated the following:</p> <p>-The 2nd drawer had 3 white pills and 2 pink pills loose in the back of the drawer along with gritty debris and paper in the back corner and back edge of the drawer.</p> <p>-The 3rd drawer had a white oval pill loose in the bottom of the drawer and gritty debris and paper in the back of the drawer.</p> <p>-The right side 3rd drawer had a pink/red sticky substance in the bottom of the drawer.</p> <p>This deficiency was cited on the annual recertification survey on January 30, 2014 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-25(j)(k)(l)</p>			

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F 441 SS=D Bldg. 00	<p>3.1-25(1)(1)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p>				

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	<p>of infection.</p> <p>Based on interview and record review, the facility failed to implement infection control protocols for 2 of 5 residents reviewed with flu like symptoms. (Resident #K and Resident #M)</p> <p>Findings include:</p> <p>1. Resident #K's record was reviewed 2-19-2015 at 9:36 AM. Resident #K's diagnoses included, but were not limited to diabetes, high blood pressure, and heartburn.</p> <p>In an interview on 2-18-2015 at 9:58 AM, a family member of Resident #K indicated there was yellowish green semi dried liquid on the floor at the bedside when the family member came in for a visit at 9 AM on 2-8-2015; the morning after the staff had indicated her loved one had been vomiting. The family member indicated Resident #K had requested someone to clean up the liquid, but had to ask CNA #1 approximately 1 hour after the first request for assistance was given prior to the liquid being cleaned.</p> <p>In an interview on 2-19-2015 at 8:36 AM, CNA #1 indicated she had cleaned a yellowish green liquid from Resident #K's room when the family had requested</p>	F 441	<p>1. CNA cleaned resident floor of semi-dried liquid and diarrhea episode. 2. Staff to be educated on March 17, 2015 on cleaning up liquid or incontinent episode immediately. For any GI outbreak, resident change of condition will be brought to morning meeting and Maintenance/Housekeeping Director will follow up to ensure rooms are clean. All residents have the potential to be affected. 3. Executive Director/designee to monitor cleanliness of facility through walking rounds. Residents' rooms that have GI illness will be cleaned daily. 4. Facility rounds will be completed three times/week for 1 month, then two times/week for 1 month, then weekly for three months Results will be forwarded to the Administrator and be reviewed monthly in QA. 5. Facility will be compliant by March 27, 2015</p>	03/27/2015	

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	<p>her to do so. CNA #1 indicated the liquid was sort of sticky, and partly dried. CNA #1 further indicated the area should have been initially cleaned by the staff member that noticed the liquid on the floor. CNA #1 indicated the facility protocol was to initially clean up the resident, and any soiled linens, then clean solid areas and carpets with a cleaning solution called Virex, after which housekeeping was to be notified to complete the disinfection process.</p> <p>2. Resident #M's record was reviewed on 2-19-2015 at 10:55 AM. Resident #M's diagnoses included, but were not limited to diabetes, high blood pressure, and muscle wasting.</p> <p>A review of Resident #M's Minimum Data Set (MDS) dated 2-4-2015 indicated Resident #M's Basic Interview for Mental Status score was a 15, indicating Resident #M was alert, oriented, and able to answer questions appropriately.</p> <p>In an interview on 2-18-2015 at 9:42 AM, Resident #M indicated she had been ill with vomiting and diarrhea on 2-5 and 2-6-2015. Resident #M indicated on 2-5-2015, she had an incontinent episode of diarrhea while on her way to the bathroom, in the night, but the staff were unable to clean the floor until after day</p>			

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F 514 SS=D Bldg. 00	<p>shift had arrived, because the CNA had so many residents that were ill. Resident #M indicated CNA #1 cleaned the floor as soon as she came on duty.</p> <p>A review of current transmission based prevention protocols dated 1-28-2015 provided by the Infection Control Nurse on 2-19-2015 at 1:48 PM indicated staff were to "Disinfect contaminated surfaces" as soon as possible.</p> <p>This Federal tag relates to Complaint IN00165298.</p> <p>3.1-18(j)</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>	F 514	1. Hospice records were obtained	03/27/2015

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	<p>A. Based on interview and record review the facility failed to maintain complete and accurate documentation for insulin to be given per sliding scale for 1 resident (Resident #73) of 3 residents reviewed for diabetes mellitus.</p> <p>B. Based on record review and interview, the facility failed to ensure facility documentation was maintained in a thorough, complete and accurate manner for narcotic reconciliation logs: 2 of 5 narcotic logs reviewed and 2 of 2 Hospice records reviewed. (Resident #43, Resident #112)</p> <p>Findings include:</p> <p>A. Review of the clinical record for Resident #73 on 2/19/15 at 1:46 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and anxiety state.</p> <p>A physician's order for Resident #73, dated 11/14/14, indicated fingerstick (blood sugar) QID (four times a day) every day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The order also indicated the following sliding scale: if blood sugar &lt;150 mg/dl (milligrams per deciliter) = no coverage; 150-200 mg/dl = 2 units; 201-250 mg/dl = 4 units;</p>		<p>immediately for both hospice residents. Both nurses were educated on proper narcotic reconciliation and in-service provided to staff on Hypo/hyperglycemia, insulin pumps. 2. All residents have the potential to be affected. IDDM residents to be reviewed of blood sugars and coverage given. Hospice residents audited to ensure appropriate documentation in charts. Also, narcotic reconciliation records were audited. 3. Licensed staff educated by the Director of Staff Development on proper narcotic reconciliation, Hypo/Hyperglycemia and coordinating care with Hospice residents. Executive Director discussed with hospice requirements for hospice charts. Hospice will be invited to the IDT walking rounds and charts will be audited to ensure proper documentation present. 4. Hospice charts will be reviewed quarterly at a minimum with IDT walking rounds to ensure integrated documentation/plan of care. IDDM residents to be reviewed five times/week for 1 month, then three times/week for 1 month and then weekly for 3 months. Results will be discussed at the QA committee until facility achieves compliance. 5. Facility will becompliant by March 27, 2015</p>				

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	<p>251-300 mg/dl = 6 units; 301-350 mg/dl = 8 units; 351-400 mg/dl = 10 units; and if &lt;50 mg/dl or &gt;400 mg/dl call MD.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 15, 2014 through November 19, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- On 11/15/14, his 6:00 a.m. blood sugar reading was 170 mg/dl (milligrams per deciliter). There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/15/14, his 8:00 p.m. blood sugar reading was 150 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 6:00 a.m. blood sugar reading was 329 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 11:00 a.m. blood sugar reading was 180 mg/dl. There was no documentation any insulin was given per sliding scale.</li> <li>- On 11/16/14, his 8:00 p.m. blood sugar reading was 215 mg/dl. There was no documentation any insulin was given per sliding scale.</li> </ul>			

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	<p>- On 11/17/14, his 6:00 a.m. blood sugar reading was 164 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/17/14, his 4:00 p.m. blood sugar reading was 409 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/17/14, his 8:00 p.m. blood sugar reading was 238 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 6:00 a.m. blood sugar reading was 235 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 11:00 a.m. blood sugar reading was 454 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 4:00 p.m. blood sugar reading was 600 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/18/14, his 8:00 p.m. blood sugar reading was 400 mg/dl. There was no documentation any insulin was given per sliding scale.</p>			

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	<p>- On 11/19/14, his 11:00 a.m. blood sugar reading was 345 mg/dl. Documentation indicated he was given 25 units of insulin instead of 8 units of insulin ordered per sliding scale.</p> <p>- On 11/19/14, his 4:00 p.m. blood sugar reading was 400 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>On 11/20/14, he was admitted to the local hospital secondary to altered level of consciousness.</p> <p>Resident #73 was re-admitted to the facility on 11/24/14.</p> <p>A Medication Administration Record (MAR) for Resident #73, dated for November 25, 2014 through November 29, 2014, indicated the following:</p> <p>- On 11/25/14, his 6:00 a.m. blood sugar reading was 204 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/25/14, his 4:00 p.m. blood sugar reading was 176 mg/dl. There was no documentation any insulin was given per sliding scale.</p>			

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	<p>- On 11/25/14, his 8:00 p.m. blood sugar reading was 176 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/26/14, his 6:00 a.m. blood sugar reading was 514 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/26/14, his 11:00 a.m. blood sugar reading was 206 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/26/14, his 4:00 p.m. blood sugar reading was 251 mg/dl. Documentation indicated he was given 12 units of insulin instead of 6 units of insulin ordered per sliding scale.</p> <p>- On 11/26/14, his 8:00 p.m. blood sugar reading was 455 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/27/14, his 11:00 a.m. blood sugar reading was 164 mg/dl. Documentation indicated he was given 3.3 units of insulin instead of 2 units of insulin ordered per sliding scale.</p> <p>- On 11/27/14, his 4:00 p.m. blood sugar reading was 251 mg/dl. There was no</p>			

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	<p>documentation any insulin was given per sliding scale.</p> <p>- On 11/27/14, his 8:00 p.m. blood sugar reading was 217 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 6:00 a.m. blood sugar reading was 400 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 4:00 p.m. blood sugar reading was 179 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/28/14, his 8:00 p.m. blood sugar reading was 301 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/29/14, his 6:00 a.m. blood sugar reading was 507 mg/dl. Documentation indicated he was given 16 units of insulin. The documentation did not indicate the physician was notified due to the blood sugar greater than 400 mg/dl and an order for insulin was received.</p> <p>- On 11/29/14, his 11:00 a.m. blood sugar reading was 487 mg/dl. Documentation indicated he was given 14 units of</p>			

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	<p>insulin. The documentation did not indicate the physician was notified due to the blood sugar greater than 400 mg/dl and an order for insulin was received.</p> <p>- On 11/29/14, his 4:00 p.m. blood sugar reading was 443 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>- On 11/29/14, his 8:00 p.m. blood sugar reading was 349 mg/dl. There was no documentation any insulin was given per sliding scale.</p> <p>LPN #4 was interviewed on 2/23/15 at 11:02 a.m. During the interview she indicated blood sugars and insulin given were documented on the MAR.</p> <p>The Consulting DON #1 was interviewed on 2/24/15 at 8:44 p.m. During the interview she indicated nurses were to document blood sugars and insulin given on the MAR.</p> <p>A current facility policy "Blood Sugar Monitoring", dated 2006 and provided by the Consulting DON on 2/23/15 at 11:18 a.m., indicated "...To monitor blood glucose level...Documentation Guidelines...Date, Time, blood glucose level...If insulin is ordered based on a sliding scale document the type and</p>			

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	<p>amount of insulin administered...Signature and title..."</p> <p>B.1. On 2/20/15 at 11 a.m. the (name of hospice) binder for Resident #43 was reviewed. The binder was observed to have the most recent nurse 's note/assessment as being dated 1/7/15 and 12/3/14. The hospice CNA (certified nursing assistant) documentation was reviewed and the following documentation from January 2015 to the present date was observed in the binder: 2/12/15, 2/3/15, 1/27/15, 1/20/15, 1/15/15, 1/13/15, 1/8/15 and 1/6/15. Documentation was lacking in the hospice binder for Resident #43 of any plans of care. Also observed in the binder for Resident #43 was a "Comprehensive Assessment - Spiritual care" and an "Interdisciplinary Team Plan of Care...Spiritual Needs..." dated 9/18/14 for a resident who is no longer on hospice care.</p> <p>On 2/23/15 at 9:35 a.m. the Nurse Supervisor (NS) for the 300 hall unit was interviewed. She indicated she thinks the hospice nurse comes once a week on Wednesdays to see Resident #43. The NS indicated when the hospice nurse has completed her duties, she asks the facility nurse to sign her hospice paperwork. The NS thought the hospice CNAs (certified</p>			

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	<p>nursing assistants) come in twice a week for Resident #43. The NS indicated the hospice nurse takes the assessment paper with her when she leaves the facility. The NS indicated that she doesn't have ready access to the hospice records at the facility but if she would need something she felt as though if she called hospice they would get her the information she needed. The NS indicated she only has ready access to the hospice records that are in the hospice binder. The NS indicated she thinks information regarding the frequency of hospice Nurse and hospice CNA visits is located in the hospice binder.</p> <p>On 2/23/15 at 10:00 a.m. the NS and the Consulting DON (Director of Nursing) were interviewed. They indicated the hospice residents should have a full, complete, accurate and updated hospice record available on the unit. The Consultant DON and the NS indicated there should have been more recent hospice nursing notes in the clinical record than 1/7/15. At the time, neither the NS and/or the Consulting DON were able to identify the plan of care for the resident. Documentation was lacking as to the determined frequency of hospice visits for the nurse, CNA and/or any other entities related to the hospice program.</p>			

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	<p>On 2/23/15 at 11 a.m. hospice Nurse #1 was interviewed. She indicated today was her first day on her own as a hospice nurse and she recently oriented with (name of hospice company). She indicated she had cared for Resident # 43 before. She indicated prior to leaving the facility, they (hospice nurse) gave report to the facility nurse. Hospice Nurse #1 indicated the facility nurse signs the hospice paper as verification the hospice nurse had actually been at the facility. Hospice Nurse #1 indicated she does look at the resident's paperwork the hospice CNAs (Certified Nursing Assistants) complete which is to be kept in the facility in the (name of hospice) binder. Hospice Nurse #1 indicated after her visit with the resident, she then has the facility nurse sign her assessment paper and she takes it back to the (name of hospice) office to make a copy and then returns the completed assessment form to the facility with her visit the next week. She indicated the reason the nursing assessment copies were not current in the binder was that another nurse had been training her and the hospice nurse doing the training had them with her.</p> <p>On 2/23/15 at 1:40 p.m. the NS and the DON Consultant was interviewed. They indicated Resident #43 began hospice</p>			

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	<p>services on 12/20/13 with a diagnosis of Chronic Obstructive Pulmonary Disease.</p> <p>On 2/23/15 at 1:50 p.m. the Receptionist #1 provided a copy of the (name of hospice) Annual Contract Review, which was last signed on 4/24/12. The a Agreement included, but was not limited to, the following:"...Resident Chart...Copies of all documents of services provided by hospice will be filed and maintained in the Facility Chart...Plan of care: A written plan of care will be established and maintained for each person admitted to hospice and the care provided to the hospice patient will be in accordance with the plan..."</p> <p>On 2/23/15 at 3 p.m. the NS was interviewed. She indicated the (name of hospice services) provided the following documentation: from the Hospice for the following dates: 2/23/15; 2/18/15; 2/11/15; 2/4/15; 1/26/15; and for the CNA for the following dates: 2/12/15 and 2/3/15.</p> <p>B.2. On 2/24/15 at 2 p.m. the hospice Binder of Resident #112 was reviewed. Documentation was lacking of any CNA visits to the resident and/or plan of care. Nursing notes were observed to be documented once a week from 1/26/15 - 2/23/15. A Nursing note dated 1/21/15</p>			

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	<p>was observed to have the entire second page, of the total 3 pages of notes left blank with the exception of the notation for heart sounds of "S1,S2." (Systolic). The areas left blank on the second page included but were not limited to, the following: "Alteration in cardiac, physical mobility, fall risk assessment, skin integrity, mental /neurological status, coping and medications. Areas on the third page left blank for this date were as follows: teaching, care plan, supervision and summary. Documentation was also lacking on this form as to the Hospice nurses signature.</p> <p>On 2/24/15 at 3 p.m. the Receptionist #1 provided a copy of the "Initial orders and plan of care" for Resident #112. Documentation was lacking at the facility of these documents prior and a request had been made to (name of hospice) by the facility for copies of these documents earlier in the day on 2/24/15. The "Initial Orders and Plan of Care", had a date of 1/13/15 with a Terminal Diagnosis of Congestive Heart Failure and a related condition of Vascular Dementia.</p> <p>On 2/25/15 at 8:51 a.m. LPN #28 was interviewed. She indicated the hospice CNA comes to see the resident every Monday, Wednesday and Friday. She indicated the hospice nurse visits the</p>			

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	<p>resident once a week.</p> <p>On 2/25/15 at 9 a.m. CNA #27 was interviewed. She indicated the hospice CNA who visited Resident # 112 this morning, brought in copies of his paperwork this morning and placed them in Resident #112's hospice Binder. CNA #27 indicated the hospice CNA indicated to her he was unaware he was to leave the paperwork in the hospice binder at the facility.</p> <p>B.3. On 2/19/15 at 9:20 a.m. the 300 hall medication cart #2 was observed with LPN #24. At the time, the narcotic shift change signature log was reviewed. The documentation for the 7 a.m. entry had initials documented for both the oncoming and off going nurses. However, the same nurse's initials from the oncoming shift at 7 a.m. were also documented in the off going nurse slot for the 3 p.m. shift, which was 5 hours and 40 minutes before the evening shift narcotics were to have been counted.</p> <p>On 2/19/15 at 9:30 a.m. the 300 hall medication cart #1 was observed with LPN #25. At the time, the narcotic shift change signature log was reviewed. The documentation for the 7 a.m. entry had initials documented for both the oncoming and off going nurses.</p>			

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F 520 SS=E	<p>However, the same nurse's initials from the oncoming shift at 7 a.m. were also documented in the off going nurse slot for the 3 p.m. shift.</p> <p>On 2/19/15 at 1:30 p.m. the DON provided copies of the Narcotic shift change signature log from both of the carts on the 300 unit. She indicated this is the log in which the ongoing nurse and the off going nurse documented their initials after reconciling the narcotic counts between shifts. She indicated the nurses were to document their initials in the designated areas at the time they actually counted the narcotics and not before. The DON indicated the nurses signatures on the narcotic logs, which were to be documented at the time the narcotic count was performed, were to indicated the nurses had reconciled the count of narcotics.</p> <p>This deficiency was cited on the annual recertification survey on 1/30/2014, and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/25/2015	
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Bldg. 00	<p><b>QUARTERLY/PLANS</b></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, interview and record review, the facility QAA Committee (Quality Assessment and Assurance Committee) failed to implement an action plan for the identified concerns regarding staff handwashing during meal service, taking the milk temperature prior to the start of the meal and recording the temperature, ensuring staff did not have bare hand contact with the food, ensuring fluid intakes were documented for a resident with a physician ordered fluid restriction, ensuring physician orders were followed</p>	F 520	<p>1. This facility will identify and implement a plan of action for identifying concerns of staff hand washing, taking milk temperature, Control Substance Record documentation, hospice record review, physician notification and monitoring of IDDM residents 2. All residents have the potential to be affected. 3. Staff will be educated by the Director of Staff Development on March 17, 2015 and action plans will be developed to ensure staff hand washing, temperature of milk is being logged, Control Substance Record is being</p>	03/27/2015			

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	<p>for PT/INR (Prothrombin Time/International Normalized Ratio-a blood test to measuring clotting time) testing, ensuring the insulin was given per sliding scale, the physician was notified for continuing elevated blood sugars results and ensuring physician orders were followed for fluid monitoring. The facility QAA Committee further failed to ensure hospice records were complete, ensure residents were not left unattended in the shower room, ensure Medication and Treatment carts and medication storage rooms were clean, medications and treatments were labeled correctly and unidentified containers of white granules were not stored in the Medication carts, ensure the Notice of Medicare Non-Coverage was signed by the resident/representative and a copy given to resident, ensuring TB (tuberculin) tests were completed prior to/on new staff start date, ensuring all unusual occurrences were reported to the ISDH (Indiana State Department of Health) and ensuring investigation of a missing resident wallet was completed, which had the potential to affect the 108 of 108 residents who resided at the facility.</p> <p>Findings include:</p> <p>An interview with the Administrator and</p>		<p>audited, hospice records are reviewed, physician notification and monitoring of IDDM residents. . 4. Results of all audits will be forwarded to the QA committee for tracking and trending monthly for a minimum of six months. These audits will include hospice record review, physician notification, Control Substance Record documentation, temperature of milk when removing from the cooler, staff hand washing and hospice record review. 5. Facility will becompliant by March 27, 2015</p>	

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	<p>the Consulting DON (Director of Nursing) #2 on 2-25-2015 from 11:55 a.m. - 12:10 p.m., indicated the Quality Assessment and Assurance Committee (QAA) consisted of all management, the pharmacist, medical director, dietitian, therapy and meets monthly.</p> <p>The QAA committee failed to implement an action plan to correct and monitor staff handwashing during meal service, taking the milk temperature prior to the start of the meal and recording the temperature, ensuring staff did not have bare hand contact with the food, ensuring fluid intakes were documented for a resident with a physician ordered fluid restriction, ensuring physician orders were followed for PT/INR testing, ensuring the insulin was given per sliding scale, the physician was notified for continuing elevated blood sugars results and ensuring physician orders were followed for fluid monitoring, ensuring Hospice records were complete, ensuring residents were not left unattended in the shower room, ensuring Medication and Treatment carts and medication storage rooms were clean, medications and treatments were labeled correctly and unidentified containers of white granules were not stored in the Medication carts, ensuring the Notice of Medicare Non-Coverage was signed by the</p>			

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	<p>resident/representative and a copy given to resident, ensuring TB test were completed prior to/on new staff start date, ensuring all unusual occurrences were reported to the ISDH and ensuring investigation of a missing resident wallet was completed.</p> <p>A current policy "Quality Management Program" updated January 2012 and provided by the Consulting DON #2 on 2-25-2015 at 1:00 p.m., indicated "...it is a policy that a functional Quality Management Program is maintained to monitor and evaluate the quality of resident care and services, pursue methods to improve quality and all areas of organizational functioning, and to promote safety by using a systematic problem identification and resolution process...primary objectives...to provide a centralized, coordinated approach to quality improvement activities...to provide a means whereby quality issues can be identified and resolved...to develop monitoring tools that provide an effective mechanism so that each resident receives the necessary care and services to attain or maintain his/her highest practical physical, mental and psychosocial well-being...."</p> <p>3.1-52(a)(2)</p>				

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F 999  Bldg. 00	<p>Based on interview and record review, the facility failed to ensure a tuberculin skin test was administered to 4 of 5 new staff prior to or on the start date of employment. (CNA #29, Environmental Director, RN #30, CNA #31)</p> <p>Findings include:</p> <p>A review on 2-24-2015 at 2:30 p.m. of the TB documentation provided by RN #7 DSD (Director of Staff Development) on 2-24-2015 at 8:30 a.m. for 4 recently hired staff indicated the following:</p> <p>-CNA #29, with a start date of 1-26-2015, had the 1st step TB test administered on 1-27-2015 and read on</p>	F 999	<p>1. All employee TB tests are up to date and current. 2. All employees have the potential to be affected. Director of Staff Development educated on the TB Skin Test Policy. 3. New hires cannot attend general orientation if they have not received their TB Skin Test. 4. Executive Director/designee to complete new hire audit on TB tests one time/month with results forwarded to QA committee for six months and until compliance achieved. 5. Facility will becompliant by March 27, 2015</p>	03/27/2015

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	<p>1-29-2015.</p> <p>-Environmental Director, with a start date of 1-26-2015. had the 1st step TB test administered on 1-28-2015 and read on 1-30-2015</p> <p>-RN #30, with a start date of 1-5-2015, had the 1st step TB test completed on 2-24-2015.</p> <p>-CNA #31, with a start date of 1-26-2015, had the 1st step TB test completed on 2-24-2015.</p> <p>An interview with RN #7 DSD on 2-24-2015 at 4:45 p.m., indicated the RN #7 DSD did not realize some of the new staff were not given the TB 1st step test until the employee records were audited the previous evening. The RN #7 DSD indicated she had had some trouble getting the Aplisol (used for TB testing) from their pharmacy and she did not realize some of the new employees did not have their TB tests completed.</p> <p>An interview with RN #7 DSD on 2-25-2015 at 11:10 a.m., indicated she did not have any documentation from the pharmacy regarding the unavailability of the Aplisol. The RN #7 DSD indicated it was more of a delivery issue with the pharmacy to the facility.</p>			

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	<p>An interview with RN #7 DSD on 2-25-2015 at 1:27 p.m., indicated the TB test should be given at orientation which is the employee start date. Further interview with the RN #7 DSD indicated she has a checklist to review that all required items for new hires are in the personnel record. She indicated the new employees were missed due to not receiving the Aplisol from pharmacy when ordered.</p> <p>A policy "Infection Prevention Manual for Long Term Care-Tuberculosis dated 2012 and provided by the Consulting DON #1 on 2-22-2015 at 12:11 p.m., indicated "...all qualified applicants for employment shall be screened for presence of infection with M. (Mycobacterium) tuberculosis using the two-step TST (tuberculin skin test)...."</p>			