

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/13/2014
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NAME OF PROVIDER OR SUPPLIER  HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 9, 10, 11, 12, and 13, 2014</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN Cynthia Stramel, RN</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 15 Medicaid: 45 Other: 10 Total: 70</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 17, 2014, by Janelyn Kulik, RN.</p>	F000000	<p>June 27, 2014 Kim Rhoades, Director of Long-Term Care Indiana State Department of Public Health 2 North Meridian St. Indianapolis, IN 46204 Dear Ms Rhoades: Please reference the enclosed 2567 as "Plan of Correction" for the June 13, 2014 Recertification and State licensure Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. I will submit signature sheets of in-servicing, content of in-services, and audit tools on July 4, 2014. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on June 27, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the "Plan of Correction", please contact me. Respectfully, Kimberly</p>	

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

TITLE

(X6) DATE

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

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident's privacy was respected while being transferred from his bed to a gurney for 1 of 1 residents reviewed for</p>	F000164	<p>ReadyExecutive Director</p> <p><b>F164 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident 77 was transferred to the hospital per</p>	07/04/2014			

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	<p>privacy. (Resident #77)</p> <p>Findings include:</p> <p>On 6/11/14 at 9:40 a.m., Resident #77's wife requested for the resident to be sent to the hospital due to a fever and respiratory difficulty. The resident's Physician was informed and orders were received to send the resident to the Emergency Room (ER). At 10:08 a.m., transport was in the facility to pick up the resident. The resident was observed in his room in bed. The resident was wearing a hospital gown at this time. The transport team placed the gurney in the resident's room. The resident was transferred from his bed to the gurney. The door to the resident's room was left open. A visitor who was walking past the resident's room at this time stopped, backed up, and looked into the resident's room.</p> <p>The record for Resident #77 was reviewed on 6/10/14 at 3:17 p.m. The resident's diagnoses included, but were not limited to, pneumonia, acute respiratory failure and aspiration pneumonia.</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 5/6/14, indicated the Brief Interview for Mental Status (BIMS) was not able to completed.</p>		<p>family's request. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Contact was made to the ambulance provider by DON to discuss the privacy issue that was identified while resident was transferred from the bed to the gurney. Representative informed DON that ambulance provider will inservice drivers on the need to maintain residents' privacy. <b>What measures will be put into place or what systemic changes will be made to</b> Education will be provided by the Staff Development Coordinator to the facility staff by July 4, 2014 regarding the importance of privacy and confidentially with regard to resident care. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Weekly random audits will be completed by the facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to ensure privacy is maintained. Any issues identified will be immediately addressed and all audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F000242 SS=D	<p>The resident had short and long term memory problems. The MDS also indicated the resident required extensive assistance for transfers.</p> <p>Interview with the Director of Nursing (DoN) on 6/11/14 at 10:45 a.m., indicated the door to the resident's room should have been closed while he was being transferred and that she would contact the transport agency and inform them of the above.</p> <p>3.1-3(p)(2)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure each resident had a choice on when to get up in the morning for 2 of 3 residents reviewed for choices of the 3 residents who met the criteria for choices. (Residents #21 and #64)</p>	F000242	<b>F242 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The care directive and care plan for resident #21 and 64 have been updated to reflect the resident choice to remain in bed longer in the morning. <b>How other</b>	07/04/2014

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	<p>Findings include:</p> <p>1. On 6/9/14 at 10:43 a.m., Resident #21 was interviewed. At that time, she indicated she had wished to stay in bed longer. She indicated the staff come into her room early around 5:00 a.m., to put her stockings on her.</p> <p>On 6/11/14 at 10:13 a.m. the resident was interviewed. At that time, she again indicated she still was awakened early so staff could put her stockings on. She indicated that she still preferred to stay in bed until later.</p> <p>On 6/12/14 at 6:10 a.m., the resident was observed in bed. At that time, she was observed with her antiembolytic stockings on her feet.</p> <p>Interview with CNA #1 6/12/14 at 6:10 a.m., indicated she works the midnight shift on a full time basis. She indicated she puts on the resident's antiembolytic stockings every shift. The CNA indicated she gets them on before she leaves, sometimes it could be 5:00 a.m., or closer to 6:00 a.m. She indicated today she put them on around 6:00 a.m. The CNA further indicated she will sometimes get her up into the wheelchair but not dressed.</p>		<p><b>residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Full facility audit of both interviewable residents, as well as families of residents that are not interviewable, will be conducted to ascertain choices requested by the residents. Documentation of these choices will be reflected on the resident's care directive and care plan. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education will be provided by the Staff Development Coordinator to facility staff by July 4, 2014 regarding in the importance of resident choices. In addition, a separate in-service will be provided by the DON and/or designee to nursing staff in regards to adherence to the resident's preferences outlined on resident's care directive and care plan. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to ensure resident choices are maintained. Any issues identified will be immediately addressed and all audit results and system components will be reviewed</p>				

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	<p>The record for Resident #21 was reviewed on 6/11/14 at 9:55 a.m. The resident was admitted to the facility on 4/2/13. The resident's diagnoses included, but were not limited to, macular degeneration, cataracts, and high blood pressure.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment dated 3/10/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident had no mood or behavior problems. Her preferences indicated it was very important to choose what to wear, and to take care of her belongings. It was somewhat important to choose her own bedtime. She needed extensive assist with one person physical assist with bed mobility and transfers.</p> <p>Review of the current plan of care updated in 5/2014 indicated there was no care plan indicating the resident prefers not to get up so early in the morning.</p> <p>Review of the midnight get up list indicated the resident was not on the list to get up early.</p> <p>Review of the resident care directive sheet indicated there was no information indicating the resident's preference to stay</p>		monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.		

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	<p>in bed longer in the morning.</p> <p>Review of resident interview and resident observation sheet dated 3/11/14 completed by the Assistant Director of Nursing (ADoN) indicated they had asked the resident this question, "Do you participate in choosing when to get up? The resident answered, "No". They then asked her, "Is this acceptable to you?" The resident responded, "Yes". There was no further information or other probing questions documented.</p> <p>Interview with the Activity Director on 6/11/14 at 11:00 a.m., indicated she interviews the residents related to preferences and routines on the MDS. She indicated she asks them the question regarding what time they wish to go to bed. However, she does not recall ever asking the resident what time she would like to get out of bed in the morning. She indicated she was unaware the resident wanted to stay in bed longer and not get up so early.</p> <p>Interview with CNA #2 on 6/11/14 at 11:35 a.m., indicated the resident was usually already up sitting in her wheelchair in her room when she starts her shift at 6:30 a.m. She further indicated the midnight shift puts on her antiembolytic stockings but do not dress</p>						

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	<p>her. The CNA further indicated she dresses her when she comes in.</p> <p>Interview with the Director of Nursing (DoN) on 6/11/14 at 2:00 p.m., indicated the resident interview/observation sheet were the QIS questions they use to ask the residents questions regarding preferences. She indicated she did not know if staff had asked more questions after the resident answered "No" to the question. The DoN indicated she was unaware those were not the same questions the surveyors ask during the resident interview.</p> <p>2. On 6/9/14 at 11:16 a.m., Resident #64 was interviewed. At that time, he indicated he was not able to choose when he wanted to get up in morning. He indicated the nurses come and wake him up early, and he would like to sleep later. The resident indicated he could go for more rest.</p> <p>On 6/11/14 at 2:15 p.m., the resident was interviewed. At that time, he again indicated he would like to stay in bed a little longer.</p> <p>On 6/12/14 at 6:20 a.m., the resident was observed in bed with his eyes closes. He was dressed in street clothes and his lights and television were on.</p>			

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	<p>On 6/12/14 at 6:41 a.m., the resident was observed up in his wheelchair propelling himself down the hall to the dining room.</p> <p>The record for Resident #64 was reviewed on 6/11/14 at 1:08 p.m. The resident was admitted to the to the facility on 11/1/13 and readmitted 2/4/14. The resident's diagnoses included, but were not limited to, anemia, chronic renal failure, high blood pressure, hepatic encephalopathy, depressive disorder, and anxiety.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment dated 11/8/13 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairments. The resident indicated it was somewhat important to choose his bed time. The resident needed extensive assist with one person physical assist with bed mobility, transfers, and dressing.</p> <p>Review of the care plan updated on 5/20/14 indicated there was no care plan for the resident wanting to stay in bed later rather than getting up early.</p> <p>Review of the resident interview and observation sheet completed on 3/14/14</p>			

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F000282 SS=D	<p>indicated the question regarding choosing when you get up in the morning was blank and not completed.</p> <p>Interview with the Director of Nursing on 6/11/14 at 3:00 p.m., indicated they were unaware the resident wanted to stay in bed longer in the morning. She further indicated the resident interview portion was not completed thoroughly.</p> <p>3.1-3(u)(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>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written related to ensuring non-skid footwear was in use and using the proper transfer technique for 2 of 4 residents reviewed for accidents of the 5 residents who met the criteria for accidents. The facility also failed to ensure bruises were monitored for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 8 residents who met the criteria for skin conditions (non-pressure related). (Residents #11, #64, and #111)</p>	F000282	<p><b>F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #111 is transferred via use of mechanical lift. The observed bruises to resident #64's left forearm and left finger will be monitored until healed. Resident #11 now wears non-skid socks when in bed and will wear socks and shoes when up in chair. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> A full facility audit of</p>	07/04/2014

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	<p>Findings include:</p> <p>1. On 6/10/14 at 9:16 a.m., Resident #111 was seated in her room in her wheelchair. The resident's left lower leg was wrapped with an ace bandage. At 3:09 p.m., the resident's left lower leg was wrapped with a gauze dressing.</p> <p>The record for Resident #111 was reviewed on 6/11/14 at 9:04 a.m. The resident's diagnosis included, but was not limited to, muscle weakness.</p> <p>An entry in the Nursing progress notes dated 6/6/14 at 10:56 p.m., indicated a CNA was transferring the resident from her wheelchair to the bed when the resident's leg hit the side rail and a laceration was obtained. The Wound Nurse inspected the laceration and determined the resident may need stitches. The Physician was notified and orders were received to send the resident to the hospital for evaluation and treatment. The resident left the facility at approximately 8:45 p.m.</p> <p>Documentation in the Nursing progress notes dated 6/7/14 at 7:31 a.m., indicated the resident returned to the facility at approximately 12:45 a.m. The resident had two skin tears to the left lower extremity and steri strips were in place.</p>		<p>care directives will be conducted to ensure transfer status is accurate. Any questions regarding method of transfer will be directed to the rehab department for review. Full facility skin audit will be completed to ensure any identified bruises have proper documentation and follow up per facility policy. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> The nursing staff will be educated by the DON and/or designee by July 4, 2014 for following care directives in regards to application of non-skid footwear, when deemed necessary, and proper transfer technique. Education will also be provided to license nurses by the DON and/or designee by July 4, 2014 related to identification of bruises and prompt notification to ensure proper documentation and follow up per facility policy. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to validate care directives are followed. Nursing staff to complete 5 weekly skin audits to ensure any identified issues related to skin integrity are addressed per facility policy. Any</p>				

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	<p>An interim care plan dated 6/5/14 indicated the resident was at risk for break in skin integrity and has breaks in skin integrity related to incontinence, pressure ulcer times 2, bruises, skin tears, a laceration on 6/6/14, and immobility. The interventions included, but were not limited to, mechanical lift for transfers and padding to bed rails.</p> <p>Review of the care directive sheet on 6/12/14 at 2:53 p.m., indicated the resident was total care for transfers and a mechanical lift.</p> <p>Interview with the Director of Nursing (DoN) on 6/12/14 at 3:15 p.m., indicated the resident should have been a mechanical lift at the time of the transfer. The DoN indicated the interim care plan indicated the resident was to be a mechanical lift for transfers. The DoN also indicated the CNA had been counseled and was given an inservice on body mechanics.</p> <p>2. On 6/12/14 at 6:20 a.m., Resident #11 was observed in bed. At that time, he was wearing plain white socks to both of his feet.</p> <p>On 6/12/14 at 8:00 a.m., the resident was observed in bed. At that time, he was wearing plain white socks to both of his</p>		<p>issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>feet.</p> <p>On 6/12/14 at 9:35 a.m., the resident was observed in bed. At that time, he was wearing plain white socks to both of his feet.</p> <p>On 6/13/14 at 9:45 a.m., the resident was observed sitting in a wheelchair. At that time, he was wearing shoes and plain white socks to both of his feet.</p> <p>Interview with CNA #3 on 6/13/14 at 9:51 a.m., indicated the resident was fully dressed and lying in bed when she arrived to work at 6:30 a.m. She further indicated the midnight girls get the resident dressed but keep him in bed. She then indicated she washes his face and checks him again for incontinence and then gets him up later in the morning. The CNA indicated the resident was wearing plain white socks to both of his feet while he was in bed. She indicated she was unaware the resident was to wear non skid socks while in bed.</p> <p>The record for Resident #11 was reviewed on 6/12/14 at 8:39 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety, dementia, dysphasia, depression, stroke, and anemia.</p>						

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	<p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 5/21/14 indicated the resident had short term and long term memory problems and was cognitively impaired. The resident needed extensive assist with one person physical assist with dressing.</p> <p>Review of Physician Orders dated 4/10/14 indicated the resident was to wear non skid socks or slippers.</p> <p>Interview with the Director of Nursing on 6/13/14 at 10:00 a.m., indicated the resident probably does not need the non skid socks when he is up in the chair, but he needs the socks when he was in bed.</p> <p>3. On 6/09/2014 at 11:29 a.m., the Resident #64 was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color. The resident indicated they were all from finger sticks and lab draws.</p> <p>On 6/10/14 at 2:00 p.m. the resident was observed laying in bed. the resident was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color.</p>				

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	<p>On 6/11/14 at 8:45 a.m., and 1:47 p.m., the resident was observed seated in his wheelchair. At those times, the resident was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color.</p> <p>The record for Resident #64 was reviewed on 6/11/14 at 1:08 p.m. The resident's diagnoses included, but were not limited to, anemia, and high blood pressure.</p> <p>Review of the Quarterly Minimum Data Set Assessment (MDS) dated 5/13/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with bed mobility, transfers, and dressing with a one person physical assist.</p> <p>Review of the current plan of care updated on 5/20/14 indicated the resident was at risk for developing a pressure ulcer related to the braden scale. The Nursing approaches were to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and daily care.</p>			

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F000309 SS=D	<p>Review of the Treatment Administration Record (TAR) for the months of May and June 2014 indicated there was no documentation regarding the resident's bruises on a yellow non pressure sore sheet.</p> <p>Interview with RN #1 on 6/11/14 2:00 p.m., indicated she was not made aware the resident had any type of bruising on either one of his hands.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to the documentation and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 8 residents who met the criteria for non pressure related skin conditions.</p>	F000309	<b>F309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The observed bruises to resident #64's left forearm and left finger will be monitored until healed. <b>How other residents having the potential to be affected by the same deficient practice will be identified and</b>	07/04/2014

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	<p>(Resident #64)</p> <p>Findings include:</p> <p>On 6/09/2014 at 11:29 a.m., the Resident #64 was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color. The resident indicated they were all from finger sticks and lab draws.</p> <p>On 6/10/14 at 2:00 p.m. the resident was observed laying in bed. the resident was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color.</p> <p>On 6/11/14 at 8:45 a.m., and 1:47 p.m., the resident was observed seated in his wheelchair. At those times, the resident was observed with a red/purple bruise to his left forearm and left finger. He also was observed with bruises to his right hand and right finger that were purple and red in color.</p> <p>The record for Resident #64 was reviewed on 6/11/14 at 1:08 p.m. The resident's diagnoses included, but were not limited to, anemia, and high blood</p>		<p><b>what corrective actions(s) will be taken:</b> Full facility skin audit will be completed to ensure any identified bruises have proper documentation and follow up per facility policy. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education will be provided to license nurses by the DON and/or designee by July 4, 2014 related to identification of bruises and prompt notification to ensure proper documentation and follow up per facility policy. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Nursing staff to complete 5 weekly skin audits for the next 6 months to ensure any identified issues related to skin integrity are addressed per facility policy. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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	<p>pressure.</p> <p>Review of the Quarterly Minimum Data Set Assessment (MDS) dated 5/13/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with bed mobility, transfers, and dressing with a one person physical assist.</p> <p>Review of the current plan of care updated on 5/20/14 indicated the resident was at risk for developing a pressure ulcer related to the braden scale. The Nursing approaches were to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and daily care.</p> <p>Review of Nursing progress notes dated 6/7/14 indicated to send the resident to the hospital for nasal bleeding and low platelets. The resident returned that day. The next documented entry was on 6/10/14 and there was no documentation regarding any bruises to the resident's arms or fingers.</p> <p>The next documented entry in the Nursing notes was dated 6/11/14 at 3:09 p.m., which indicated, "noted 3 bruises to left forearm, left middle finger, and right</p>				

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	<p>ring finger. Investigation shows they might be from blood draws but resident states that he bruises easily when bumped. He denies any abuse. Paged MD (Medical Doctor) and unable to reach family."</p> <p>Review of the Weekly Skin Integrity sheet completed on shower days indicated on 5/26/14 skin intact, 6/5/14 skin intact, and 6/9/14 skin intact.</p> <p>Review of the Treatment Administration Record (TAR) for the months of May and June 2014 indicated there was no documentation regarding the resident's bruises on a yellow non pressure sore sheet.</p> <p>Interview with the Wound Nurse on 6/11/14 at 1:24 p.m., indicated she was not aware of any bruising for the resident. She further indicated there were no yellow non pressure sore sheets completed for the resident regarding bruises to his arms.</p> <p>Interview with RN #1 on 6/11/14 2:00 p.m., indicated she was not made aware the resident had any type of bruising on either one of his hands. She then indicated she would assess the resident and document the bruises.</p>			

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F000312 SS=D	<p>Review of the non pressure sore sheet dated 6/11/14 indicated bruises on the left forearm: 3 centimeters (cm) by 1.7 cm, left middle finger: 2 cm by 2.4 cm, right ring finger: 5 cm by 3 cm, top of right hand: 2 cm by 2 cm, right inner arm: 8 cm by 7 scattered, side of left hand: 2 cm by 2.5 cm. The assessment indicated all the bruises were purple in color.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure activities of daily living were completed related to nail care and bathing for 2 of 3 residents reviewed for activities of daily living of the 10 residents who met the criteria for activities of daily living. (Residents #111 and #112)</p> <p>Findings include:</p> <p>1. On 6/10/14 at 9:17 a.m., and 3:09 p.m., Resident #111 was observed with long fingernails. There was a dark</p>	F000312	<p><b>F312 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Facility staff provided nail care to resident #111 and washed resident #112's hair on 6/12/14. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Full facility audit completed on 6/12/14 by department managers to identify any residents in need nail and/or hair care. Care was render when</p>	07/04/2014			

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	<p>substance underneath her fingernails.</p> <p>On 6/11/14 at 9:02 a.m., and 3:34 p.m., the resident was observed with long fingernails with a dark substance underneath the nails.</p> <p>On 6/12/14 at 2:58 p.m., the resident was in her room and in bed. The resident was awake at the time. CNA #4 was in the room with the resident and the Wound Care Nurse was preparing to enter the resident's room. The resident's fingernails remained long with a dark substance underneath some of the nails. The Wound Care Nurse was informed at this time.</p> <p>The record for Resident #111 was reviewed on 6/11/14 at 9:04 a.m. The resident's diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>Review of the care directive sheet on 6/12/14 at 11:00 a.m., indicated the resident was total care for bathing. Showers were to be given in the afternoon on Monday and Thursday.</p> <p>Interview with the Director of Nursing on 6/12/14 at 3:15 p.m., indicated that it could not be determined if the resident had received a bath or shower since admission to the facility. She also</p>		<p>deemed necessary. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Staff Development Coordinator to provide education to nursing staff by July 4, 2014 in related to the ongoing inspection of nails to ensure they are neat, clean, and trimmed. In addition, hair care will be provided on shower days and as needed in between shower days. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to ensure appropriate nail and/or hair care is provided to residents. Any issues identified will be immediately brought to nursing staff's attention for resolution and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>indicated the resident would be put in the tub this evening and her fingernails would be trimmed and cleaned.</p> <p>2. On 6/10/14 at 10:35 a.m., Resident #112 was observed laying in her bed, her hair appeared greasy, there were white flecks in her hair near her temples. Her hair was combed back from her face. She indicated her hair was washed every day.</p> <p>On 6/11/14 at 8:21 a.m., the resident was observed in the dining room, her hair appeared greasy, it was combed back away from her face.</p> <p>On 6/12/14 at 7:40 a.m., the resident was observed in the dining room. She was using the fingernails of both hands and scratching at her scalp. She indicated to a nearby CNA that her head was itching.</p> <p>The resident's record was reviewed on 6/11/14 at 2:00 p.m. She was admitted to the facility on 5/21/14. The Resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and pneumonia.</p> <p>The Admission Minimum Data Set Assessment (MDS) dated 6/3/14 indicated the resident had a Brief Interview for Mental Status (BIMS) score</p>			

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	<p>of 11, which indicated mild cognitive impairment. Her functional status indicated she required extensive assistance for transferring and bed mobility.</p> <p>A care plan dated 5/27/14 was for self care deficit related to difficulty breathing and weakness. The goal was for the resident to participate in activities of daily living with staff assistance. Approaches included to provide safety equipment as needed and to explain all procedures prior to the task.</p> <p>The shower schedule located on the North unit indicated the resident was scheduled for showers on Mondays and Thursdays.</p> <p>Review of the residents June 2014 Monthly Flow Report indicated the resident was bathed on Monday 6/2/14 and not again until Wednesday 6/11/14. The Monthly Flow Report did not specify if hair was washed during the shower. There was a Skin Assessment slip dated 6/5/14 that indicated the resident had refused her shower on that day. There was no additional documentation that the resident had refused another shower that week.</p> <p>Interview with CNA #3 on 6/12/14 at</p>				

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	<p>8:30 a.m., indicated she had showered the resident this morning at 7:00 a.m. and that her hair was washed at that time. She indicated her hair was just stringy and the resident was always itching.</p> <p>Interview with LPN #1 on 6/12/14 at 8:35 a.m., indicated she saw the resident in the shower room after her shower that morning for her weekly skin check, and indicated her hair was not wet.</p> <p>Interview with the Director of Nursing (DoN) on 6/12/14 at 8:45 a.m., indicated when a resident refused a shower, CNA's were to notify nursing staff so they could encourage the resident to accept the shower. If they refused showers or hair washing regularly, CNA's should notify nursing staff so it could be care planned. She then stated she was not aware the resident had been refusing showers and/or hair washings. Further interview at 9:10 a.m., the DoN indicated they would dry shampoo the residents hair later that day. At the time, she also indicated the resident's hair had looked greasy.</p> <p>On 6/13/14 at 9:35 a.m., the resident was observed in the Physical Therapy room, her hair appeared clean and fluffy, it was not slicked back away from her face.</p>				

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F000323 SS=D	<p>3.1-38a(3)(B) 3.1-38a(3)(E)</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, record review and interview, the facility failed to ensure adequate supervision was provided during transfers for 1 of 4 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Resident #111)</p> <p>Findings include:</p> <p>On 6/10/14 at 9:16 a.m., Resident #111 was seated in her room in her wheelchair. The resident's left lower leg was wrapped with an ace bandage. At 3:09 p.m., the resident's left lower leg was wrapped with a gauze dressing.</p> <p>The record for Resident #111 was reviewed on 6/11/14 at 9:04 a.m. The resident's diagnosis included, but was not limited to, muscle weakness.</p>	F000323	<p><b>F323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #111 is transferred via use of mechanical lift. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> A full facility audit of care directives will be conducted to ensure transfer status is accurate. Any questions regarding method of transfer will be directed to the rehab department for review. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education to be provided by DON and/or designee by July 4, 2014 for following care</p>	07/04/2014

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	<p>An entry in the Nursing progress notes dated 6/6/14 at 10:56 p.m., indicated a CNA was transferring the resident from her wheelchair to the bed when the resident's leg hit the side rail and a laceration was obtained. The Wound nurse inspected the laceration and determined the resident may need stitches. The Physician was notified and orders were received to send the resident to the hospital for evaluation and treatment. The resident left the facility at approximately 8:45 p.m.</p> <p>Documentation in the Nursing progress notes dated 6/7/14 at 7:31 a.m., indicated the resident returned to the facility at approximately 12:45 a.m. The resident had two skin tears to the left lower extremity and steri strips were in place.</p> <p>An interim care plan dated 6/5/14 indicated the resident was at risk for break in skin integrity and has break in skin integrity related to incontinence, pressure ulcer times 2, bruises, skin tears, laceration 6/6/14 and immobility. The interventions included, but were not limited to, mechanical lift for transfers and padding to bed rails.</p> <p>Review of the care directive sheet on 6/12/14 at 2:53 p.m., indicated the</p>		<p>directives in regards to proper transfer technique. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to ensure care directives are followed. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>resident was total care for transfers and a mechanical lift.</p> <p>Review of the incident follow-up and recommendation form dated 6/9/14, indicated the summary of investigative facts section indicated the resident sustained a skin tear to the left lower extremity during a transfer. Use a mechanical lift when transferring.</p> <p>Interview with CNA #4 on 6/12/14 at 2:47 p.m., indicated the resident was a 1-2 person assist. She indicated the resident's legs can give out at times but she can be transferred with 1 assist. The CNA indicated the resident was not a lift for transfers.</p> <p>Interview with the Director of Nursing (DoN) on 6/12/14 at 3:15 p.m., indicated the resident should have been a mechanical lift at the time of the transfer. The DoN indicated the interim care plan indicated the resident was to be a mechanical lift for transfers. The DoN also indicated the CNA had been counseled and was given an inservice on body mechanics. She also indicated that she was going to inform CNA #4 of the resident's transfer status.</p> <p>3.1-45(a)(2)</p>				

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regime was free from unnecessary drugs related to behavior monitoring and monitoring a resident with critical lab values related to anticoagulant use for 2 of 5 residents reviewed for unnecessary medications. (Residents #11 and #54)</p> <p>Findings include:</p>	F000329	<p><b>F329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #11 receives going monitoring for behaviors. Resident's plan of care reviewed with staff and education provided related to importance of behavior documentation utilizing behavior monitoring flowsheet and/or behavior log. The DON assessed resident #54 for sign and/or symptoms of bleeding with none</p>	07/04/2014	

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	<p>1. The record for Resident #11 was reviewed on 6/12/14 at 8:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, dementia, depression, and bipolar.</p> <p>Review of the Physician Orders with the original date of 12/20/11 and on the current 6/2014 recap indicated Zyprexa (an antipsychotic medication) 5 milligrams (mg) two times a day. Another Physician Order with the original date of 10/14/12 and on the current 6/2014 recap indicated Ativan (an antianxiety medication) 1 mg four times a day. A Physician Order with the original date of 8/22/11 and on the current 6/2014 recap indicated Remeron (an antidepressant medication) 30 mg at bed time. A Physician Order with the original date of 8/23/11 and on the current 6/2014 recap indicated Effexor 150 mg daily.</p> <p>Further review of the Physician Orders dated 5/30/14 indicated Lithium (an antipsychotic medication) 450 mg every morning and 300 mg every night.</p> <p>Review of the 4/21/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. He had short term and long</p>		<p>noted along with physician being notified with no new orders received. The follow up PT/INR was completed on 5/28 and Coumadin resumed as per physician order. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Full facility audit was completed by nursing administration related resident requiring use of anti-psychotic medications. This audit reviewed the behavior flow records to ensure behaviors were documented when exhibited. Full facility audit was completed by nursing administration related to residents with lab orders. The audit served as validation that follow up assessments were completed when required for any identified abnormal lab results. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education will be provided by the Staff Development Director to facility staff by July 4, 2014 regarding the importance of recognizing resident behaviors and the necessary documentation on the behavior log accessible to all staff. In addition, a separate in-service will be provided to nursing staff by the DON and/or designee in regards to documenting behaviors for</p>		

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	<p>term memory problems as well as some cognitive impairment. The resident needed extensive assist with two person physical assist with bed mobility, transfers, and locomotion. The resident was receiving seven days of an antipsychotic medication, seven days of an antianxiety medication, and seven days of an antidepressant medication.</p> <p>Review of the Social Service Progress Note dated 4/29/14 indicated the resident was cognitively impaired, and he had no mood or behavior problems. The resident was receiving Remeron and Effexor for depression. This was the only documented Social Service Note from 1/2014 through June 12, 2014</p> <p>Review of the Psychiatric Progress Notes indicated the resident was seen on a monthly basis by the Nurse Practitioner.</p> <p>Review of the Psychiatric Progress Note dated 3/14, 4/11 and 5/9/14 indicated "Social Service reports no behavior disturbances."</p> <p>Review of the Psychiatric Progress Note dated 5/30/14 indicated "Social Service reports increased anxiety, fidgeting, and restlessness on a daily basis.</p> <p>Review of the Behavior Monitoring</p>		<p>residents on anti-psychotic medication via the behavior monitoring flowsheet. Education will be provided to license nurses by the DON and/or designee by July 4, 2014 in regards to "Coumadin Side Effect Flowsheet". This flow record will validate per shift assessment and documentation of any unusual occurrence secondary of use to anti-coagulant therapy. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> The current behavior management meeting will be changed from the monthly to weekly and all flowsheets and logs will be reviewed at this time. During the change of condition meeting (M-F), physician orders related to psychotropic medications will be conveyed to the Social Service Director for implementation or revision of the behavior monitoring flowsheet and/or behavior log. Weekly random audits will be completed by nursing administration for the next 6 months on various shifts to observe a minimum of 5 residents to ensure the "Coumadin Side Effect Flowsheet" is completed every shift to validate assessment. Any issues identified will be immediately addressed and all meeting minutes from weekly behavior management meeting to be discussed and system components will be reviewed monthly by the QA</p>				

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	<p>Record for the months of October, November, and December 2013, and January, February, March, April, and May 2014 there was no evidence of any documentation regarding the behaviors the resident was exhibiting.</p> <p>Review of the Behavior/Intervention monitoring flow record for the months of January, February, March, and April indicated the flow record were either blank or of full of zeros.</p> <p>Review of the Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Ativan medication due to "The resident continues to show signs of anxiety and agitation noted. It is clinically contraindicated at this time."</p> <p>Review of the Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Effexor and Remeron due to "It is clinically contraindicated to reduce the medications. He still exhibits mood changes and a reduction may impair his daily functioning."</p>		Committee with subsequent plans of correction developed and implemented as deemed necessary.				

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	<p>Review of the Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Zyprexa medication due to "It is clinically contraindicated to reduce medication at this time, may impair his daily functioning.</p> <p>Review of the Pharmacy Consultant Recommendation dated 5/10/13 indicated the resident was receiving Lithium and Zyprexa (antipsychotic medications) since 2011, Ativan since 2012, Remeron since 2009, and Effexor since 2011. Please consider documenting that gradual dose reduction (GDR) is clinically contraindicated in this individual with bipolar, depression, and anxiety. The Physician's response was with a check mark to "GDR is clinically contraindicated for this individual as indicated below." At the bottom of the page there was documentation by the Assistant Director of Nursing dated 5/21/13 which indicated, "TO (Telephone Order) no change."</p> <p>Interview with the Director of Nursing on 6/12/14 at 10:20 a.m., indicated there have been no pharmacy recommendations to reduce any of his psychotropic medication since May of</p>				

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	<p>last year (2013). She further indicated Nursing staff were to document the resident's behaviors on the behaviors flow sheets and/or the behavior monitoring sheets that social service provided.</p> <p>Interview with the Social Service Director (SSD) on 6/12/14 at 10:25 a.m., indicated her only Social Service Progress Note was on 4/29/14. She further indicated Nursing staff were to document the resident's behaviors on the behavior monitoring sheets provided to them. She indicated the resident was seen on a monthly basis by the Psychiatric Nurse Practitioner.</p> <p>Interview with the SSD on 6/13/14 at 9:35 a.m., indicated she had a behavior monitoring system for residents with behaviors in place and the books were on the unit, so that Nursing staff can document what they see. She indicated the Psychiatric Nurse Practitioner had indicated a GDR was contraindicated due to his continuous behaviors of anxiety; however, the SSD indicated there was no evidence of documenting to support that recommendation.</p> <p>Interview with LPN #1 on 6/13/14 at 9:40 a.m., indicated when the resident had behaviors, she would document them</p>			

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	<p>on the behavior monitoring flow sheet in the Medication Administration Record (MAR) or on the behavior sheets. She further indicated she would only document a "true behavior of anxiety, like if he was trying to get up out of his chair or something like that. Otherwise sometimes he tries to talk to us and cannot get the words out and becomes anxious we just take him for a walk at that time, but I do not write that down."</p> <p>2. The record for Resident #54 was reviewed on 6/10/14 at 2:53 p.m. The resident was admitted to facility on 5/15/14. The resident's diagnoses included but were not limited to, septic shock, depression, high blood pressure, cancer, and cardiac arrhythmias.</p> <p>Review of the Physician Orders dated 6/9/14 indicated the resident was receiving Coumadin (a medication used to thin the blood) 3 milligrams (mg) daily.</p> <p>Review of the 5/15/14 Physician Orders indicated a PT/INR on 5/19/14 and then weekly.</p> <p>Review of the 5/23/14 laboratory results indicated the PT was 68.4 a critical value and the INR was 5.7 another critical value</p>				

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F000332 SS=E	<p>Review of the bottom of the lab result page indicated the resident's Physician was notified and to hold the Coumadin until 5/27/14 and repeat PT/INR. Give Vitamin K (a medication used to help clot the blood) Intramuscular today 10 mg times one dose.</p> <p>Review of the Nursing Progress Notes dated 5/23/14 indicated there was no information regarding the resident's critical PT or INR. There was no follow up assessment or documentation of the resident regarding the critical PT/INR.</p> <p>Interview with the DoN on 6/10/14 at 10:10 a.m., indicated all the Physician Orders were written on the bottom of the 5/23/14 lab sheet for the Coumadin and Vitamin K. She indicated there was no follow up assessment of the resident after the critical levels of the PT/INR.</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a</p>	F000332	<b>F332 What corrective action(s) will be accomplished for those residents found to have been</b>	07/04/2014			

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	<p>medication error rate of less than 5% was maintained for 3 of 5 residents observed during medication pass. Three errors were observed during 30 opportunities for errors during medication administration. This resulted in a medication error rate of 10%. (Residents #35, #31 and #66)</p> <p>Findings include:</p> <p>1. On 6/11/14 at 8:25 a.m., LPN #2 was observed administering medications to Resident #35. After the resident took his oral medications, the LPN indicated his Exelon (medication for dementia) 13.3 milligram (mg) patch needed to be changed. She removed the old patch from his back and applied the new one to his chest.</p> <p>The Physician Order Statement (POS) for June 2014 was reviewed on 6/11/14 at 9:00 a.m. The time the Exelon patch was to be applied was initially 8:30 a.m., this had been crossed out and 2:00 p.m. was written in. The Medication Administration Record (MAR) also had 8:30 a.m. crossed out and 2:00 p.m. written in.</p> <p>Interview with the LPN at that time indicated the time had been changed and the Exelon patch was supposed to be</p>		<p><b>affected by the deficient practice:</b> The physician and the family members were made aware of the medication errors for resident #35, #31, and #66. Orders were received and implemented for resident #31.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Per review of current resident medication administration records and interviews with LPN #2, RN #1, RN #2 no other residents were affected by the deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education was immediately provided to LPN #2, RN #1, and RN #2 related to timely administration of ordered medications by DON. Education for licensed nursing staff will be completed by July 4, 2014 on the five rights of medication administration by the Staff Development Coordinator. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Nursing administration to observe for the next 6 months 2 nurses weekly on medication administration pass. These audits will be conducted on various shifts and education immediately</p>				

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	<p>applied at 2:00 p.m.</p> <p>2. On 6/11/14 at 8:35 a.m., RN #1 was observed preparing medications for Resident # 31. She removed an Amlodipine (blood pressure medication) 10 mg tablet and placed it in the medication cup with his other medications. She took the pills to the resident and he swallowed them.</p> <p>The June 2014 POS was reviewed on 6/11/14 at 9:10 a.m. The POS indicated Amlodipine 5 mg one time daily. The MAR was reviewed at that time and also indicated Amlodipine 5 mg once daily. The medication cart was opened by the RN at that time and the box containing the residents Amlodipine was labeled 10 mg. The RN indicated a medication error had occurred.</p> <p>3. On 6/13/14 at 7:25 a.m., interview with RN #2 indicated she had already given Resident #66 his 8:30 a.m., medications. She indicated she had given them at 7:00 a.m., and medications should be given within one hour before or one hour after the scheduled time of 8:30 a.m.</p> <p>Review of the residents June 2014 POS indicated he was to receive Metoprolol (a blood pressure medication) 25 mg twice</p>		<p>provided as deemed necessary. All audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F000441 SS=D	<p>daily, Famotidine (medication to treat gastritis) 40 mg twice daily and Klor-Con (a mineral supplement) 25 meq twice daily at 8:30 a.m., and 8:30 p.m.</p> <p>Interview with the Director of Nursing on 6/13/14 at 7:50 a.m., indicated the medications were not given at the correct time.</p> <p>3.1-25(b)(9)</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>						

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to maintain infection control related to the storage of wash basins and urinals in resident rooms on 2 of 2 units. (North and South Units)</p> <p>Findings include:</p> <p>The North Unit:</p> <p>a. On 6/9/14 at 10:55 a.m., two pink wash basins were observed sitting on the floor by the sink and a urinal was observed hanging from the grab bar in Room 110, a shared bathroom. On 6/13/14 at 1:45 p.m., the urinal was observed hanging from the grab bar.</p>	F000441	<p><b>F441 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident wash basins and urinals are now stored in a sanitary manner in resident's rooms in accordance with facility policy. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Per completion of room audits, any unlabeled resident care equipment was immediately discarded and new items redistributed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Facility</p>	07/04/2014

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	<p>Two residents resided in this room. Four residents shared this bathroom.</p> <p>b. In Room 110, on 6/9/14 at 10:55 a.m., there was a plastic urinal without a lid sitting on the bedside table. On 6/13/14 at 1:45, there was a urinal without a lid sitting on the bedside table. Two residents resided in this room.</p> <p>The South Unit:</p> <p>a. In Room 223 on 6/10/14 at 9:18 a.m., a urinal without a lid was hanging from the side rail of the bed near the door. On 6/13/14 at 1:47 p.m., a urinal without a lid was sitting on the bedside table.</p> <p>Interview with the Housekeeping Supervisor on 6/13/14 at 1:00 p.m., indicated urinals and wash basins should be in plastic and stored underneath bedside tables when not in use.</p> <p>The policy titled Offering &amp; Removing the Urinal was received from the Director of Nursing on 6/13/14 at 2:10 p.m. The policy indicated, "29. Clean the urinal...Store the urinal. Do not leave it in the bathroom or on the floor", and "33. Clean and store the wash basin".</p> <p>3.1-18(j)</p>		<p>staff will be educated by the Staff Development Coordinator and/or DON by July 4, 2014 on proper storage of wash basin and urinals. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> For the next 6 months, department managers to complete weekly rounds on 5 resident rooms to validate proper storage wash basin and urinals. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to discolored floor tiles, marred and unpainted walls and missing baseboards on 2 of 2 units in the facility. (North and South Units)</p> <p>Findings include:</p> <p>During the Environmental Tour on 6/13/14 at 1:10 p.m., with the Maintenance and Housekeeping Supervisors and the Administrator, the following was observed on the North Unit:</p> <p>a. Rooms 105 and 107, shared bathroom was missing the baseboard behind the sink. Two residents resided in each room. Four residents shared this bathroom.</p> <p>c. In Room 110, the wall next to the bed was gouged and the caulking around the air conditioner was cracked. Two</p>	F000465	<p><b>F465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The baseboard has been replaced in the shared bathroom between rooms 105 and 107. The wall next to the bed in room 110 has been repaired along with the caulked replaced around the air conditioner. The baseboard behind sink in shared bathroom between room 114 and 116 has been replaced. The baseboard behind sink in shared bathroom between room 115 and 117 has been replaced also. The bathroom floor in rooms 201, 207, and 214 will be replaced by July 4, 2014. The holes in both the bathroom and the wall next to the window in room 223 have been repaired. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Environmental rounds have been completed by maintenance department and a plan has been</p>	07/04/2014			

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	<p>residents resided in this room.</p> <p>d. Rooms 114 and 116, shared bathroom was missing the baseboard behind the sink. Two residents resided in each room. Four residents shared this bathroom.</p> <p>e. Rooms 115 and 117, shared bathroom was missing the baseboard behind the sink. The wall behind the sink was unpainted on 6/9/14, it had since been painted. Two residents resided in each room. Four residents shared this bathroom.</p> <p>f. Room 101 on 6/9/14 at 11:28 a.m., the phone jack was observed hanging out of the wall causing a large hole. The Maintenance Supervisor indicated he repaired it on 6/9/14 when it was brought to his attention. Two residents resided in this room.</p> <p>During the Environmental tour on 6/13/14 at 1:00 p.m. with the Maintenance and Housekeeping Supervisors and the Administrator, the following was observed on the South Unit:</p> <p>a. Room 201 the bathroom floor was worn and discolored. The doorframe in the bathroom was chipped and marred on</p>		<p>put in place for identified issues and/or items to be replaced. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> The maintenance director will include identified areas in the preventive maintenance program and conduct routine rounds according to facility protocol. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Department managers to conduct resident room observation 5 times weekly and will report any maintenance related issues to the maintenance department upon identification of any concerns. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F000505 SS=D	<p>6/9/14 at 9:47 a.m.. The Maintenance Supervisor indicated it had since been painted. Two residents resided in this room.</p> <p>b. Room 207 the bathroom floor tile was worn and discolored. Two residents resided in this room.</p> <p>c. Room 214 the bathroom floor tile was worn and discolored. Two residents resided in this room .</p> <p>d. Room 223, there were four small holes in the bathroom wall where something had been screwed into the wall. There were also screws in the wall next to the window. Two residents resided in this room.</p> <p>The Maintenance and Housekeeping Supervisors indicated the above items were in need of repair.</p> <p>3.1-10(f)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview,</p>	F000505	<b>F505 What corrective action(s) will be accomplished for those</b>	07/04/2014			

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	<p>the facility failed to ensure the resident's Physician was promptly notified of abnormal lab values related to a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP) for 1 of 5 residents reviewed for Unnecessary Medications. (Resident #54)</p> <p>Findings include:</p> <p>1. The record for Resident #54 was reviewed on 6/10/14 at 2:53 p.m. The resident was admitted to facility on 5/15/14. The resident's diagnoses included but were not limited to, septic shock, depression, high blood pressure, cancer, and cardiac arrhythmias.</p> <p>Review of the Physician Orders dated 5/15/14 indicated a CBC and CMP on 5/19/14.</p> <p>Review of the lab results indicated the CBC and CMP were completed on 5/21/14.</p> <p>Review of the CBC indicated the resident's Red Blood Cell, Hemoglobin, and Hematocrit were all below normal levels. The CMP indicated the Carbon Dioxide was elevated.</p> <p>Interview with the Director of Nursing on</p>		<p><b>residents found to have been affected by the deficient practice:</b> Resident #54's physician was notified of lab results. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> The lab provider for the facility completed a full facility audit of all ordered lab work to ensure tests were completed as ordered and physician notification was complete. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education will be provided to licensed nurses in regards to the lab process and the "Diagnostic Services" policy, as related to physician notification by the DON and/or designee by July 4, 2014. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> For the next 6 months, nursing administration to complete lab audits 3 times weekly to ensure timely completion of ordered labs as well as physician notification in a timely manner. Any issues identified will be immediately addressed and all audit results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of</p>				

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F000520 SS=D	<p>6/10/14 at 10:10 a.m., indicated the resident had refused the lab draw on 5/19/14. The lab tech rescheduled the draw for 5/21/14. She indicated this was the first time Nursing staff had reviewed those labs. She further indicated the Physician was not notified of the labs timely.</p> <p>3.1-49(e)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will</p>		correction developed and implemented as deemed necessary.		

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	<p>not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to identify non-compliance for the use of unnecessary medications related to not identifying behavior monitoring as a concern through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Executive Director (ED) on 6/13/14 at 2:55 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, the Assistant Director of Nursing, Staffing, Medical Records, Rehab, Social Service, Dietary, Activities, Nursing, as well as the Medical Director. The ED indicated at the time, unnecessary medications related to the monitoring of behaviors had not been discussed, addressed or identified as being a problem in Quality Assurance.</p> <p>The record for Resident #11 was reviewed on 6/12/14 at 8:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, dementia, depression, and bipolar.</p> <p>Review of Physician Orders with the original date of 12/20/11 and on the</p>	F000520	<p><b>F520 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The facility's QA process has now been amended to include discussion of behavior monitoring/unnecessary medication. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> Minutes from the newly implemented weekly behavior management meeting will be brought to the monthly QA Meeting for review and recommendations by QA committee members. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> Education to be provided to the IDT team/QA committee members on the revised agenda for the discussion of behavior monitoring/unnecessary medication. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> The change to this QA process will be ongoing with revisions made as required. Any issues identified will be immediately addressed and all results will be discussed and system components will be</p>	07/04/2014	

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	<p>current 6/2014 recap indicated Zyprexa (an antipsychotic medication) 5 milligrams (mg) two times a day. Another Physician Order with the original date of 10/14/12 and on the current 6/2014 recap indicated Ativan (an antianxiety medication) 1 mg four times a day. A Physician Order with the original date of 8/22/11 and on the current 6/2014 recap indicated Remeron (an antidepressant medication) 30 mg at bed time. A Physician Order with the original date of 8/23/11 and on the current 6/2014 recap indicated Effexor 150 mg daily.</p> <p>Further review of Physician Orders dated 5/30/14 indicated Lithium (an antipsychotic medication) 450 mg every morning and 300 mg every night.</p> <p>Review of the 4/21/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident was not alert and oriented. He had short term and long term memory problems as well as some cognitive impairment. The resident needed extensive assist with two person physical assist with bed mobility, transfers, and locomotion. The resident was receiving seven days of an antipsychotic medication, seven days of an antianxiety medication, and seven days of an antidepressant medication.</p>		<p>reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>Review of the Social Service Progress Note dated 4/29/14 indicated the resident was cognitively impaired, and he had no mood or behavior problems. The resident was receiving Remeron and Effexor for depression. This was the only documented Social Service Note from 1/2014 through June 12, 2014</p> <p>Review of the Psychiatric Progress Notes indicated the resident was seen on a monthly basis by the Nurse Practitioner.</p> <p>Review of the Psychiatric Progress Note dated 3/14, 4/11 and 5/9/14 indicated "Social Service reports no behavior disturbances."</p> <p>Review of the Psychiatric Progress Note dated 5/30/14 indicated "Social Service reports increased anxiety, fidgeting, and restlessness on a daily basis."</p> <p>Review of the Behavior Monitoring Record for the months of October, November, and December 2013, and January, February, March, April, and May 2014 there was no evidence of any documentation regarding the behaviors the resident was exhibiting.</p> <p>Review of the Behavior/Intervention monitoring flow record for the months of</p>						

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	<p>January, February, March, and April indicated the flow record were either blank or of full of zeros.</p> <p>Review of Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Ativan medication due to "The resident continues to show signs of anxiety and agitation noted. It is clinically contraindicated at this time."</p> <p>Review of Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Effexor and Remeron due to "It is clinically contraindicated to reduce the medications. He still exhibits mood changes and a reduction may impair his daily functioning."</p> <p>Review of Psychiatric Specialty Group Gradual Dose Reduction (GDR) information prepared by the Nurse Practitioner indicated a GDR was not recommended at that time for the Zyprexa medication due to "It is clinically contraindicated to reduce medication at this time, may impair his daily functioning."</p>			

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	<p>Review of the Pharmacy Consultant Recommendation dated 5/10/13 indicated the resident was receiving Lithium and Zyprexa (antipsychotic medications) since 2011, Ativan since 2012, Remeron since 2009, and Effexor since 2011. Please consider documenting that gradual dose reduction (GDR) is clinically contraindicated in this individual with bipolar, depression, and anxiety. The Physician's response was with a check mark to "GDR is clinically contraindicated for this individual as indicated below." At the bottom of the page there was documentation by the Assistant Director of Nursing dated 5/21/13 which indicated, "TO (Telephone Order) no change."</p> <p>Interview with the Director of Nursing on 6/12/14 at 10:20 a.m., indicated there have been no pharmacy recommendations to reduce any of his psychotropic medication since May of last year (2013). She further indicated Nursing staff were to document the resident's behaviors on the behaviors flow sheets and/or the behavior monitoring sheets that social service provided.</p> <p>Interview with the Social Service Director (SSD) on 6/12/14 at 10:25 a.m.,</p>				

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	<p>indicated her only Social Service Progress Note was on 4/29/14. She further indicated Nursing staff were to document the resident's behaviors on the behavior monitoring sheets provided to them. She indicated the resident was seen on a monthly basis by the Psychiatric Nurse Practitioner.</p> <p>Interview with the SSD on 6/13/14 at 9:35 a.m., indicated she had a behavior monitoring system for residents with behaviors in place and the books were on the unit, so that Nursing staff can document what they see. She indicated the Psychiatric Nurse Practitioner had indicated a GDR was contraindicated due to his continuous behaviors of anxiety; however, the SSD indicated there was no evidence of documenting to support that recommendation.</p> <p>Interview with LPN #1 on 6/13/14 at 9:40 a.m., indicated when the resident had behaviors, she would document them on the behavior monitoring flow sheet in the Medication Administration Record (MAR) or on the behavior sheets. She further indicated she would only document a "true behavior of anxiety, like if he was trying to get up out of his chair or something like that. Otherwise, sometimes he tries to talk to us and cannot get the words out and becomes</p>						

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F009999	<p>anxious, we just take him for a walk at that time, but I do not write that down."</p> <p>Further interview with the Executive Director (ED) on 6/13/14 at 2:55 p.m., indicated, behavior meetings are held monthly, however, the monitoring of behaviors had not been discussed due to it not being identified as a concern.</p> <p>3.1-52(b)(2)</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the State survey and certification agency.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the facility's Administration was notified immediately regarding an unusual occurrence related to a resident choking. (Resident #82)</p>	F009999	<p><b>9999 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The nurse caring for resident #82 is no longer employed at this facility. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</b> As per review of 24-hour clinical reports 30 days prior to the incident, there were no other identified resident incidents categorized as Level 3 or 4. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> The licensed nursing staff will receive re-education by July 4, 2014 from</p>	07/04/2014			

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	<p>Findings include:</p> <p>The record for Resident #82 was reviewed on 6/13/14 at 11:00 a.m. The resident was originally admitted on 10/5/12. Her diagnoses included, but were not limited to, congestive heart failure, vascular dementia with depressive mood, anxiety, muscle weakness, and oral phase dysphasia.</p> <p>Review of the Incident Report Form dated 5/19/14 indicated, "...at approximately 1:20 a.m., Resident #82 was eating a peanut butter and jelly sandwich and began to choke. Staff performed the Heimlich Maneuver (an emergency technique for preventing suffocation when a person's airway (windpipe) becomes blocked by a piece of food or other object) on resident, called Code Blue (medical emergency) and 911. Cardiopulmonary Resuscitation (CPR) was initiated on resident by staff until paramedics arrived to take over CPR. Resident was taken to hospital for further care. Family and Physician notified of incident." There was no evidence of documentation indicating the facility's Administration was notified.</p> <p>Review of the Resident Progress Note dated 5/19/14 at 2:26 a.m., indicated at</p>		<p>the DON and/or designee on the facility policy regarding "Incident Levels &amp; Notification Protocols".</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b> Nurse Management Team to continue monitoring for physician/family notification as well as timely notification of facility leadership (ED/DON) during the Change of Condition meeting. This meeting takes place Monday – Friday with oversight on Saturday and Sunday. This process will continue indefinitely. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>1:20 a.m., the resident was observed wandering in and out of another resident's room. She was brought near the nurse's station and offered a half a peanut butter and jelly sandwich and a drink. After she finished the sandwich, she coughed weakly and was not responding appropriately. Heimlich Maneuver performed times 3, but resident still was not responding. She was laid flat on the floor, CPR initiated, Automated external defibrillator (AED) applied, and 911 notified and here momentarily. CPR continued and was intubated per paramedics and resident was transported to the Emergency Room (ER). Primary contact, daughter notified. There was no evidence of documentation indicating the facility's Administration was notified.</p> <p>Review of the Incident Levels and Notification Protocols, Chapter 3, Level III Response Protocols indicated, "4. Notify the Director of Nursing (DoN) and Executive Director (ED) Immediately. The supervisor notifies the DoN or designee and the ED of the incident immediately."</p> <p>Interview with the ED on 6/13/14 at 2:13 p.m., indicated RN #3 was the Charge Nurse on 5/19/14 and did not notify her of the incident until 5/19/14 at 8:22 a.m. She further indicated RN #3 was</p>						

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	terminated on 5/21/14 for not following facility policy related to immediate notification of Physician and/or facility Administration.  3.1-28				