

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2016
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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 6, 7, 8, 9 and 10, 2016</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicaid: 73 Other: 1 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on June 14, 2016.</p>	F 0000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited.</p> <p>However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>Plan of Compliance is effective: June 25, 2016</p>	
F 0247 SS=D Bldg. 00	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in</p>			

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

TITLE

(X6) DATE

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

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	<p>the facility is changed.</p> <p>Based on interview and record review, the facility failed to notify a resident prior to a room change for 1 of 3 residents interviewed for room change and transfers (Resident #81).</p> <p>Findings include:</p> <p>During an interview, on 6/6/16 beginning at 10:09 a.m., Resident #81 indicated she had been transferred to another room in the facility the previous Saturday. Resident #81 indicated she had not been notified prior to the transfer and was only told that a new resident would be moving into that room, She also indicated she had been told that day that the new roommate was the same age as the two other residents in the room. She indicated she was given the choice between two new roommates in two different rooms, who were closer to her in age. She further indicated her close friend resided next door to her previous room, and she now had to come from another unit to visit with her.</p> <p>Review of Resident #81's clinical record began on 6/6/16 at 2:33 p.m. A progress note, dated 6/5/16 at 4:30 p.m., indicated the resident was tolerating her room change well. There was no documentation prior to that date</p>	F 0247	<p>F247D Notification of Room Changes Corrective action for affected resident: Room change notification made to resident #81, guardian and physician. Identification of others at risk: All residents who change rooms and/or roommates have the potential to be affected. An audit was completed and no residents were identified. Measures to ensure this deficient practice does not recur: Staff re-educated on room and roommate change notifications prior to room moves and change in roommate. Monitoring of corrective action: An audit of 2 room or roommate changes will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, and monthly for 6 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p>	06/25/2016			

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	<p>regarding the resident changing rooms.</p> <p>A "Discharge & Transfer-ELC-Notification of Room change" document, dated 6/6/16 at 2:58 p.m., indicated Resident #81's guardian was notified of the room change on 6/6/16 and the room change had occurred at the resident's request on 6/4/16 at 1:24 p.m. The area of the document titled, "Documentation and Outcome of Advance Notification", was left blank and indicated at the signature line "Nursing Completed".</p> <p>During an interview, on 6/9/16 at 1:57 p.m., the Social Services Director (SSD) indicated she was not at the facility on the Saturday Resident #81 was moved. She further indicated she was told to complete the room change paperwork on the Monday following the resident's move. She indicated she was under the impression Resident #81 had requested the move herself due to the other residents in the room being younger than her, but she had not spoken to the resident about it directly.</p> <p>During an interview, on 6/9/16 at 2:41 p.m., Speech Therapist (ST) #9 indicated she had been the manager on duty the weekend Resident #81 had changed rooms. She further indicated Resident</p>			

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F 0248 SS=D Bldg. 00	<p>#81 had changed rooms due to a new resident moving into Resident #81's room that day, but Resident #81 had asked to move. She further indicated Resident #81 was given a choice between two other rooms and roommates, or they could have moved another bed into her previous room, indicating there had not been a fourth bed in the room. She indicated she had assumed the nurses would have completed the proper notifications for the room change, and could not provide documentation showing the room change had occurred at the resident's request.</p> <p>On 6/10/16 at 12:20 p.m., the SSD indicated the facility followed state guidelines requiring advance notification for room changes.</p> <p>3.1-3(v)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and</p>	F 0248	F 248D Activities Corrective action for affected resident:	06/25/2016

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	<p>record review, the facility failed to provide activities programs for 2 of 2 cognitively impaired residents reviewed for activities (Residents #82 and #58).</p> <p>Findings include:</p> <p>1. On 6/6/16 at 1:54 p.m., Resident #82 was awake in bed. A small T.V. was on across the room, partially covered by the privacy curtain.</p> <p>On 6/7/16 at 8:52 a.m., Resident #82 was awake in bed. The privacy curtain was pulled around her bed.</p> <p>On 6/7/16 at 1:17 a.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>On 6/8/16 at 2:18 p.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>On 6/8/16 at 3:10 p.m., Resident #82 remained in bed, awake and looking toward a balloon on her feeding pump.</p> <p>On 6/9/16 at 7:53 a.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>On 6/9/16 at 9:09 a.m., Resident #82 was seated in her wheelchair in her room. A</p>		<p>Activity preferences reviewed for Residents #58 and #82 and care plans updated as needed</p> <p>Identification of others at risk: Activity preferences for all residents reviewed and care plan updated as needed</p> <p>Measures to ensure this deficient practice does not recur: Staff re-educated on honoring all resident choices and activity preferences and providing these programs.</p> <p>Monitoring of corrective action: An audit of activity in individual rooms and groups will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, and monthly for 6 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p>	

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	<p>small T.V. was on across the room.</p> <p>On 6/9/16 at 10:40 a.m., Resident #82 was seated in her wheelchair in the small dining room during a music and dancing activity with 13 other residents. She was chewing on the fingers of her left hand with a tambourine in her lap and her feeding pump was plugged into the wall behind her. Three staff members were alternating twirling some of the other resident's wheelchairs to the music. At 10:48 a.m., Resident #82 remained in the same area of the room with her tube feeding pump plugged in to the wall. A staff member approached her and moved her wheelchair briefly side-to-side, and then returned to the other residents in the room.</p> <p>On 6/9/16 at 1:22 p.m., Resident #82 was awake in bed. The privacy curtain was pulled around her bed. A small T.V. was on across the room.</p> <p>On 6/9/16 at 2:44 p.m., Resident #82 was being propelled in her wheelchair from the shower room back to her room.</p> <p>On 6/10/16 at 8:44 a.m., Resident #82 was seated in her wheelchair next to her bed. The privacy curtain was pulled around the bed. A small T.V. was on across the room.</p>						

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	<p>On 6/10/16 at 9:06 a.m., Resident #82 was seated in her wheelchair next to her bed, with her roommate sitting beside her. A small T.V. was on across the room with the volume low.</p> <p>On 6/10/16 at 12:14 p.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>Review of Resident # 82's clinical record began on 6/6/16 at 1:59 p.m. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disabilities, failure to thrive, and expressive language disorder.</p> <p>Resident #82 had an admission Minimum Data Set assessment, dated 5/17/16, which indicated she was rarely or never understood and rarely or never made decisions. The assessment further indicated she was totally dependant on others for mobility.</p> <p>Review of an activity assessment, dated 5/18/16, indicated Resident #82 liked having books read to her. It further indicated she would receive one on one visits to evaluate her likes and dislikes, as well as attending small group activities.</p> <p>Resident #82 had a current activities</p>			

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	<p>careplan, indicating the need for assistance to become familiar with staff, peers, routines, and the facility. It further indicated to include Resident #82 in a variety of activities and social interactions to help familiarize her with her environment.</p> <p>Review of activity's reports, since Resident #82's admission on 5/10/16, indicated the following activities on the following dates:</p> <p>Read a book to her: 5/19, 5/21, and 6/3.</p> <p>One-on-one visit: 5/23, 6/1, and 6/7.</p> <p>Watched a movie: 5/27 and 6/5.</p> <p>Outdoor walk: 6/1.</p> <p>Nails painted: 6/6.</p> <p>Music: 6/9.</p> <p>2. On 6/8/16 at 3:10 p.m. Resident #58 was awake in bed. A small T.V. was on near her bed.</p> <p>On 6/9/16 at 7:53 a.m., Resident #58 was awake in bed. A small T.V. was on near her bed.</p> <p>On 6/9/16 at 9:09 a.m., Resident #58 was</p>			

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	<p>up in her wheelchair next to her bed. A small T.V. was on near her bed.</p> <p>On 6/9/16 at 10:40 a.m., Resident #58 was seated in her wheelchair in the small dining room during a music and dancing activity with 13 other residents. She was holding a small bell in her hand, but was not moving it.</p> <p>On 6/9/16 at 1:22 p.m., Resident #58 was awake in bed. A small T.V. was on near her bed.</p> <p>On 6/10/16 at 8:44 a.m., Resident #58 was in bed awake. The privacy curtain was pulled around her bed.</p> <p>On 6/10/16 at 9:06 a.m., Resident #58 was seated in her wheelchair, next to her roommate and her roommate's bed. A small T.V. was on near her bed across the room with the volume low.</p> <p>On 6/10/16 at 12:14 p.m., Resident #58 was up in her wheelchair next to her bed. A small T.V. was on near her bed.</p> <p>Review of Resident #58's clinical record began on 6/6/16 at 2:03 p.m. Diagnoses included, but were not limited to, diffuse traumatic brain injury, profound intellectual disabilities, quadriplegia, blindness in both eyes, and aphasia.</p>			

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	<p>Resident #58 had an admission Minimum Data Set assessment, dated 5/17/16, which indicated she was rarely or never understood and rarely or never made decisions. The assessment further indicated she was totally dependant on others for mobility.</p> <p>Resident #58 had a current activities careplan, indicating the need for interaction with others to promote social and sensory stimulation.</p> <p>Resident #58 had a current careplan problem of legal blindness with risk for sensory deprivation. Interventions included, but were not limited to, using tactile stimulation and encouraging vocalizations.</p> <p>Review of activity's reports, for May through June 9, 2016, indicated participation in the following activities on the following dates:</p> <p>Read a book to her: 5/4, 5/19, 5/20, 5/21, 6/5, and 6/9.</p> <p>Outdoor walk: 5/21 and 6/1.</p> <p>Music: 5/31, 6/6, and 6/9.</p> <p>Nails painted: 6/6.</p>			

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	<p>Watched a movie: 6/5.</p> <p>Review of an activity report, dated 5/6/16, indicated Resident #58 participated in coloring a picture of a flower garden using rainbow colors. The note further indicated the activity provided Resident #82 with education on the colors of the rainbow. There was no indication how long the resident had been in any activity.</p> <p>Review of an activity report, dated 5/9/16, indicated Resident #58 participated in coloring and painting a patriotic themed craft.</p> <p>During an interview, on 6/10/16 at 1:08 p.m., the Activity Director indicated she had not had the opportunity to review the activity careplans for residents since taking over the position. She indicated it would be her responsibility to update the care plans, but since she had just started in this position on 5/18/16, she hadn't started on them yet.</p> <p>During an interview, on 6/10/16 at 1:17 p.m., Activity Aide #13 indicated Resident #82 enjoyed musical activities and being outside. She further indicated Resident #58 couldn't grip or hold things and was dependant on others to do these</p>			

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F 0250 SS=D Bldg. 00	<p>things for her. She indicated Resident #58 could grasp things, but needed help with movement, and only recently had she realized the resident was blind. She further indicated since Resident #82 and Resident #58 were in school during the school year, the staff did quieter activities like reading due to being close to bedtime. She indicated the residents' activities had not been modified since school had ended for the year.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident on anti-psychotic and psychopharmacological medications had a monitoring and management program with specific target behaviors and effective interventions in place for 1 of 5 residents reviewed for behaviors. (Resident #55)</p> <p>Findings include:</p>	F 0250	<p>F 250D Social Services Corrective action for affected resident: Behavior tracking log and effective interventions implemented for Resident #55. Care plan updated as needed. Gradual Dosage Reduction of Naltraxone implemented per physician's order. Care Plan reviewed and updated as needed. Identification of others at risk: All residents receiving psychoactive medication have the potential to be affected.</p>	06/25/2016

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	<p>Resident #55's clinical record was reviewed on 6/8/16 at 8:20 a.m. Diagnoses included, but were not limited to, spastic diplegic cerebral palsy, profound intellectual disabilities, intermittent explosive disorder, anxiety and agitation. The Quarterly Minimum Data Set Assessment, dated 3/31/16, indicated the resident was severely cognitively impaired.</p> <p>Resident #55 had current physician's orders for the following psychoactive medication: ordered 3/1/16, sertraline 50 mg (anti-depressant medication) 1 tablet daily for anxiety and agitation.</p> <p>During an interview on 6/10/16 at 9:13 a.m., the Social Service Director (SSD) indicated she realized on 6/9/16 that Resident #55 did not have a behavior tracking for sertraline, anxiety or agitation.</p> <p>A current care plan, dated 5/18/15, indicated "I am at risk for adverse consequences of my anti-psychotic medications for treatment of SIB [self injury behaviors]....I was started on Revia and Cogentin by [name of physician] on 8/20/13....3/1/16 Added Zolof 50 mg." Interventions included, but were not limited to, "assess and record</p>		<p>Behavior tracking logs and intervention strategies reviewed and updated for residents requiring behavior monitoring. Care plans updated as needed. Measures to ensure this deficient practice does not recur: The interdisciplinary team members were re-educated on behavior management, including but not limited to Gradual Dose Reduction of pharmacological medications, utilization/management/ monitoring of behavior tracking sheets and evaluation of intervention effectiveness.</p> <p>Monitoring of corrective action: An audit of 2 residents behavior management programs that includes last gradual dose reduction date, behavior tracking logs and intervention strategies will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, and monthly for 6 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p>	

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	<p>effectiveness of drug, attempt gradual dose reduction, monitor resident's behavior and response to medication and pharmacy consultant review."</p> <p>Review of the current facility policy, dated 4/15/13, titled "Behavior Assessment and Management ", provided by the SSD on 6/10/16 at 2:35 p.m., included, but was not limited to, the following:</p> <p>"It is important to understand causes of behavior problems in our residents. Examples of behavior problems can include a depressed resident withdrawing from other people, an agitated resident shouting repeatedly, an agitated resident hitting someone, or a confused resident wandering from his or her unit.</p> <p>...The behavior monitoring form assists in identifying the types of behaviors, time of day behavior occurred, how many times behavior occurs and can be utilized in determining potential dose reduction or discontinuation of antipsychotic, or other psychoactive medications.</p> <p>Care planning of resident behaviors: ...Once behaviors have been assessed, the next step is to develop a resident-specific care plan....</p>			

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F 0280 SS=D Bldg. 00	<p>...goal is to identify what is causing behaviors and address that cause.</p> <p>Review of the current facility policy, dated 12/1/07, titled "Psychopharmacological Medication Use", provided by the SSD on 6/10/16 at 2:35 p.m., included, but was not limited to, the following:</p> <p>"Procedure:</p> <ol style="list-style-type: none"> 1. Facility should comply with the Psychopharmacologic Dosage Guideline created by the Centers for Medicare and Medicaid Services ("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions. 2. Facility staff should monitor the resident's behavior pursuant to Facility policy using behavioral monitoring chart or behavioral assessment...." <p>3.1-34(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or</p>						

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	<p>changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure revisions were completed to individualize plans of care for activities programs for 2 of 2 residents reviewed for activities (Resident #82 and Resident #58).</p> <p>Findings include:</p> <p>1. On 6/6/16 at 1:54 p.m., Resident #82 was awake in bed. A small T.V. was on across the room, partially covered by the privacy curtain.</p> <p>On 6/7/16 at 8:52 a.m., Resident #82 was awake in bed. The privacy curtain was pulled around her bed.</p> <p>On 6/7/16 at 1:17 a.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p>	F 0280	<p>F 280D Care plans, revisions</p> <p>Corrective action for affected resident: Activity care plans for Residents # 58 and #82 have been reviewed and updated.</p> <p>Identification of others at risk: All residents have the potential to be affected. Residents activity care plans have been reviewed and updated as needed.</p> <p>Measures to ensure this deficient practice does not recur: The Interdisciplinary team members have been</p>	06/25/2016

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	<p>On 6/8/16 at 2:18 p.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>On 6/8/16 at 3:10 p.m., Resident #82 remained in bed, awake and looking toward a balloon on her feeding pump.</p> <p>On 6/9/16 at 7:53 a.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>On 6/9/16 at 9:09 a.m., Resident #82 was seated in her wheelchair in her room. A small T.V. was on across the room.</p> <p>On 6/9/16 at 10:40 a.m., Resident #82 was seated in her wheelchair in the small dining room during a music and dancing activity with 13 other residents. She was chewing on the fingers of her left hand with a tambourine in her lap and her feeding pump was plugged into the wall behind her. Three staff members were alternating twirling some of the other resident's wheelchairs to the music. At 10:48 a.m., Resident #82 remained in the same area of the room with her tube feeding pump plugged in to the wall. A staff member approached her a moved her wheelchair briefly side-to-side, and then returned to the other residents in the room.</p>		<p>re-educated on the initiation and revision to individualize plans of care for activities</p> <p>Monitoring of corrective action: An audit of activity care plans will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, and monthly for 6 months. The audits will be ongoing with the results reported and further recommendations made through the Quality Assurance Committee monthly.</p>	

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	<p>On 6/9/16 at 1:22 p.m., Resident #82 was awake in bed. The privacy curtain was pulled around her bed. A small T.V. was on across the room.</p> <p>On 6/9/16 at 2:44 p.m., Resident #82 was being propelled in her wheelchair from the shower room back to her room.</p> <p>On 6/10/16 at 8:44 a.m., Resident #82 was seated her wheelchair next to her bed. The privacy curtain was pulled around the bed. A small T.V. was on across the room.</p> <p>On 6/10/16 at 9:06 a.m., Resident #82 was seated in her wheelchair next to her bed, with her roommate sitting beside her. A small T.V. was on across the room with the volume low.</p> <p>On 6/10/16 at 12:14 p.m., Resident #82 was awake in bed. A small T.V. was on across the room.</p> <p>Review of Resident # 82's clinical record began on 6/6/16 at 1:59 p.m. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disabilities, failure to thrive, and expressive language disorder.</p> <p>Resident #82 had an admission Minimum Data Set assessment, dated 5/17/16,</p>			

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	<p>which indicated she was rarely or never understood and rarely or never made decisions. The assessment further indicated she was totally dependant on others for mobility.</p> <p>Review of an activity assessment, dated 5/18/16, indicated Resident #82 liked having books read to her. It further indicated she would receive one on one visits to evaluate her likes and dislikes, as well as attending small group activities.</p> <p>Resident #82 had a current activities careplan, indicating the need for assistance to become familiar with staff, peers, routines, and the facility. It further indicated to include Resident #82 in a variety of activities and social interactions to help familiarize her with her environment. Interventions included, but were not limited to, explaining the activity and asking if she would like to attend, hand-in-hand assistance, and encouraging interaction with others.</p> <p>2. On 6/8/16 at 3:10 p.m. Resident #58 was awake in bed. A small T.V. was on near her bed.</p> <p>On 6/9/16 at 7:53 a.m., Resident #58 was awake in bed. A small T.V. was on near her bed.</p>			

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	<p>On 6/9/16 at 9:09 a.m., Resident #58 was up in her wheelchair next to her bed. A small T.V. was on near her bed.</p> <p>On 6/9/16 at 10:40 a.m., Resident #58 was seated in her wheelchair in the small dining room during a music and dancing activity with 13 other residents. She was holding a small bell in her hand, but was not moving it.</p> <p>On 6/9/16 at 1:22 p.m., Resident #58 was awake in bed. A small T.V. was on near her bed.</p> <p>On 6/10/16 at 8:44 a.m., Resident #58 in bed awake. The privacy curtain was pulled around her bed.</p> <p>On 6/10/16 at 9:06 a.m., Resident #58 was seated in her wheelchair, next to her roommate and her roommate's bed. A small T.V. was on near her bed across the room with the volume low.</p> <p>On 6/10/16 at 12:14 p.m., Resident #58 was up in her wheelchair next to her bed. A small T.V. was on near her bed.</p> <p>Review of Resident #58's clinical record began on 6/6/16 at 2:03 p.m. Diagnoses included, but were not limited to, diffuse traumatic brain injury, profound intellectual disabilities, quadriplegia,</p>			

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	<p>blindness in both eyes, and aphasia.</p> <p>Resident #58 had an admission Minimum Data Set assessment, dated 5/17/16, which indicated she was rarely or never understood and rarely or never made decisions. The assessment further indicated she was totally dependant on others for mobility.</p> <p>Resident #58 had a current activities careplan, indicating the need for interaction with others to promote social and sensory stimulation. Interventions included, but were not limited to, taking Resident #58 to card and board games, arts and crafts, video games, computer time, and showing her pictures.</p> <p>Resident #58 had a current careplan problem of legal blindness with risk for sensory deprivation. Interventions included, but were not limited to, using tactile stimulation and encouraging vocalizations.</p> <p>During an interview, on 6/1016 at 1:08 p.m., the Activity Director indicated she had not had the opportunity to review the activity careplans for residents since taking over the position. She indicated she had started the position on 5/18/16.</p> <p>3.1-35(d)(2)(B)</p>			

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F 0322 SS=E Bldg. 00	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received proper administration of medications via gastrostomy tube for 1 of 7 residents observed for medication administration (Resident #6). The facility also failed to ensure residents received proper administration of water via gastrostomy tube for 2 of 3 residents reviewed for tube feedings (Residents #9 and #43).</p> <p>Findings include:</p> <p>1. During a medication administration</p>	F 0322	<p>F322E-NG</p> <p>Treatment/Services Corrective action for affected resident: Residents #6 (no Resident #6 listed on resident identifier; this is actually resident #76), #9, and #43 have been assessed with no adverse effects identified.</p> <p>Identification of others at risk: All residents receiving medication or water administration via gastrostomy tube have the potential to be affected. Identified residents have been assessed with no adverse effects identified.</p> <p>Measures to ensure this deficient practice does not recur: Licensed nurses have been re-educated on proper</p>	06/25/2016

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	<p>observation on 6/8/16 that began at 8:00 A.M., LPN #1 combined crushed medications and Miralax powder into an unmarked plastic cup. LPN #1 then poured water into the same cup with the medications. She did not measure how much water was poured in. LPN #1 then poured 30 milliliters (ml) of water into a cup marked with ml measurements. LPN #1 then walked into Resident #6's room.</p> <p>LPN #1 washed her hands and donned gloves. She removed an extension tube with an attached 60 ml. syringe and plunger from a plastic bag hanging on a pole. She then approached Resident #6 and attached the extension tube to his gastrostomy tube (g-tube).</p> <p>LPN #1 used the syringe and plunger and drew up about 40 ml of air. She then attached the syringe to the extension tube. She placed her stethoscope on the left side of Resident #6's g-tube site. She then pushed the plunger down into the syringe. LPN #1 clamped the extension tube. She then removed the plunger from the syringe.</p> <p>LPN #1 poured 30 ml of water into the syringe. She unclamped the extension tube and allowed the water to flow by gravity into Resident #6's g-tube.</p>		<p>medication and water administration via gastrostomy tube and verified by the Director of Nursing or designee by return demonstration. Monitoring of corrective action: A random audit of medication and water administration will be completed 3 times a week for 4 weeks, one time a week for 4 weeksthen monthly for 6 months. Results of the audits will be ongoing withthe results reported through the Quality Assurance Committee monthlyfor further review and recommendation</p>				

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	<p>LPN #1 poured the water with medications into the syringe. She then placed the plunger into the syringe and began to push on it. The water with medications did not flow into Resident #6's g-tube.</p> <p>LPN #1 removed the syringe from the extension tube. Water with medications spilled on to Resident #6's pants. LPN #1 then re-attached the syringe to the extension tube. She then used the plunger to push the water with medications. Some of the water with medications spilled on the floor. The remaining water with medications flowed by gravity into Resident #6's g-tube . LPN #1 clamped the extension tubing.</p> <p>LPN #1 left Resident #6's room and indicated she forgot the last 30 ml of water to flush Resident #6's g-tube. LPN #1 then poured water into an unmarked plastic cup. She did not measure the water.</p> <p>LPN #1 walked back into Resident #6's room, unclamped the extension tube and poured the water into the tube. The water flowed by gravity into Resident #6's g-tube. LPN #1 then clamped the extension tube and removed it from Resident #6's g-tube.</p>			

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	<p>During an interview with LPN #1 on 6/8/16 at 8:21 A.M., she indicated that she sometimes had to use the plunger because Resident #6 resists the feeding. She also indicated that she did not like to use the plunger but felt it was necessary. Furthermore, she indicated that it was typical for medications and liquids to spill out sometimes.</p> <p>Resident #6's clinical record was reviewed on 6/10/16 at 8:44 A.M. Resident #6's current diagnoses included, but were not limited to, cerebral palsy, aphasia, gastro-esophageal reflux disease (GERD) and seizure disorder.</p> <p>Resident #6 had a current, 3/25/16, significant change, Minimum Data Set (MDS) assessment which indicated Resident #6 did not speak and rarely or never understood. He was severely cognitively impaired and relied totally on staff for eating.</p> <p>Resident #6 had a current, 4/7/16, care plan problem that indicated he received no food or fluids by mouth and was dependent on gastric feeding for all nutrients, medications and hydration. He also had a care plan problem that indicated he had increased gas and would push the gas out of the gastric tube during feedings. An approach to this problem</p>			

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	<p>was to allow gas to escape from the gastric tube prior to feedings and flushes.</p> <p>2. During a g-tube flush observation on 6/10/16 at 1:13 P.M., LPN #2 removed an extension tube with attached syringe and plunger hanging from a pole in Resident #9's room. LPN #2 approached Resident #9 who was sitting in a recliner chair. LPN #2 then attached the extension tube to Resident #9's g-tube.</p> <p>LPN #2 unclamped the extension tube and then pulled up on the plunger. She then clamped the extension tube and removed the plunger from the syringe. She poured 30 ml of water into the syringe and unclamped the extension tube. The water flowed by gravity into Resident #9's g-tube.</p> <p>LPN #2 poured 20 ml of water with medications into the syringe. The water flowed by gravity into Resident #9's g-tube. LPN #2 then poured 30 ml water into the syringe. The water flowed by gravity into Resident #9's g-tube.</p> <p>LPN #2 poured water from a cup with 250 ml water into the syringe until all of the water was in the syringe. LPN #2 placed the plunger into the syringe and pushed on it when the syringe had 40 ml of water left in it. She then clamped the</p>			

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	<p>extension tube and removed it from Resident #9's g-tube.</p> <p>During an interview with LPN #2 on 6/10/16 at 1:13 P.M., she indicated she sometimes used the plunger to ensure the last of the fluids went in. She also indicated she did not always use it on residents but felt Resident #9 could handle it.</p> <p>Resident #9's clinical record was reviewed on 6/8/16 at 9:58 A.M. Resident #9's diagnoses included, but were not limited to, traumatic brain injury, gastrostomy status, gastro-esophageal reflux disease (GERD) and dysphagia.</p> <p>Resident #9 had a current, 3/25/16, annual, MDS assessment that indicated he was severely cognitively impaired, received less than 25% of total calories through tube feeding and received 501 ml or more of average fluid intake per day through tube feeding.</p> <p>Resident #9 had a current, 3/31/16, problem that indicated he had the potential for constipation. An approach to this problem was to give 1560 ml of water per pump per g-tube at 150 ml per hour for 12 hours.</p>			

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	<p>Resident #9 had a current order, dated 12/24/14, to flush his g-tube with 250 ml of water four times daily.</p> <p>3. During a g-tube flush observation on 6/10/16 at 1:15 P.M., LPN #2 removed an extension tube with attached syringe and plunger hanging from a pole in Resident #43's room. LPN #2 approached Resident #43 who was sitting in a wheelchair. LPN #2 then attached the extension tube to Resident #43's g-tube.</p> <p>LPN #2 poured water from a cup with 200 ml of water into the syringe until all of the water was in the syringe. LPN #2 placed the plunger into the syringe and pushed on it when the syringe had 40 ml of water left in it. She then clamped the extension tube and removed it from Resident #43's g-tube.</p> <p>During an interview with the Director of Nursing (DON) on 6/10/16 at 1:42 P.M., she indicated the plunger should not be used to force down fluids or medications for any resident.</p> <p>Resident #43's clinical record was reviewed on 6/8/16 at 11:30 A.M. Resident #43's diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual</p>			

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F 0329 SS=D Bldg. 00	<p>disabilities, gastro-esophageal reflux disease (GERD) and aphasia.</p> <p>Resident #43 had a current, 12/15/15 quarterly MDS assessment that indicated he was severely cognitively impaired and totally dependent on staff for eating.</p> <p>Resident #43 had a current, 3/25/16, care plan problem that indicated he required a feeding tube. An approach to this problem was to flush his G-tube with 400 ml of water twice daily.</p> <p>Review of a document titled, "Enteral Medication Administration Clinical Performance Evaluation Checklist", undated, and provided by the DON, included the following: "...Allows medication to flow down tube via gravity...."</p> <p>3.1-44(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p>						

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	<p>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 attempt a gradual dose reduction or to obtain a letter from the Physician stating a gradual dose reduction was clinically contraindicated for two psychoactive medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #55)</p> <p>Findings include:</p> <p>Resident #55's clinical record was reviewed on 6/8/16 at 8:20 a.m. Diagnoses included, but were not limited to, spastic diplegic cerebral palsy, profound intellectual disabilities, intermittent explosive disorder, anxiety and agitation. The Quarterly Minimum Data Set Assessment, dated 3/31/16, indicated the resident was severely cognitively impaired.</p>	F 0329	<p>F 329D</p> <p>Unnecessary Drugs</p> <p>Corrective action for affected resident: For resident # 55 a pharmacy recommendation for a gradual dose reduction, which included the practitioner's documentation of clinical contraindication was provided during the survey. A letter from the practitioner was also provided.</p> <p>Resident #55 was re-assessed with no adverse effects noted.</p> <p>Identification of others at</p>	06/25/2016

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	<p>Resident #55 had current physician's orders for the following psychoactive medications:</p> <p>a.) 2/11/14, naltrexone 50 mg (opiate antagonists medication) 1 tablet twice daily for self abuse and impulse control.</p> <p>b.) 8/20/13, benzotropine 1 mg (anti-cholinergic medication) - 2 times daily for self abuse, impulse control and pseudoparkinsonism.</p> <p>Review of the Gradual Dose Reduction (GDR) tracking report, provided by the Social Service Director on 6/10/16 at 1:07 p.m., indicated the following:</p> <p>Naltrexone, start of therapy 8/20/13, next GDR evaluation 1/27/17. Initial start dose 25 mg daily. On 11/12/13, increased to 50 mg daily. On 2/11/14, the medication was increased to 50 mg twice daily.</p> <p>There was no monitoring or tracking for benzotropine in the GDR book.</p> <p>The Pharmacy Medication Regimen Review log, indicated the pharmacist reviewed all medications on 6/1/16.</p> <p>Review of the Pharmacy Consultation Report, dated 1/06/16, indicated the following: "[name of resident] has received naltrexone 50 mg bid [twice daily] for self-abuse, impulse control</p>		<p>risk: Residents receiving psychoactive medications have the potential to be affected. An audit was completed to identify residents not having gradual dose reductions of pharmacological psychoactive medications. No further residents were identified.</p> <p>Measures to ensure this deficient practice does not recur: Interdisciplinary team members have been re-educated on gradual dose reductions of pharmacological psychoactive medications.</p> <p>Monitoring of corrective action: An audit of gradual dose reductions of pharmacological psychoactive medications will be completed 3 times a week for 4 weeks, one time a week for 4 weeks then monthly for 6 months. The audit results will be</p>		

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	<p>since 2-2014 Medication was started 8-2013". The Nurse Practitioner declined the reduction of the medication related to intrusive behavior and wandering on 1/27/16.</p> <p>During an interview on 6/10/16 at 12:55 p.m., the SSD indicated she would call the pharmacy to see if they had any tracking of benzotropine. She indicated she was not sure why there was no GDR listed in the book.</p> <p>During an interview on 6/10/16 at 1:07 p.m., the SSD indicated she could not find any GDR for naltrexone for 2015. She also indicated there was no GDR ever done for benzotropine because the medication was being used for tremors, not self abuse and impulse control as listed on the physician orders.</p> <p>A current care plan dated 5/18/15, indicated "I am at risk for adverse consequences of my anti-psychotic medications for treatment of SIB [self injury behaviors]....I was started on Revia and Cogentin by [name of physician] on 8/20/13...." Interventions included, but were not limited to, "assess and record effectiveness of drug, attempt gradual dose reduction, monitor resident's behavior and response to medication and pharmacy consultant review."</p>		discussed in morning meeting and in the monthly QAC meeting for further recommendations.		

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	<p>Review of the current facility policy, dated 12/1/07, titled "Psychopharmacological Medication Use", provided by the SSD on 6/10/16 at 2:35 p.m., included, but was not limited to, the following:</p> <p>"Procedure:</p> <p>1. Facility should comply with the Psychopharmacologic Dosage Guideline created by the Centers for Medicare and Medicaid Services ("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions.</p> <p>...1.2 If Physician/Prescriber orders a psychopharmacological medication in the absence of a diagnosis or specific behavior listed in the State Operations Manual, Facility should ensure that the ordering Physician/Prescriber reviews the medication plan and considers a gradual dose reduction ("GDR") of psychopharmacological medications for the purpose of finding the lowest effective dose unless a GDR is clinically contraindicated.</p> <p>1.3 Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction</p>			

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F 0332 SS=D Bldg. 00	<p>at that time would be likely to impair the resident's function or increase distressed behavior."</p> <p>3.1-48(b)(2)</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, interview and record review, the facility failed to ensure a less than 5 percent medication error rate during medication pass observation regarding a resident receiving the proper amount of water with the administration of Miralax (Resident #6) and a resident receiving the proper administration of an enteric-coated aspirin (Resident #37) for 11 of 26 opportunities observed for medication administration. These deficient practices resulted in a medication error rate of 42.3%.</p> <p>Findings include:</p> <p>1. During a medication administration observation on 6/8/16 that began at 8:00 A.M., LPN #1 put crushed medications and Miralax powder into an unmarked plastic cup. LPN #1 then poured water</p>	F 0332	<p>F332 D Free of Medication Errors Corrective action for affected resident: Residents #76 and #37 have been assessed with no adverse effects identified. Identification of others at risk: All residents with an order to crush all meds and receiving medications that cannot be crushed have the potential to be affected. Identified residents have been assessed with no adverse effects identified. A list of "Do Not Crush" medications is available on each medication cart. Measures to ensure this deficient practice does not recur: Licensed nurses have been re-educated on Medication Administration. Monitoring of corrective action: A random audit of medication pass observations will be completed 3 times a week for 4 weeks, one</p>	06/25/2016

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	<p>into the same cup with the medications. She did not measure how much water was poured in. LPN #1 then poured 30 milliliters (ml) of water into a cup marked with ml measurements. LPN #1 then walked into Resident #6's room. The mixed medications included: Miralax 17 gm to be mixed in 4 ounces of water, Divalproex 3 capsules of 125 mg each, docusate 100 mg., keppra 500 mg., lorazepam 2 mg., Nuedexta 20 mg/10 mg, protonix 40 mg packet, quetiapine 100 mg and 50 mg., and 80 mg of simethicone with 40 mg/0.6 ml.</p> <p>LPN #1 washed her hands and donned gloves. She removed an extension tube with an attached syringe and plunger from a plastic bag hanging on a pole. She then approached Resident #6 and attached the extension tube to his gastrostomy tube (g-tube).</p> <p>LPN #1 used the 60 ml syringe and plunger and drew up 40 ml of air. She then attached the syringe to the extension tube. She placed her stethoscope on the left side of Resident #6's g-tube site. She then pushed the plunger down into the syringe. LPN #1 clamped the extension tube. She then removed the plunger from the syringe.</p> <p>LPN #1 poured 30 ml of water into the</p>		time a week for 4 weeks then monthly for 6 months. Results of the audits will be ongoing with the results reported through the Quality Assurance Committee monthly for further review and recommendation.		

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	<p>syringe. She unclamped the extension tube and allowed the water to flow by gravity into Resident #6's g-tube.</p> <p>LPN #1 poured the water with all ten medications into the syringe. She then placed the plunger into the syringe and began to push it. The water with the medications did not flow into Resident #6's g-tube, but spilled out.</p> <p>LPN #1 removed the syringe from the extension tube. Water with medications spilled on to Resident #6's pants. LPN #1 then re-attached the syringe to the extension tube. She then used the plunger to push the water with medications. Some of the water with medications spilled on the floor. The remaining water with medications flowed by gravity into Resident #6's g-tube . LPN #1 clamped the extension tubing. There was no way to determine which of the ten medications the resident actually received or how much of any of them had spilled.</p> <p>LPN #1 left Resident #6's room and indicated she forgot the last cup of water to flush Resident #6's g-tube. LPN #1 then poured water into an unmarked plastic cup. She did not measure the water.</p>			

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	<p>LPN #1 walked back into Resident #6's room, unclamped the extension tube and poured the water into the tube. The water flowed by gravity into Resident #6's g-tube. LPN #1 then clamped the extension tube and removed it from Resident #6's g-tube.</p> <p>Resident #6 had a current physician's order for all 10 of the medications mixed to be given via the g-tube.</p> <p>During an interview with LPN #1 on 6/8/16 at 8:21 A.M., she indicated she gave 100 ml of fluid with the medication administration for Resident #9. She also indicated she only measured one cup of water and it was 30 ml. She further indicated she estimated the cup with medications to have 30 ml of water and the last cup of water to have 40 ml of water. She indicated she was aware of the Miralax order and thought 100 ml equaled 4 ounces (oz).</p> <p>During an interview with the Director of Nursing (DON) on 6/10/16 at 1:42 P.M., she indicated the Miralax should have been mixed with 120 ml of water because 4 oz equaled 120 ml of water.</p> <p>Resident #6's clinical record was reviewed on 6/10/16 at 8:44 A.M. Resident #6's current diagnoses included,</p>						

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	<p>but were not limited to, cerebral palsy, aphasia, gastro-esophageal reflux disease (GERD) and seizure disorder.</p> <p>Resident #6 had a current, 3/25/16, significant change, Minimum Data Set (MDS) assessment which indicated Resident #6 did not speak and rarely or never was understood. He was severely cognitively impaired and relied totally on staff for eating.</p> <p>2. During a medication administration observation on 6/10/16 at 7:31 A.M., LPN #3 crushed pills, including an enteric-coated (EC) aspirin, placed them in a cup and mixed them with pudding.</p> <p>LPN #3 entered Resident #37's room and spoon fed the crushed pills and pudding mixture to Resident #37.</p> <p>During an interview with LPN #3 on 6/10/16 at 7:31 A.M., she indicated that she should not have crushed the enteric-coated aspirin.</p> <p>Resident #37's clinical record was reviewed on 6/10/16 at 10:34 A.M. Resident #37's current diagnoses included, but were not limited to, cerebral palsy, hypertension, hyperlipidemia and seizure disorder.</p>			

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	<p>Resident #37 had a current, 5/14/16, MDS assessment which indicated Resident #37 did not speak and rarely or never was understood. He was severely cognitively impaired and relied totally on staff for all activities of daily living (ADLs).</p> <p>Resident #37 had a current physician's order for aspirin 81 milligrams (mg) one tablet orally once a day.</p> <p>Review of a document titled, "6.0 General Dose Preparation and Medication Administration", dated 1/1/13, and provided by the Director of Nursing (DON) on 6/10/16 at 12:00 P.M., included the following, "...Procedure:...3.8 Facility staff should crush oral medications only in accordance with Pharmacy guidelines as set forth in <u>Appendix 16: Common Oral Dosage Forms that Should Not Be Crushed</u> and/or Facility policy...</p> <p>Review of a document titled, "Common Oral Dosage Forms that Should Not Be Crushed", dated 2013, and provided by the DON on 6/10/16 at 12:00 P.M., included the following: "...ASPIRIN EC Tablet... Reason... Delayed Release..."</p> <p>3.1-25(b)(9)</p>			

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F 0356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure accurate posting of direct-care staff for 3 of 5 days during the survey. This</p>	F 0356	F 356C Staffing Hours Posted Corrective action for affected resident: No specific resident cited. Identification of others at risk: No residents	06/25/2016

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	<p>practice had the potential to affect 74 of 74 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour of the facility, on 6/6/16 at 9:47 a.m., the nursing staff posting was hanging at the 200 hall nurses' station. The form was dated 6/2/16. At 10:45 a.m., a form dated 6/5/16, was posted and indicated there were 4 RNs, 2 LPNs, and 9 CNAs working on day shift in the facility. Observation of staff present and review of a "Daily Staffing" document indicated there was one RN, two LPNs, and 8 CNAs with a direct care assignment. There was no facility census documented on the form.</p> <p>On 6/7/16, the staffing posting remained for 6/6/16.</p> <p>On 6/8/16 at 9:00 a.m., the staffing posting remained for 6/6/16.</p> <p>On 6/10/16 at 9:17 a.m., the staffing posting was dated 6/9/16. The D.O.N. indicated at that time the staff posting was to be changed and updated daily. The staffing posting, dated 6/10/16, indicated 4 RNs, 3 LPNs, and 9 CNAs with direct care assignments. Observation of staff present and review</p>				<p>affected. Measures to ensure this deficient practice does not recur: The staff were educated on requirement to have staffing hours posted, accurate and up to date. The scheduler/designee will ensure daily staffing hours are posted and up to date at the 200 hall nurses station daily. The weekend manager will validate hours posted are accurate and up to date. Monitoring of corrective action: An audit of posted nurse staffing will be completed 3 times a week for 4 weeks, one time a week for 4 weeks then monthly for 6 months. The audit results will be discussed in morning meeting and in the monthly QAC meeting for further recommendations.</p>		

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F 0371 SS=E Bldg. 00	<p>of a "Daily Staffing" document indicated there was one RN, two LPNs, and 7 CNAs with a direct care assignment. There was no facility census documented on the form.</p> <p>During an interview, on 6/10/16 at 12:20 p.m., LPN #15 indicated she was responsible for scheduling nursing staff and completing the staffing posting. She indicated she completed the posting form in advance and the floor nurses were to update it daily according to staff present in the building. She further indicated she was told to include Unit Managers, the MDS coordinator, and herself in the staffing total, even if they did not provide direct care to any residents. She indicated the staff posting and the daily staffing sheet were not always kept up to date, due to call-ins and scheduling changes.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was prepared and served under</p>	F 0371	F 371E Kitchen Sanitation Corrective action for affected resident: No residents affected Identification of others at risk:	06/25/2016			

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	<p>sanitary conditions. Of the facility's 74 residents, this deficient practice had the potential to impact 38 who were served daily food from the facility's kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Kitchen sanitation tour, accompanied by the Dietary Manager on 6/6/16 at 9:32 a.m. indicated the following: <ol style="list-style-type: none"> a. The drip pan under the stove-top had several areas of accumulation of grease and food debris built up on the tray. b. Four dials on the front of the oven had an accumulation of dust and visible fuzz. c. Six of 6 burners had burnt, dried food on and around the reflector pans. <p>During an interview with the Dietary Staff #10 on 6/6/16 at 9:49 a.m., she indicated she was not aware there was a drip tray under the stove. She indicated she works until about 11:30 a.m. when scheduled.</p> <p>During an interview with the Dietary Manager on 6/7/16 at 8:15 a.m., she indicated Dietary Staff #10 had worked at the facility for over a year and should have known there was a drip tray under the stove-top. She also indicated the</p>		<p>Drip pan cleaned, dust and fuzz removed on June 6, 2016. All residents have potential for risk.</p> <p>Measures to ensure this deficient practice does not recur: Dietary staff have been re-educated on cleaning schedules and cleaning documentation. Monitoring of corrective action: The Dietary Manager or designee will check dietary equipment for cleanliness and sanitation and documentation 3 times a week for 4 weeks, one time a week for 4 weeks then monthly for 6 months. The results of the audits will be reviewed during morning clinical meeting and forwarded to the Quality Assurance Committee monthly for recommendations.</p>	

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	<p>burners, drip pan and fuzz around the dials were cleaned yesterday (6/6/16).</p> <p>Review of the March, April and May "CLEAN List", provided by the Dietary Manager on 6/7/16 at 8:05 a.m., the "Oven Drip Pans", "Stove all over" and Grease Trap/Stove Burners" columns did not have one initial indicating the areas had been cleaned for those 3 months.</p> <p>A review of a facility policy dated 1/22/12, titled "CLEANING INSTRUCTIONS: RANGES", was provided by the Dietary Manager on 6/7/16 at 11:32 a.m., and indicated the following:</p> <p>"Purpose: The cook on each shift is responsible for keeping the range as clean as possible during the preparation of the meal. Clean the range after each use. Wipe spills and food particles up as they occur.</p> <p>...B. Scrape burned particles and grease off with a non-metal scouring pad...</p> <p>C. Wipe the outside surface of the appliance using a sanitizing solution.</p> <p>D. Wash the drip pans as needed and/or according to the cleaning schedule."</p>			

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F 0431 SS=E Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure medications and supplies were disposed of following expiration dates for 2 of 2 medication storage rooms, 3 of 5 medication carts and 1 of 3 treatment carts observed. (200 and 300 hall medication storage rooms, 100 and 200 hall medication carts and 100 hall treatment cart)</p> <p>Findings include:</p> <p>1. During an observation of the 300 hall medication storage room with RN #11 on 6/9/16 at 2:05 p.m., the following was observed:</p> <p>a. Two boxes of "Micro-kill bleach germicidal bleach wipes" (used to disinfect blood glucose monitors) with an expiration date of 11/2015. Box number one contained 45 of the 100 wipes and box number two contained 26 of the 100 wipes.</p> <p>b. Two boxes of sterile wound closure strips with an expiration date of 9/24/2009. Each box contained 50 of the 50 single packet strips.</p> <p>c. One box that contained 150 single packets of "E-Z lubricating jelly" with an expiration date of 1/16.</p>	F 0431	<p>F431E Medication Storage Corrective action for affected resident: Resident #74 has been assessed with no adverse effect identified. Identification of others at risk: All residents receiving medications and/or treatments have the potential to be affected. A house-wide audit was completed of medication carts, medication rooms, treatment carts and Central Supply. No other residents were identified as having received expired medications or treatments. Items identified as being expired have been discarded. Measures to ensure this deficient practice does not recur: Nursing staff have been re-educated on Medication Storage and Expiration Dates. Monitoring of corrective action: A random audit of medication carts, treatment carts, medication rooms and Central Supply will be conducted one time a week for 4 weeks then monthly for 6 months. Results of the audits will be ongoing with the results reported through the Quality Assurance Committee monthly for further review and recommendation.</p>	06/25/2016

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	<p>d. One 16 ounce "Epi-clenz instant foam hand antiseptic latex free" with an expiration date of 01/15.</p> <p>e. One 8 ounce "Epi-clenz instant foam hand antiseptic latex free" with an expiration date of 12/14.</p> <p>f. Seven boxes of "Compound Benzoin Tincture 10% swab sticks (a topical skin preparation) with an expiration date of 06/2009. Six of the boxes contained 50 of 50 packets and one box contained 23 of the 50 packets. Each packet contained one swab stick.</p> <p>2. During an observation of the medication cart, located in the 200 hall medication storage room with RN #12 on 6/9/16 at 2:38 p.m., the following was observed:</p> <p>a. One "Gluco-Chor" packet (used to disinfect blood glucose monitors) with an expiration date of 01/13.</p> <p>3. During an observation of the medication cart, located in the 200 hall medication storage room with RN #12 on 6/9/16 at 2:49 p.m., the following was observed:</p> <p>a. Two 3x3 inch pre-saturated</p>			

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	<p>"Micro-kill bleach germicidal wipes" with an expiration of 11/2015</p> <p>4. During an observation of the white mini refrigerator located in the 200 medication storage room with RN #12 on 6/9/16 at 3:03 p.m., the following was observed:</p> <p>a. One house stock of aplisol (used to screen for tuberculosis) 5tu (tuberculin units) /0.1 milliliter vial with an open date of 4/29/16 and an expiration date of 5/29/16. RN #12 indicated the vial contained approximately 0.25 milliliters left of the 1.0 milliliters.</p> <p>b. One 60 ml (milliliters) bottle of lansoprazole 30 mg (milligrams)/10 m for Resident #74 with a physician order to give 5 milliliter (15 mg) via g tube (gastrostomy tube) every morning for GERD (gastroesophageal reflux disease) with an expiration date of 5/27/16. RN #12 indicated the bottle had 20 ml of the 60 ml left.</p> <p>A review of Resident #74's medication administration record for May and June 2016 indicated Resident #74 received 14 doses from 5/27/16 to 6/9/16 after the medication had expired.</p> <p>5. During an observation of the 100 hall</p>			

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	<p>treatment cart with LPN #14 on 6/9/16 at 3:15 p.m., the following was observed:</p> <p>a. One house supply box of sterile Xeroform petroleum (a non-adherent wound dressing) 4x4 inch dressings with an expiration date of 03/2013. The box contained 13 single sealed packets and 2 opened packets of the 25. RN #12 indicated, open packet number one had 1/4 of the dressing left and open packet number two had 3/4 of the dressing left.</p> <p>b. One 1.5 ounce house supply box of Thera honey gel, a honey wound gel with an expiration date of 11/2014.</p> <p>During an interview with the Director of Nursing (D.O.N.) on 6/9/16 at 3:43 p.m., the D.O.N. indicated nursing staff should monitor the medication storage rooms, treatment and medication carts every time an item gets pulled to use and the unit managers should audit the medication storage rooms monthly for expired medications and supplies. The D.O.N. further indicated the pharmacy technician audits the medication carts and medication storage rooms monthly and was last completed in May 2016.</p> <p>A review of the policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with</p>			

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	<p>a revision date of 01/01/13 was provided by the D.O.N. on 6/9/16 at 4:45 p.m., indicated the following:</p> <p>"...Procedure:</p> <p>...4. Facility should ensure that medication and biologicals:</p> <p>...4.2. Have not been retained longer than recommended by manufacturer or supplier guidelines...</p> <p>...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications...</p> <p>...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medication).</p> <p>17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis...."</p> <p>3.1-25(o)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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