

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2014
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NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 8, 9,10,13,14, & 15, 2014</p> <p>Facility Number: 000491 Provider Number: 155495 AIM Number: 100291230</p> <p>Survey Team: Deb Kammeyer, RN TC Lora Swanson, RN Julie Wagoner, RN</p> <p>Census Bed Type: SNF: 7 SNF/NF: 43 Total: 50</p> <p>Census by Payor Type: Medicare: 5 Medicaid: 34 Private: 10 Other: 1 Total: 50</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This plan of correction is submitted by Lakeland Rehabilitation and Healthcare Center in order to respond to the alleged deficiencies sited during our annual survey which was conducted on January 10, 2014. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective February 14, 2014. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Lakeland Rehabilitation and Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Corrections.</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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	Quality Review completed on January 22, 2014, by Brenda Meredith, R.N.			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	POC MilfordF2251. Abuse-	02/14/2014			

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	<p>interview, the facility failed to ensure an allegation of abuse was reported to other state agencies for 1 of 3 allegations reviewed for abuse. (Resident #58 and Resident #27)</p> <p>Findings include:</p> <p>On 1/13/14 at 2:00 P.M., an allegation of abuse for Resident #58 and Resident #27 was reviewed. The allegation was provided by the Administrator.</p> <p>Review of the altercation/concern investigation, dated 12/17/13 at 1406 (2:06 P.M.), indicated "Physical altercation between resident/resident at the South hall. The Executive Director, Medical Doctor and responsible party was notified."</p> <p>Review of a note from the Social Service Director, dated 12/17/13, indicated "...On this date it was reported that Resident #58 and Resident #27 got into a physical altercation in the hallway of the facility. It was reported that the residents encountered each other in the hallway and their chairs were bumping into each other. Both residents became aggravated and were seen "swatting" at each other</p>		<p>Failure to report resident to resident. (1). Resident 27 & 58 state report was completed and sent to the ISDH on 1/22/14 by Assistant Director of Nursing. (2) All residents with incidents for the last 30 days were reviewed on 1/22/14 by the Executive Director for any state reportables not being reported. No deficiencies were noted at this time.(3) Director of Nursing Services (DHS) and Assistant Director of Nursing (ADHS) were re-inserviced on 1/22/14 concerning requirements State requirements of reporting allegations of abuse, Executive Director. Executive Director or designee will review weekly incident log to ensure all requirements are being met. Executive Director or designee will report findings monthly to QAA.(4) QAA will monitor for any trends and make recommendation to the Plan as correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained. (5) F225 will be completed by 2/14/14</p>		

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	<p>and speaking aggressively. Both of the residents were immediately separated from each other, with Resident #27 being encouraged to attend a movie in the community room, while Resident #58 remained in the south end of the building near his room. Writer followed up with both residents, who did not appear to recall the incident and showed no signs of agitation or being upset. Both residents have been put on 15 minute checks for the next 24 hours to ensure that they have no more encounters of this kind. Incident forms have been started and family's made aware of the incident...."</p> <p>On 1/13/14 at 2:30 P.M., an interview with the interim Director of Nursing indicated, "on 12/17/13 an incident report and investigation was completed, but we can't find documentation that the state agency was notified and they should have been."</p> <p>3.1-28(c)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their abuse prevention protocol was implemented related to reporting an allegation to other state agencies for 1 of 3 allegations reviewed for abuse. (Resident #58 and Resident # 27)</p> <p>Findings include:</p> <p>On 1/13/14 at 2:00 P.M., an allegation of abuse for Resident #58 and Resident #27 was reviewed. The allegation was provided by the Administrator.</p> <p>Review of the altercation/concern investigation, dated 12/17/13 at 1406 (2:06 P.M.), indicated "Physical altercation between resident/resident at the South hall. The Executive Director, Medical Doctor and responsible party was notified."</p>	F000226	F226 Same as F225	02/14/2014			

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	<p>Review of a note from the Social Service Director, dated 12/17/13, indicated "...On this date it was reported that Resident #58 and Resident #27 got into a physical altercation in the hallway of the facility. It was reported that the residents encountered each other in the hallway and their chairs were bumping into each other. Both residents became aggravated and were seen "swatting" at each other and speaking aggressively. Both of the residents were immediately separated from each other, with Resident #27 being encouraged to attend a movie in the community room, while Resident #58 remained in the south end of the building near his room. Writer followed up with both residents, who did not appear to recall the incident and showed no signs of agitation or being upset. Both residents have been put on 15 minute checks for the next 24 hours to ensure that they have no more encounters of this kind. Incident forms have been started and family's made aware of the incident..."</p> <p>Review of the current policy revised on 9/16/2011 titled "Abuse and Neglect Procedural Guidelines" received from the Administrator</p>				

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	<p>indicated, "...vii. The Executive Director is responsible for: Notification to the State Department of Health (per state guidelines) and other agencies...Reporting: ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies...."</p> <p>On 1/13/14 at 2:30 P.M., an interview with the interim Director of Nursing indicated "On 12/17/13 an incident report and investigation was completed but we can't find documentation that the state agency was notified and they should have been."</p> <p>3.1-28(a)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interviews, the facility failed to initiated a care plan to address hallucinations for 1 of 5 residents reviewed for unnecessary medications. (Resident #12)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #12 was reviewed on 01/10/14 at 10:30 A.M. Resident #12 was admitted to the facility, on 06/18/03, with diagnosis, including but not limited to, muscle weakness,</p>	F000279	F 279Develop Comprehensive Care Plans Develop (1) Resident 12 Care Plan was updated to reflect current behaviors. No adverse side effects were noted related to Care Plan on 1/22/14 by the MDS nurse.(2) All residents with behaviors Care Plans were assessed on 1/22/14 by MDS Nurse and Social Services. Any resident without a Care Plan was updated at this time. No adverse side effects were noted related to lack of Care Plan.(3) Social Service and Nsg Administration were re-inserviced by Clinical Support on Care Plans to reflect residents current	02/14/2014

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	<p>abnormal posture, lack of coordination, late effects of cranial nerve injury, convulsions, difficulty in walking, contracture of multiple joints, status post traumatic brain injury related to motor vehicle accident, dysphagia, major depressive disorder, organic personality syndrome, conductive hearing loss, scoliosis, and aphasia.</p> <p>The current physician's orders for Resident #12 included the antipsychotic medication, zyprexa zydis 5 mg twice a day for hallucinations. The medication had originally been ordered on 10/30/12.</p> <p>Review of psychiatric notes, dated 07/19/12, indicated Resident #12's Zyprexa had been reduced from 10 mg a day to 5 mg a day on 02/08/12, but the resident had complained of an increase in vivid dreams about her family members traumatic death and OCD (obsessive compulsive disorder) type behaviors. The resident was also noted to have been on an antibiotic for a urinary tract infection at the time. Resident #12's Zyprexa was increased to 5 mg twice a day.</p> <p>The current health care plans for Resident #12, located on the clinical</p>		<p>behavioral issues. Social Service will review all residents with antipsychotic medication and ensure Care Plan reflect current behaviors. All new admissions on Antipsychotic medications will be reviewed in Clinical At Risk meeting to ensure the Care Plan is updated with this meeting. MDS or designee will monitor 5 residents per week to ensure Care Plan reflect resident's current behaviors. MDS or designee will report findings to QAA monthly.(4) QAA will monitor monthly for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.(5) F 279 will be completed on 2/14/14</p>		

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	<p>record and also on an electronic screen utilized by facility nursing staff, included the following plans related to Resident #12's mood and behavior issues:</p> <p>"Cognition: I currently have a diagnosis of vascular dementia, which is the result of injuries I suffered in the car accident I was in many years ago. My dementia causes me to sometimes obsess or focus on particular things for days on end, which can cause me some anxiety or depression. I can also sometimes forget requests that I made regarding my care or my medications. In spite of my dementia, I am still always oriented x3 and want to be able to make as many decisions for myself as possible, as long as I am safe to do so. My goal is to be aware of my current health condition and to have a say in my care...General Information:...I am currently taking antipsycotic and antidepressant. Please observe me for adverse effects. Please notify the doctor as needed of adverse effects. Please attempt to use the lowest dose necessary...I have a dx [diagnoses] of depression. Please provide my medication as ordered. Please provide empathetic listening and</p>				

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	<p>support when needed....Moods and Behaviors: I haven't had any behaviors or mood issues in quite a while, but I have a history of resisting care and being physically abusive. I also have a history of mood issues and currently have a diagnosis of depression with psychotic features as well as insomnia. I am currently prescribed an antidepressant and an antipsychotic for these diagnosis [sic]. I have been feeling down lately due to the realization that my health or my condition is not going to improve much (deny any thoughts of self-harm or suicide). This is something that have been very difficult for me to accept, so please be supportive of me right now. My goal is to be happy and content here at the facility, to be able to have as much independence as possible, and to be able to fully communicate without frustration. Please continue to monitor my moods and depression and if you notice any negative changes, please inform my doctor. Please ensure that I continue to see the psychologist from [name of psychiatric specialty group] on a regular basis, as this is something that I benefit from...."</p> <p>Hallucinations or "vivid dreams"</p>			

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F000282 SS=D	<p>were not mentioned in the care plan and there were very few interventions except "support" and "provide medications" listed on the plan to address any of the resident's potential behavior or mood issues.</p> <p>3.1-35(a)(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. Based on interview and record review the facility failed to follow physician's orders regarding withholding blood pressure medication based on systolic blood pressure parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record of Resident # 30 was reviewed on 1-13-14 at 10:39 A.M. The resident's diagnoses</p>	F000282	F282 Services by Qualified persons/per Care Plan (1) Resident #30 was assessed related to Blood Pressure. No adverse side effects were noted related to the Blood pressure.(2) All current residents on blood pressure medication with parameters were reviewed. No adverse side effects were noted at this time.(3) License Nurses will be re-inservice by 2/14/14 related to parameters and administration of the medications outside the parameters. Director of Health Services (DHS) will monitor 10 residents receiving	02/14/2014

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	<p>included, but were not limited to: chronic obstructive pulmonary disease, congestive heart failure with implantable cardiac defibrillator and anemia.</p> <p>Readmission orders, dated 9-2-13, indicated the resident had an order for "Lisinopril 5 mg. [milligrams] po [by mouth] dly [daily] HTN [hypertension] Hold for SBP [systolic blood pressure] < [less than] 130 or HR [heart rate] < 60...."</p> <p>On 1-13-14 at 10:47 A.M., the current care plans included a plan related to Resident #30's diagnosis of Coronary Artery Disease, hypertension and congestive heart failure. Interventions included, but were not limited to: administer medications per order, monitor for edema, monitor lab values and monitor vital signs per order.</p> <p>On 1-13-14 at 10:50 A.M., review of the Medication Administration Record (MAR) for January 2014 indicated the nurse was to obtain a Systolic Blood Pressure (SBP) prior to administration of Lisinopril, a blood pressure medication. The MAR further indicated the Lisinopril was not to be given to the resident if the SBP was less than 130 or if the</p>		<p>medication with B/P parameters to ensure the MD orders were followed to hold the medications. DHS or designee will report findings to QAA monthly.(4) QAA will monitor monthly for any trends and make recommendations to the Plan of Correction. QAA will monitor for 90 days or until 100% compliance is obtained.(5) F 282 will be completed by 2/14/14</p>		

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	<p>heart rate (HR) was less than 60. The following SBP's were recorded and initialed to indicated Lisinopril was administered by the nurse on the following dates:</p> <p>1-2-14 128/70 1-6-14 100/62 1-7-14 120/58 1-8-14 112/60 1-10-13 122/64</p> <p>On 1-14-14 at 11:30 A.M., during an interview with ADON (Assistant Director of Nursing) to review the above dates, B/P and medication documentation, the ADON confirmed she was unable to identify if the medication was withheld or administered to Resident #30. She further indicated there was no facility policy regarding a procedure the nurse should follow to document withheld medications.</p> <p>On 1-14-14 at 1:55 P.M., during an interview with RN #2 indicated she was unsure of the facility's policy regarding a medication being withheld due to SBP parameters. RN #2 indicated she would circle her initials to denote the medication was withheld but she not necessarily note withholding the medication on back of MAR.</p>			

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F000314 SS=D	<p>On 1-14-14 at 2:16, review of the facility policy titled "Specific Medication Administration Procedures," dated 9-1-13, indicated the following "...To administer medications in a safe and effective manner...." and on line E "...Check MAR for order...." There were no instructions for withholding medication and/or how to document when medications were not administered when ordered.</p> <p>3.1-35 (g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to implement specific interventions to</p>	F000314	F 314 Prevention/Heal Pressure Ulcers(1) Resident #39 was discharged from the facility.(2) All residents had a skin assessment	02/14/2014

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	<p>prevent heel and toe pressure ulcers for 1 of 2 residents reviewed for pressure ulcer development. (Resident #39)</p> <p>Findings include:</p> <p>On 1/10/14 at 2:57 P.M., record review indicated, Resident #39's was admitted to the facility on 09/25/13, with diagnoses including, but not limited to, "...hypertension, fractured pelvis, osteoarthritis, diabetes mellitus, diabetic neuropathy of lower extremities, coronary artery disease, history of seizures...."</p> <p>The nursing admission assessment, completed on 9/25/13, indicated there were no pressure ulcers noted on Resident #39.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 10/2/13, indicated the resident had no pressure ulcers, but was at risk for pressure ulcer development. The MDS further indicated the resident was totally dependent for bed mobility.</p> <p>The health care plan for Resident #39, titled, Potential for alteration in skin integrity, initiated on 9/25/13,</p>		<p>completed by the DHS. Any resident identified as having a need for preventive measures were put into place. No adverse side effects were noted related to the interventions. Care plans were updated reflect the interventions.(3) License Nurses were re-inservice on preventive measures and updating the Care Plan. All new admissions will be assessed for preventive measures and ensure these devices are in place. Care plans will be updated with the preventive measures. DHS will audit 5 resident's charts per week to ensure implementation of preventive measures and will ensure the Care Plan is updated. DHS will report findings to QAA monthly.(4) QAA will monitor monthly for any trends and make recommendations to the plan of corrections as noted. QAA will monitor for 90 days or until 100% compliance is obtained.(5) F 314 will be completed by 2/14/14</p>		

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	<p>included the following interventions: "Examine skin daily for signs of redness, discoloration. Assess areas prone to breakdown especially over bony prominences. Provide peri-care after each incontinent episode. Apply moisture barrier after incontinent episode. Pressure reducing mattress on bed. Closely monitor labs as ordered by medical doctor. Monitor meal consumption and provide meal replacement if intake less than 50 %."</p> <p>The health care plan for Alteration in mobility related to status post fracture, initiated on 9/25/13, included the following interventions: "Transfer with the assist of 2. May be up in the wheelchair. Requires assist of 1 to reposition self in bed."</p> <p>Review of the skilled nursing assessments, indicated for 10/5/13, the boxes to mark if the skin was assessed was not checked. On 10/6/13, the skin assessment indicated, currently has skin impairment: the box was checked for bruise. On 10/7/13, the skin assessment indicated, currently has skin impairment: the box was checked for pressure ulcer.</p> <p>An assessment, titled, "Skin</p>			

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	<p>Impairment Circumstance, Assessment and Intervention," completed on 10/7/13, indicated the resident had a new wound. The description of the wound indicated the following: "Stage II area noted to right heel measuring 1.0 cm by 2.0 cm. Color is gray/white. Surrounding tissue pink around blister. Wound margins irregular. Area is painful."</p> <p>The health care plan for Alteration in skin integrity, initiated on 10/7/13, included the following interventions: "Pressure/wound assessment per schedule. Examine skin daily for signs of redness, discoloration. Provide peri-care after each incontinent episode. Pressure reducing mattress on bed. Pressure reducing cushion to chair. Provide supplements as ordered. Monitor meal consumption and provide with meal replacement if intake less than 50%. Educate resident regarding risks associated with non-compliance of treatment and repositioning regarding pressure reduction and development/worsening of skin condition. Weekly skin assessment by licensed nurse."</p> <p>An assessment, titled, "Skin Impairment Circumstance,</p>			

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	<p>Assessment and Intervention," completed on 10/13/13, indicated the resident had a new wound. The description of the wound indicated the following: "Stage II area noted to right middle toe measuring 0.75 cm by 0.75 cm. Color is pink. Surrounding tissue is pink. Wound margins irregular. No pain."</p> <p>On 1/13/14 at 9:15 A.M., an interview with LPN #7 indicated, that upon admission all resident's received pressure relieving mattresses. LPN #7 further indicated that the Resident #39 did not have any pressure ulcers upon admission and a Copra boot (pressure relieving device) was applied to the right heel after the pressure ulcer was identified. There was no indication specific interventions to protect the resident's heel and toe were in place prior to the development of his heel and toe pressure areas.</p> <p>3.1-40(a)(1)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the mattresses fit the bed frames and were free of gaps for 1 of 4 residents in a sample of 30 reviewed for accident hazards. (Resident #77)</p> <p>Finding includes:</p> <p>On 1-8-14 at 1:37 P.M. during an observation of Resident #77's mattress, there was a gap noted between the mattress and bed frame that measured over 5 inches at the top of the bed.</p> <p>On 1-14-14 at 9:45 A.M. during an environmental tour with the Administrator in Training, employee #1, Resident #77's mattress was observed to have a gap at the top of the bed. The gap measured 6 inches from the mattress to the head board.</p> <p>On 1-14-14 at 9:49 A.M. during an interview with Resident #77, she indicated she had never gotten stuck</p>	F000323	F323 Free of Accidents(1.) Resident #77 bed head board was moved in 2 1/2 inches to prevent the gap.(2). All beds were assessed for any gaps. Any bed with gaps were correct at this time. No adverse side effects were noted.(3) Plant operations or designee will monitor 5 rooms per week for any gaps with mattress. Plant operations or designee will report findings to QAA monthly.(4) QAA will monitor monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.	02/14/2014			

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	<p>or wedged in her bed. She further indicated she was able to move herself in bed with the assistance of her side rail.</p> <p>The clinical record of Resident # 77 was reviewed on 1-14-14 at 10:16 A.M. The resident's diagnoses included, but were not limited to: asthma, right groin hematoma, embolism, arthritis, and muscle weakness in lower extremities.</p> <p>On 1-14-14 at 10:58 A.M. a review of the 15 day assessment Minimum Data Set (MDS), completed on 1-1-14 indicated, the resident was alert, oriented, and required assistance for bed mobility and transfers.</p> <p>3.1-45(a)(1)</p>				

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F000329 SS=D	<p>483.25(I) 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 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 observation, record review and interviews, the facility failed to ensure there were adequate indications for the use of an antipsychotic medication and failed to ensure attempts at gradual dose reductions of the antipsychotic medication was attempted for 1 of 5 residents reviewed for unnecessary medications. (Resident #41) In addition the facility failed to ensure there was adequate monitoring of the medical symptom requiring the</p>	F000329	F 329(1) Resident #12 had a gradual dose reduction on 1/20/14. Resident #41 had her chart reviewed and appropriate diagnosis were clarified.(2) All residents with antipsychotic medications were reviewed for gradual dose reductiona and appropriate diagnosis.(3) DHS or designee will monitor residents on antipsychotic medications on a monthly basis and upon admission, for new residents. The information will be reviewed daily in our Clinically at Risk meetings. The findings will be	02/14/2014			

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	<p>use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #12).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #12 was reviewed on 01/10/14 at 10:30 A.M. Resident #12 was admitted to the facility, on 06/18/03, with diagnosis, including but not limited to, muscle weakness, abnormal posture, lack of coordination, late effects of cranial nerve injury, convulsions, difficulty in walking, contracture of multiple joints, status post traumatic brain injury related to motor vehicle accident, dysphagia, major depressive disorder, organic personality syndrome, conductive hearing loss, scoliosis, and aphasia.</p> <p>The current physician's orders for Resident #12 included the antipsychotic medication, zyprexa zydys 5 mg twice a day for hallucinations. The medication had originally been ordered on 10/30/12.</p> <p>Review of psychiatric notes, dated 07/19/12, indicated Resident #12's Zyprexa had been reduced from 10 mg a day to 5 mg a day on</p>		<p>reviewed with Doctor every 6 months to ensure any new GDR's are followed through. Social Service or designee will review all new admissions for appropriate diagnosis. Social Service or designee will monitor 5 charts per week to ensure correct diagnosis and will monthly review resident due for dose reduction. Social Service or designee will report findings to QAA monthly.(4) QAA will monitor monthly for and trends and make recommendations to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p>		

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	<p>02/08/12, but the resident had complained of an increase in vivid dreams about her family members traumatic death and OCD (obsessive compulsive disorder) type behaviors. The resident was also to have been on an antibiotic for a urinary tract infection at the time. Resident #12's Zyprexa was increased to 5 mg twice a day.</p> <p>The current health care plans for Resident #12, located on the clinical record and also on an electronic screen utilized by facility nursing staff, included the following plans related to Resident #12's mood and behavior issues:</p> <p>"Cognition: I currently have a diagnosis of vascular dementia, which is the result of injuries I suffered in the car accident I was in many years ago. My dementia causes me to sometimes obsess or focus on particular things for days on end, which can cause me some anxiety or depression. I can also sometimes forget requests that I made regarding my care or my medications. In spite of my dementia, I am still always oriented x3 and want to be able to make as many decisions for myself as possible, as long as I am safe to do</p>				

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	<p>so. My goal is to be aware of my current health condition and to have a say in my care...General Information:...I am currently taking an antipsychotic and antidepressant. Please observe me for adverse effects. Please notify the doctor as needed of adverse effects. Please attempt to use the lowest dose necessary...I have a dx [diagnoses] of depression. Please provide my medication as ordered. Please provide empathetic listening and support when needed....Moods and Behaviors: I haven't had any behaviors or mood issues in quite a while, but I have a history of resisting care and being physically abusive. I also have a history of mood issues and currently have a diagnosis of depression with psychotic features as well as insomnia. I am currently prescribed an antidepressant and an antipsychotic for these diagnosis [sic]. I have been feeling down lately due to the realization that my health or my condition is not going to improve much (deny any thought of self-harm or suicide). This is something that have been [sic] very difficult for me to accept, so please be supportive of me right now. My goal is to be happy and content here at the facility, to be able to have as</p>				

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	<p>much independence as possible, and to be able to fully communicate without frustration. Please continue to monitor my moods and depression and if you notice any negative changes, please inform my doctor. Please ensure that I continue to see the psychologist from [name of psychiatric specialty group] on a regular basis, as this is something that I benefit from...."</p> <p>Hallucinations or "vivid dreams" were not mentioned in the care plan and there were very few interventions except "support" and "provide medications" listed on the plan to address any of the resident's potential behavior or mood issues.</p> <p>Interview with LPN #11, on 01/13/14 at 9:50 A.M. indicated the staff documented any behavior tracking on the electronic care tracker system. She indicated the nurses could also document behaviors in the nursing notes.</p> <p>Interview with CNA #12, on 01/13/14 at 10:00 A.M., indicated she could locate Resident #12's care plans on the electronic charting screen but she was not aware of any specific tracking she needed to watch for for resident #12. She indicated if the</p>			

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	<p>resident did have a behavior there was a place to document behaviors in the care tracker. Observation of the mood and behavior documentation screen for Resident #12 indicated there were general categories for staff to choose if they were to document a behavior but hallucinations was not specifically listed or identified for staff.</p> <p>Interview with Social Services Director, Employee #13 and RN nurse consultant, Employee #14, on 01/13/14 at 10:30 A.M. indicated the facility did not daily track any specific behaviors or medical symptoms but CNA's (certified nursing assistants) were to document any abnormal behaviors. It was not clear how the aides were supposed to know they should be aware of the need to document hallucinations or "vivid dreams" as a behavior for Resident #12 or how often anyone was asking the resident, who was aphasic but could respond to questions on her computer tablet, of the presence of any of these issues.</p> <p>Review of the Psychotropic Medication Usage and Gradual Dose Reductions policy, dated August 2013, indicated the following: "Procedure: 1. Residents shall</p>						

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	<p>receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process. 2. Regular review of continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacological medications are therapeutic and remain beneficial to the resident. 3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate...." There was no specific policy regarding the frequency and need to monitor for the presence of the medical symptoms for which a psychotropic medication was ordered.</p> <p>2. On 1/14/14 at 2:35 P.M., record review indicated, Resident #41 was admitted to the facility on 07/17/13, with diagnoses including but not limited to, "...dementia with behavioral disturbances, essential hypertension, cardiovascular disease, urinary incontinence and osteoporosis...."</p> <p>The admission MDS (Minimum Data</p>				

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	<p>Set) assessment, completed on 7/24/13, indicated Resident #41's cognitive skills were severely impaired and required extensive assistance with bed mobility and transfers.</p> <p>Admission physician orders, dated 7/17/13, indicated "...Risperdal 0.25 mg (milligrams) 1 tab daily upon rising and Risperdal 0.25 mg 2 tablets at bedtime with a diagnosis of depression...."</p> <p>The resident's current medication regimen included, but were not limited to, "...Celexa 20 mg 1 tablet daily for depression, Risperdal 0.25 mg 1 tablet upon rising for depression and Risperdal 0.5 mg 1 tablet every bedtime for depression...."</p> <p>The health care plan for Moods and Behaviors, no date initiated, included the following: "... I do not have any mental health diagnosis but due to my dementia I do have the behavior of wandering...Please continue to monitor this behavior and if you notice an increase or worsening of this behavior, inform my doctor...."</p> <p>A Mood and Behavior report, dated</p>			

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	<p>7/18/13-1/14/14, indicated on 7/19/13, 7/20/13, 7/21/13, 7/25/13, 7/27/13 and 7/28/13 the resident had an incident of wandering. No other documentation of wandering or any other behaviors are noted.</p> <p>Initial Psychosocial Assessment/MDS Supportive Documentation Tool and Progress Notes dated, 7/24/13, 9/11/13, 10/23/13 and 12/11/13, indicated that the resident had no hallucinations or delusions, the resident has not been physically or verbally abusive towards others, the resident does not scream or make disruptive sounds and the forms indicate the resident has no other behaviors.</p> <p>A Note to the Attending Physician, dated 11/13/13, indicated "...Resident #41 is currently taking Celexa 20 mg daily and Risperdal 0.5 mg at bedtime and 0.25 mg every morning both for depression. She is due for a dose evaluation in an attempt to establish the lowest effective dose...Would a trial reduction of either drug be appropriate at this time?...Physician response: currently dose is felt to be the lowest clinically effective dose...."</p>						

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	<p>On 1/14/13 at 2:26 P.M., an interview with the Social Service Director indicated that the only diagnosis for the Risperdal was depression and that the resident does not have any behaviors other than a few occasions upon admission of wandering.</p> <p>On 1/15/14 at 9:50 A.M., an interview with CNA #9 indicated that she was not aware any any specific behaviors that she was suppose to watch for this resident. CNA #9 further indicated that if the resident did have any mood/behavior issues she would indicate that in the Kiosk, an electronic system.</p> <p>On 1/15/14 at 11:15 A.M., an interview with RN #8 indicated that she contacted Resident #41's attending physician that the resident had prior to her admission to the facility and obtained a physician progress note, dated 4/23/13, the progress note indicated, "...talking to people who aren't present...Diagnosis: Dementia with behavioral disturbance...Plan: Continue Celexa tablet 20 mg 1 tab daily, Continue Risperdal 0.25 mg 1 tab in the morning and 2 tabs in the evening...."</p>						

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F000371 SS=F	<p>There was no documentation of any medical symptom requiring the continued use of an antipsychotic medication. In addition, although the resident's current physician indicated the resident's dose of Risperdal was at the lowest effective dose, there had been no attempts to reduce the antipsychotic medication since the resident had been at the facility and under his care, despite the absence of any behaviors and/or medical symptoms.</p> <p>3.1-48(a)(6)</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 distribute and serve food under sanitary conditions. In addition, the facility failed to ensure that kitchen equipment was clean and sanitary, related to a dirty steam cart and a</p>	F000371	F 371 Kitchen Sanitary(1) The vents and steam table were cleaned per the facility policy.(2) All equipment was assessed and cleaned as needed. No adverse side effects noted at this time.(3) Dietary staff was re-inservice on sanitary and cleaning policies. Cleaning schedule was updated	02/14/2014

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	<p>dirty ceiling vent. This had the potential to affect 50 of 50 residents that receive meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 1/8/14 at 10:45 A.M., during the initial kitchen tour with the Dietary Manager, the following was observed: the ceiling vent above the dish drying rack had dust hanging from the edges of the vent. The steam cart was observed to have a dried yellow substance all along the track of the sliding door located below the steam wells.</p> <p>On 1/8/14 between 12:00 P.M. -12:26 P.M., the following was observed: Cook #6, who was serving the noon meal onto plates, was noted to handle biscuits with his gloved hand that had touched the handles of serving utensils, the handle of a serving cart with a wet dish cloth on it, his face, and paper menu tickets. Cook #6 was not observed to change his gloves or wash his hands before continuing to serve food.</p> <p>On 1/13/14 at 10:55 A.M., an observation of the ceiling vent above the dish drying rack had dust</p>		<p>to include daily and weekly duties to maintain cleanliness, which will be assigned to staff daily. Director of Food Services (DFS) will monitor, and make saniary rounds 3 times per week checking the daily and weekly cleaning schedules. Any deficiencies noted will be corrected at that time. DFS will report findings to QAA monthly.(4) QAA will monitor monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p>				

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	<p>hanging from the edges of the vent. The sliding door track on the steam table was observed to have bread crumbs, a yellow dried substance and rust in the track. Upon opening the sliding door of the steam table an observation was made of the bottom shelf indicating a dried yellow/green substance in the shape of a circle.</p> <p>On 1/13/14 between 11:00 A.M. -11:15 A.M., the following was observed during the preparation of the puree macaroni and cheese: Cook #6 placed the macaroni and cheese into the food processor. While the food was processing Cook #6 was observed plugging the radio into an outlet and then turning on the volume and then wipe the counter off with a wet dish cloth. Cook #6 did not wash his hands before removing the macaroni from the food processor. While Cook #6 held the processor bowl with his left hand his thumb was observed to be inside the bowl touching the puree food.</p> <p>On 1/13/14 at 11:20 A.M., an interview with the Dietary Manager indicated that the steam table was not clean and would be cleaned immediately. The Dietary Manager indicated that the steam table was</p>				

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	<p>not listed on the daily cleaning schedule but that the dietary staff were to clean it daily along with all of the other appliances in the kitchen. The Dietary Manager further indicated that the ceiling vents were to be cleaned by the maintenance department and she was unsure when they were last cleaned.</p> <p>On 1/13/14 at 2:15 P.M., review of the current policy titled "Guidelines for Handwashing" received from the Dietary Manager indicated "...1. All health care workers shall wash their hands frequently and appropriately...3. a. Health care workers shall wash hands at times such as: before/after eating, after smoking, toileting, blowing nose, coughing, sneezing, handling hair, etc. b. Before/after preparing/serving meals...."</p> <p>On 1/13/14 at 2:20 P.M., review of the current policy titled "Preventative Maintenance Procedure" received from the Dietary Manager indicated "...Ceilings: Should ceilings show signs of dust collection around ceiling vents, the air filters should be replaced for the HVAC unit servicing those vents. The ceiling should be cleaned using a feather duster...."</p>			

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	<p>On 1/14/14 at 11:45 A.M. review of the current policy titled "Steam table Cleaning Procedure" received from the Dietary Manager indicated "...1. As needed: A. Wipe down outside of equipment with a clean cloth dipped in sanitizing solution. B. Clean up spills...."</p> <p>3.1-21(i)(3)</p>			

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F000431 SS=D	<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> <p>Based on observation, record review and interviews, the facility failed to ensure narcotic and antianxiety medications were reconciled on 1 of</p>	F000431	F431 Drugs Records(1) Resident #30 Mediations in the narcotic drawer were counted and verified by 2 Licensed Nurses.(2) All medications in the narcotic	02/14/2014			

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	<p>3 medications carts observed for medication storage. This deficient practice potentially affected 1 of 50 residents currently residing in the facility. (Resident #30)</p> <p>Finding includes:</p> <p>1. Observation of the medication carts, conducted on 01/14/14 between 1:30 - 2:00 P.M., indicated there were 5 bottles of medications located in the narcotic lock box of medication cart #2. Interview with RN #2, on 01/14/14 at 2:00 P.M., indicated the medication belonged to Resident #30. RN #2 indicated Resident #30's family usually purchased her medications from a private pharmacy and brought them to the facility. Resident #30 had recently received skilled Medicare coverage so her medications were ordered from the facility's pharmacy during this time. She indicated the five bottles, which had been taped closed with masking tape and had the narcotic record, folded and wrapped around the bottles, secured with a rubberband, were not being used or reconciled while there were medication cards for the same medications from the facility pharmacy.</p>		<p>drawer were counted.(3) Licensed Nurses were re-inserviced on counting of all scheduled narcotics. Each nurse will do an oncoming and off going shift count. All medications in the box will be counted. DHS or designee will monitor 5 times per week to ensure count is being completed- this will include audits of all 3 shifts. DHS or designee will report findings to monthly to QAA.(4) QAA will monitor monthly for any trends and make recommendations to the plan of corrections as needed. QAA will monitor for 90 days or until 100% compliance is obtained.</p>				

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	<p>Interview with RN #14, a corporate nurse, on 01/15/14 at 11:00 A.M., indicated the facility narcotic policy indicated the medications in the narcotic drawer should have been counted and documented on the narcotic sheets. On 01/15/14 at 11:20 A.M., RN #14 provided documentation which indicated the five bottles of medications for Resident #30, which were not being reconciled, were as follows: three bottles of Lorazepam .5 mg tablets (a medication to treat anxiety), one bottle of Lortab 5/500 mg tablets (a narcotic pain medication), and one bottle of zolpidem 5 mg tablets (a hypnotic medication to induce sleep).</p> <p>Review of the facility's Medication Storage in the Facility policy, dated 09/01/13, and verified as current by RN #14, on 01/15/14 at 11:00 A.M., included the following procedures: "...B. Schedule II - V medications and other medications subject to abuse are stored in a permanently affixed compartment separate from all other medications under double lock. The access system to controlled medications is not the same as the system giving access to other medications. If a key system</p>						

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	<p>is used, the medication nurse on duty maintains possession of the key to controlled medication storage areas. Back up keys to all medication storage areas, including those for controlled medications, are kept by the director of nursing. C. A controlled medication accountability record is prepared by the (pharmacy/facility) for all Schedule II, III, IV, and V medications..., including those in the emergency supply. The following information is completed: 1) Name of resident, if applicable 2) Prescription number, if applicable 3) Name, strength, and dosage form of medication 4) Date received 5) Quantity received 6) Name of person receiving medication supply D. At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record...."</p> <p>There were no other instructions regarding taping medication bottles closed and not using the accountability record system.</p> <p>3.1-25(e)(3)</p>				

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