STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

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F000000	This visit was for the Recertification and State Licensure Survey. Survey dates: February 10, 11, 12, 13, 14, 17, 18, and 19, 2014. Facility number :012644 Provider number : 155793 AIM number : 201046710 Survey team : Michelle Hosteter, RN-TC February 10, 11, 12, 13, 17, 18, and 19, 2014 Gloria Bond RN, February 12, 13, 14, 17, 18, and 19, 2014. Sandra Nolder RN February 11, 12, 13, 14, 17, 18, and 19, 2014. Janet Stanton RN Census bed type: SNF: 36 SNF/NF : 67 Residential : 27 Total : 130 Census payor type: Medicare : 32 Medicaid : 30 Other : 68 Total : 130 Residential Sample : 7	F000000	March 7, 2014 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on February 19, 2014. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on March 21, 2014. If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 19,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 Quality Review was completed by Tammy Alley RN on February 25, 2014.		201. Please accept this plan of correction as Hamilton Trace of Fisher's credible allegation of compliance by March 21, 2014. This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	
F000242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. 4. In an interview on 2/12/14 at 3:00 P.M., Resident #93 indicated she would enjoy having a tub bath occasionally. She indicated she used to take a tub bath at home, but had not been able to for a long time because she could not physically get into the regular soaker tub at home. No one in the facility had informed her that a handicapped-accessible tub was	F000242	F242 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #93 no longer resides at the community. Resident #240 no longer resides at the community. Resident #119 is being offered a shower/bath per her preferred time. The C.N.A. assignment sheet were updated to reflect the resident's time	03/21/2014

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	available, or had ever asked her if she would like a tub bath. The clinical record for Resident #93 was reviewed on 2/13/14 at 1:49 P.M. Diagnoses included, but were not limited to, history of acute respiratory failure and interstitial pneumonitis, muscle weakness, edema, transient cerebral ischemia, chronic obstructive pulmonary disease, acute pain, and depressive disorder. An Admission MDS (Minimum Data Set) assessment, dated 11/27/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "15" (a score of 13-15 indicated cognitively intact). The section for "Preference for Customary Routine and Activities" indicated it was "Somewhat important" for the resident to choose between a tub bath, shower, bed bath or sponge bath. An "Activity Assessment," completed by the Activity Director on 11/26/13, repeated the questions from the MDS and was marked to reflect the same information: "Somewhat important" to choose shower, tub bath, etc. One Care Plan entry, dated 11/27/13, indicated the resident required staff		preference. Resident #51 is inaccurate. Resident should be #104. Resident #104 is being offered a shower/bath. The C.N.A. assignment sheet, and Physicians order has been updated to reflect the residents preferred bathing time and method of bathing. Resident #239 did receive his requested amount of insulin. LPN #10 received education regarding a resident's right to refuse a physicians ordered medication. II. The facility will identify other residents that may potentially be affected by the deficient practice. Resident's residing in the facility had the potential to be affected. The facility has completed an audit of current residents to determine their choice of shower/ bath and preferred bathing times. C N A assignment sheets were updated to reflect the preferences of bath/shower and preferred bathing times. Residents receiving insulin could potentially be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. New admissions will be interviewed upon admission to determine their choice of shower/ bath and preferred bathing time. Nursing personnel were re-educated on the importance of giving choice of a bath/shower, preferred bathing times and following the C.N.A. assignment sheets. New nursing personnel	

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	assistance with ADL (Activity of Daily Living) skills. There were no interventions related to giving resident a choice of tub bath. No Care Plan entries were found addressing resident's preference for an occasional tub bath. The "CNA Daily Assignments" sheet, provided by LPN #12 who indicated it had been updated on 2/14/14, indicated the resident was to receive a "Shower/Bed Bath" on Monday and Friday evenings. There were no instructions to offer a tub bath, no information about resident's desire to have a tub bath, or that making that choice was "somewhat important" to her. On 2/17/14 at 9:15 A.M., the Social Service Director provided an "Observation Report" for "Social History Assessment," completed on 2/4/14. She indicated this form addressed the residents preferences related to a shower or bath. Two questions on the form addressed: "What was resident's method of bathing as a child? Include type, frequency, day, etc.;" and "What is resident's method of bathing as an adult? Include type, frequency, day, etc." The answer to both questions was marked as "Shower," with no other information.		will be educated on the importance of giving resident's choice of a bath/ shower and preferred time of day. Licensed nurses were re-educated on resident choice regarding insulin administration. Resident preferences will be discussed during MDS assessment periods and during resident Care Plans, updating the and C.N.A. assignment sheet as needed. Resident preferences will be discussed during Resident Council Meetings and the information will be presented to the appropriate Department for follow-up. IV The facility will monitor the corrective action by implementing the following measures. The DON or designee will audit new admissions for bathing preferences 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. Staff Development Coordinator or designee will audit by observation of insulin administration rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed immediately. Results of audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of	

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	On 2/19/14 at 9:40 A.M., the Marketing/Admissions Director provided a "Prior Level of Function Assessment" form, dated 11/21/13 by a family member. The form indicated the resident had a "Prior Level of Function" for bathing by using "sink, tub, walk-in shower with help." 5. In an interview on 02/13/14 at 9:01 A.M., Resident #240 indicated she "would love to take a tub bath." She indicated she had never asked to have one, but had never been asked if she would like one, either. The resident indicated she was not aware that a handicap-accessible tub bath was available in the facility. The clinical record for Resident #240 was reviewed on 2/14/14 at 1:04 P.M. Diagnoses included, but were not limited to, muscle weakness, difficulty walking, mild cognitive impairment, chronic coronary artery occlusion, depressive disorder, acute pain, osteoporosis, and diabetic neuropathy. An Admission MDS (Minimum Data Set) assessment, dated 2/3/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "15" ((a score of 13-15 indicated cognitively intact).		Correction completion date. Plan of Completion date is March 21, 2014.	

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	The section for "Preference for Customary Routine and Activities" indicated it was "Very important" to the resident to choose between a tub bath, shower, bed bath or sponge bath. An "Activity Assessment," completed by the Activity Director on 1/30/14, repeated the questions from the MDS and was marked to reflect the same information: "Very important" to choose shower, tub bath, etc. A Care Plan entry, dated 1/30/14, indicated the resident required staff assistance with ADL (Activity of Daily Living) skills. There were no interventions related to giving resident a choice of tub bath. No Care Plan entries were found addressing resident's preference for an occasional tub bath. The "CNA Daily Assignments" sheet, provided by LPN #12 who indicated it had been updated on 2/14/14, indicated the resident was to receive a "Shower/Bed Bath" on Tuesday and Thursday on day shift. There were no instructions to offer a tub bath, no information about resident's desire to have a tub bath, or that making that choice was "very important" to her.			

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	On 2/17/14 at 9:15 A.M., the Social Service Director provided an "Observation Report" for "Social History Assessment," completed on 2/3/14. She indicated this form addressed the residents preferences related to a shower or bath. Two questions on the form addressed: "What was resident's method of bathing as a child? Include type, frequency, day, etc.;" and "What is resident's method of bathing as an adult? Include type, frequency, day, etc." The answer to both questions was marked as "Shower," with no other information. On 2/19/14 at 9:40 A.M., the Marketing/Admissions Director provided an undated "Prior Level of Function Assessment" form. In an interview at that time, she indicated the form was completed on the date of the resident's admission. The form indicated the resident had a "Prior Level of Function" for bathing by using a "walk-in shower." 6. In an interview on the 800 Hall on 2/13/14 at 2:13 P.M., LPN #4 indicated there was no tub bath on that unit--all of the resident rooms had a shower. The nurse indicated there was a whirlpool tub on the Skilled unit (the 600/700 Hall). In an interview on the 600/700 Hall on			

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	2/13/14 at 2:20 P.M., CNA #5 indicated there was only one bath tub in the building, and it was located in the central shower room on this unit, the Skilled unit. She indicated if a resident expressed a preference or desire for a tub bath, that information would be available to the CNAs in the computerized Nurse Aide assignment sheet information. The CNA indicated she had never used the tub to give a resident a tub bath from the time she was hired about 4 months ago. The central shower room observed at that time. There was a handicapped accessible whirl-pool tub available. In an interview on the 300/400 Rehab Hall on 2/13/14 at 2:28 P.M., LPN #6 indicated there was no bath tub available on that unit, only on the Skilled Unit. In an interview on 2/13/14 at 2:52 P.M., the Activity Director indicated that although she completes the Activity MDS Assessment form, she does not really have anything to do with the "care preference" part. She indicated she dealt mainly with the activity preferences. She indicated there was a "personal preference" form completed at admission. The Activity Director indicated that most of the residents did not express specific preferences, but if they did, she would go			

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	to the unit nurse and tell them about that preference. In an interview on 2/13/14 at 3:14 P.M., the Administrator indicated the Admission Director completed a paper "Preference" form at admission for each resident, which was then copied and handed out to the nurses on the unit. She indicated the nurses were supposed to see that any specific preferences identified on the paper were incorporated into the plan of care. She indicated these forms were discussed during the stand-up staff meetings. On 2/13/14 at 3:25 P.M., the Administrator provided a copy of the paper "Preference" form used by the Marketing/Admission Director. The form listed "Care Requests" for preferred awakening time, preferred bedtime, type of bathing ("shower, whirlpool, bedbath, other"), time for bathing ("morning, afternoon, evening'), and day of week. In an interview on 2/14/14 at 10:21 A.M., the Marketing/Admissions Director indicated she verbally goes over the paper "preference" form with each new resident. She indicated she specifically asked if the resident wanted a shower or a tub bath. She indicated she made sure the resident was aware that a			

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	handicap-accessible tub was available to use. The Director indicated she scans the paper and e-mails it to the nurse on the unit. In an interview on 2/14/14 at 1:27 P.M., LPN #7 and RN #8 indicated the paper "Preference" sheet was scanned by the Admission Director and e-mailed to the Unit Manager nurse. The Unit Manager nurse was responsible for placing that information into the computer for the CNA assignment sheets, which listed routine and special care information. In an interview on 2/14/14 at 2:40 P.M., the Administrator indicated they were unable to find the "Preference" form e-mails, which were supposed to be completed at admission, scanned, and sent to Unit Manager for Residents #93, #104, #119, #239, and #240. 3.1-3(u)(1) Based on observation, interview, and record review, the facility failed to honor the residents preferences for time of day for bathing, number of baths per week, and of method of bathing for 4 of 4 residents reviewed for bathing choices. (Resident #119, #51 & #93, & #240). In			

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	addition the facility failed to honor the preference for amount of insulin medication for 1 of 1 resident reviewed for medication choice. (Resident #239) Findings include: 1. The record for Resident #119 was reviewed on 2/14/2014 at 11:30 A.M. Diagnoses included, but were not limited to, melanoma, hypertension, and hemorrhoids. The February 2014, just updated on 2/14/2014, CNA (Certified Nursing Assistant) daily assignment sheet indicated this resident was scheduled to get a shower on Tuesdays and Fridays on the 3 P.M. to 11 P.M. shift. The assignment sheet also indicated Resident #119 was alert and oriented and that her family member visited often. In an interview on 2/12/2014 at 2:45 P.M., the resident indicated she was informed when her shower times were by the nursing assistants, but the time does not work out. The CNAs come and ask her usually during a time when her family member is visiting, or at a time that is not convenient for her, and then she ends up not getting a shower that was scheduled. In an interview on 2/14/2014 at 10:45			

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	A.M., the Admissions Director indicated regarding the residents preferences, she filled out a preference form on admission. The Unit Managers were sent the form by e-mail and then the Unit Managers made the schedules out. In an interview on 2/18/2014 at 10:40 A.M., Resident #119 indicated she usually does not get her scheduled shower, and she use to take a tub bath when she was more independent, but she does not suppose she could get in and out of a tub at this time. She was never offered the choice of a tub bath either but did not want to bother the staff. In an interview on 2/18/2014 at 9:07 A.M., LPN #2 indicated as the Unit Manager, she did not regularly go and ask if a resident's shower schedule or method of bathing was working out. Resident #119's "Prior Level of Function Assessment" dated 3/22/13 was provided by the Admissions Director on 2/19/2014 at 9:30 A.M., and reviewed at this time. The record indicated only level of function but no questionnaire regarding preferences or choices. The record indicated the resident bathed using a sink. The other choices listed were tub and walk-in shower but an X was only next to sink.			

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	2. During an interview on 02/12/14 at 2:59 P.M., Resident #51 indicated he had asked the staff to get a whirlpool bath instead of a shower because he thought it would help his left shoulder and back pain. He indicated the staff told him there was a whirlpool tub available, but they did not have time to give him a whirlpool bath. He indicated he wished to have whirlpool baths. The resident indicated he was scheduled to receive his showers on Wednesdays and Saturdays, but he indicated he would not get his showers as scheduled. On 02/12/14 at 2:59 P.M., the dry erase board in the resident's room listed Wednesday and Saturday for the resident's shower days. The "Point of Care History" dated 11/1/2013 to 2/18/2014, indicated the resident was scheduled to get a shower on the following dates, but he received a partial bath: 11/23/13, 12/07/13, 01/15/14, and 01/22/14. The "Point of Care History" dated 11/01/2013 to 02/18/2014 indicated the resident was scheduled to get a shower and there was no documentation found to indicate he received a shower or a partial bath on:11/20/13, 11/30/13, 12/04/13,			

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	12/11/13, 12/21/13, 01/01/14, 01/04/14, 01/08/14, 01/18/14, 02/01/14, 02/05/14, and 02/15/14. The resident's record was reviewed on 02/13/13 at 10:31 A.M. Diagnoses included, but were not limited to, acute pain. A medication list dated for February 2014 indicated the resident's Physician's orders included, but were not limited to the following: 08/09/13-Shower twice weekly on Mondays and Thursdays at 8 A.M. An undated document titled "CNA Daily Assignment," provided by an unidentified CNA on 02/14/14 at 1:30 P.M., indicated the resident's shower days were scheduled for Wednesdays and Saturdays on the 7-3 shift. A Quarterly Minimum Data Set Assessment dated 01/04/14 indicated the resident's Brief Interview for Mental Status was a 14, which indicated he was cognitively intact. The assessment also indicated the resident's choices for choosing between a tub bath, shower, bed bath or sponge bath was very important for him. During an interview on 02/14/14 at 02:00			

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	P.M., LPN #2 indicated she got the "Preference List" from the admission persons, then she verified with the resident that the preferences on the list were correct. After she verified the preferences with the resident she placed them on the "CNA Daily Assignment" sheet. During an interview on 02/18/14 at 1:40 P.M., CNA #9 indicated the resident had a whirlpool tub bath when he first came into the facility, but he required 3 person assist to transfer him into the whirlpool tub. She indicated the assignment sheet told her he received showers, so she gave him showers. She indicated she did not give him a choice between a shower and a whirlpool bath. She indicated he received showers on Wednesdays and Saturdays. During an interview on 02/18/14 at 1:59 P.M., LPN #2 indicated she did not know why the nurses were signing off the resident's shower days as Mondays and Thursdays when he received his showers on Wednesdays and Saturdays. She indicated when he was admitted to the facility his shower days were probably on Mondays and Thursdays and no one changed the Physician's order in the computer when his shower days changed to Wednesdays and Saturdays.			

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	3. Resident # 239's record was reviewed on 02/19/14 at 9:00 A.M. Diagnoses included, but were not limited to, end stage renal disease, anxiety and diabetes mellitus type II. An Admission Minimum Data Set Assessment dated 02/15/14 indicated the resident had a Brief Interview for Mental Status of 13, which indicated he was cognitively intact. A medication list dated for February 2014 indicated the resident's Physician's orders included, but were not limited to the following: 02/08/14-Novolin 70/30 insulin 100 unit/ml 8 units subcutaneous twice a day On 02/14/14 at 9:15 A.M., LPN #10 was observed to perform a finger blood glucose stick. After she finished she indicated to the resident he required eight units of Insulin for his blood sugar reading. The resident indicated he did not want the eight units of insulin, he wanted four units of insulin. LPN #10 excused herself. A progress note dated 02/14/14 at 9:15 A.M., indicated the doctor was notified the resident had refused his eight units of Novolin 70/30 insulin and he was only			

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	going to take four units. The doctor gave an order the resident was to be given the four units of Novolin 70/30 if he continued to refuse the eight units. LPN #10 then returned to the medication cart and drew eight units of Novolin 70/30 insulin into a syringe before she entered the residents room. She indicated to the resident the doctor wanted him to receive the eight units. He refused and indicated he wanted four units because his blood sugar would drop too low and his blood sugar would be monitored at dialysis for hyperglycemia (high blood sugar) and they would treat him if needed. LPN #10 cleansed the resident's abdomen with an alcohol swab and began to administer the insulin. At that time, the LPN was asked to step into the hallway. When queried how much insulin she was going to administer, she indicated she was not going to inject the 8 units, but rather waste 4 units onto the floor before administering the insulin. The LPN then re-entered the resident's room and wasted 4 units of the insulin in the sink and administered the insulin to the resident. During an interview on 02/14/14 at 3:00 P.M., the Director of Nursing indicated she would have asked the resident if he			

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	wanted the eight units of Insulin before she drew that amount into a syringe and took it into his room to administer it.			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview, the facility failed to have a Care Plan for a resident with a diagnosis of Addison's disease, or a behavior care plan for a resident with dementia who displayed behaviors for 2 of 26 residents reviewed for care plans. (Resident #230 and Resident #114) Findings include:	F000279	F279 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. We disagree with the findings due to there was erroneous information submitted in the 2567. Resident #230 no longer resides in the community. The care plan for resident #114 has been updated to reflect behavior of crying with appropriate	03/21/2014

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	1. The record review for Resident # 230 was completed on 2/13/14 at 10:30 AM. Diagnoses included, but were not limited to, anxiety disorder, depression, and Addison's disease. A physician's order dated 1/27/14, indicated the resident had received a medication of Cortef (a steroid) 20 milligrams (mg) in the morning and 10 mg. in afternoon. A hospital discharge summary report dated 1/27/14, indicated, "...2. Addison's disease/crisis-Pt c/o [complained of] generalized weakness over the course of this week, worse today and was unable to walk. Typically takes cortef 20 mg in morning and 10 mg in evening. Given intravenous Cortef 100 milligrams in the emergency department with resolution of weakness and hypotension. Will continue stress dose of Solu-Crotef every 8 hours. Monitor blood pressure closely...." There was no Care Plan addressing the resident's Addison's disease, or how nursing staff were to monitor the resident for side effects of medications or signs and symptoms of complications from Addison's disease.		interventions. Resident #114 had care plans in place for wandering, hoarding, anxiety, nervousness and aggression. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who have Addison's disease could potentially be affected. Current residents who have dementia who display behavioral symptoms could potentially be affected. Residents on the behavior program were reviewed and care plans were reviewed and updated as needed to determine that appropriate interventions were present. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Staff were re-educated on the development of comprehensive care plans. IDT associates have been provided education on the requirement to update the care plan for any residents who have dementia who display behavioral symptoms and/or when the intervention in place needs to be changed for more appropriate care and treatment of a resident. Care plans are reviewed and revised, as needed, during IDT at Risk Meetings, quarterly or with significant changes to ensure they reflect the resident's individualized plan of care. IV The facility will monitor the corrective action by implementing the following measures. The	

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	On 2/17/14 at 10:15 A.M., the Director of Nursing indicated they did not have a care plan for Resident #230 for Addison's disease. 2. The record review for Resident #114 was completed on 2/17/14 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, and dementia with delusions. The physician's recapitulation for February 2014 indicated the resident was on Zyprexa (an antipsychotic medication) 5 milligrams 1 tablet every evening at 5:00 P.M. and 2.5 milligrams in morning for dementia with delusions. The progress notes for nursing and the behavior symptom reports were reviewed for February 2013 through February 2014. There was documentation of the resident's behaviors of hoarding, wandering, anxiousness, agitation, and crying. There was no care plan for the resident's behaviors. On 2/17/14 at 10:03 A.M., the Director of Nursing indicated there was no behavior care plan for Resident #114. 3.1-35(a)		DON or designee will audit new admissions for care plans related to admitting diagnosis 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. The DON or designee will audit new admissions for care plans for residents on a steroid medication 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. The Social Service Director or designee will review care plans of residents with behavioral symptoms 5 times a week for 2 weeks, 3 times a week for 2 weeks, weekly for 2 months and then monthly thereafter for a total of 12 months. Any identified concerns will be addressed. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date Plan of Completion date is March 21, 2014.	

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to monitor bowel movements and administer laxatives for 1 of 1 residents reviewed for bowel movements. (Resident #104) Findings include: Resident # 104's record was reviewed on 02/13/13 at 10:31 A.M. Diagnoses included, but were not limited to, constipation and paralysis agitans (Parkinson's). The Quarterly Review Minimum Data Set Assessment dated 01/04/14 indicated the resident's Brief Interview for Mental Status score was 14, which indicated the resident was cognitively intact. A medication list dated for February 2014 indicated the resident's Physician's orders included, but were not limited to the following:	F000309	F309 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #104 bowel movements have been monitored daily through the Clinical Daily Meeting (Monday through Friday). Resident #104 has not had a negative outcome related to their bowel function. Medication for constipation is given as needed per the physician's orders. II. The facility will identify other residents that may potentially be affected by the deficient practice. Current residents with a diagnosis of constipation have the potential to be affected. BM records were audited to identify any residents who have not had a BM in 3 consecutive days. Any residents identified were provided treatment per the Bowel Management Policy and Procedure. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Nursing associates	03/21/2014

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	10/10/13-Milk of Magnesia (laxative) 30 ml daily as needed for constipation. 10/10/13-Miralax (laxative) 17 grams daily as needed for constipation. 10/15/13-2 liter fluid restriction. Special Instructions: Dietary: 1000 ml/day (milliliters) and Nursing: 330 ml/shift. 10/15/13-Colace (stool softener) 100 mg 1 capsule twice a day for constipation. The resident had a Care Plan dated 10/11/13, that addressed the problem of constipation related to decreased mobility. Interventions included, but were not limited to the following, 02/05/14-"document and record all bowel movements, Observe for s/s [signs and symptoms] of constipation," 10/11/13-"report any concerns to md [physician], Administer medications per MD order. Monitor effectiveness and side effects, Assess bowel sounds as needed." A document titled "Vitals Report" dated 11/01/13 to 02/18/14 indicated the following dates were documented as no bowel movement or had no documentation that the resident had a bowel movement: 11/17/13 thru 11/19/13 (3 days); 12/5/13 thru 12/7/13 (3 days); 12/15/13 thru 12/17/13 (3 days); 12/21/13 thru		were re-educated on community's management of constipation. Current resident's bowel movements will be monitored daily with interventions as indicated in the facility's Bowel Management Policy/Procedure, as needed. Daily reports of the resident's bowel movements will be monitored by the licensed nursing staff and interventions will be administered per physician orders. IV The facility will monitor the corrective action by implementing the following measures. The unit manager or designee will review the resident's bowel record daily to ensure each resident's bowel pattern is maintained within the facility's Bowel Management Policy/Procedure. The DON/designee will review bowel movement reports 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then weekly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	12/23/13 (3 days); 12/25/13 thru 12/28/13 (4 days); 12/30/13 thru 01/02/14 (4 days); 01/06/14 thru 01/09/14 (4 days); 01/31/14 thru 02/03/14 (4 days); 02/09/14 thru 02/11/14 (3 days); 02/13/14 thru 02/16/14 (5 days) No documentation was found to indicate the resident had been given a laxative on the above dates for no bowel movement after a 3 day period. During an interview on 02/18/14 at 4:02 P.M., CNA #11 indicated she documented bowel movements in the computer under the resident's name in one section for continence then charted on the characteristics of the bowel movement (BM). She indicated if the BM had a foul odor, was loose, or was not the correct color or she had any other concern she would report her concerns to her nurse. During an interview on 02/18/14 at 4:06 P.M., RN #8 indicated if a resident did not have a BM for three days she would give Milk of Magnesia (MOM) first. She would wait for eight hours and if no BM, then she would call the Physician for orders. She indicated usually a suppository would be ordered next and if that did not work by the end of her shift			

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	she would call the Physician back for new orders. She indicated the doctor would most likely order an enema at that time. She indicated she would open a "Change of Condition Event", which would include assessing the bowel sounds and palpating the abdomen. She indicated every shift was responsible for assessing if the residents had a BM and responsible for the administration of laxatives as needed. A current policy titled "Management of constipation," dated 01/2012, indicated "The bowel elimination pattern of each resident is considered regular if the resident has at least one movement every three days. Constipation is defined as having 2 or fewer bowel movements per week, or having to strain more than 1 out of 4 times when having a bowel movement... Laxatives should be considered when there is no bowel movement for 3 or more days... The Evening Shift Nurse will assess and offer the PRN laxative to any appropriate resident who has not had a BM for 3 days. If the laxative is refused, this will be recorded on the BM report and in the nurses notes of the applicable patients chart. Each additional day the patient has not had an adequate bowel movement the nurse will assess and provide additional interventions. Medication will be			

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	administered only with Physician order. If after above interventions have been provided per Physician order have been provided and the patient has not had an adequate bowel movement, the patient will be assessed and the Physician will be notified." 3.1-37(a)			
F000314 SS=G	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 observation. interview and record review, the facility failed to provide effective and timely interventions to prevent a facility acquired unstageable pressure ulcer for 1 of 1 residents and a stage 2 pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. This deficient practice affected 2 of 2 residents in a sample of 2 residents reviewed for	F000314	F314 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #163 no longer resides in the community. Resident #51 has had a complete skin assessment performed and is receiving appropriate treatment, weekly skin assessments, and preventative care. There is	03/21/2014

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	pressure ulcers. Resident #51's pressure ulcer to the right heel was first identified on 02/03/14 as an unstageable ulcer. (Residents #51 and #163) Findings include: 1. Resident #51's record was reviewed on 02/17/14 at at 2:32 P.M. The resident's diagnoses included, but were not limited to, fractured hip aftercare, muscle weakness, difficulty in walking, gait abnormality, depressive disorder, backache, Vitamin B12 deficiency anemia, Vitamin D deficiency, dementia, chronic pain syndrome. A medication list dated February 2014 indicated the residents Physician's orders included, but were not limited to the following: 10/08/12-Skin integrity checks weekly on Tuesdays. 12/13/13-Skin prep (skin protective barrier wipes) to both heels at bedtime. 02/04/14-Santyl (wound debridement medication) to wound bed, cover with telfa and wrap with kerlix at bedtime. (Discontinued on 02/11/14) 02/11/14-Cleanse right heel with normal saline or wound cleanser. Pat dry. Apply skin prep to periwound. Apply a thick layer of Santyl to wound bed, cover with guaze, wrap with loosely kerlix and		evidence on the weekly skin assessment that the wound is healing. We disagree with the findings and had additional information that we were not permitted to submit. Physician for resident #163 and #51 was on site during survey and prepared to speak with ISDH surveyors. Survey team told physician they did not need to speak with him. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who admit with a hip fracture and are at risk for pressure ulcers could be affected. Residents who are at risk for pressures ulcers have been identified. Care plans for residents identified as high-risk for developing skin breakdown have been reviewed to ensure appropriate interventions are in place. C N A assignment sheets were updated with appropriate interventions as needed. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Nurse managers have been re-educated on updating C.N.A. assignment sheets for new or updated pressure reduction interventions. Licensed nurses will conduct rounds on residents with care plan interventions to ensure interventions are occurring. Pressure reduction interventions will be documented on the resident TAR. Nursing staff will	

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	secure with tape. Change daily and as needed for soilage or dislodgement (comes loose) at bedtime. A Significant Change Minimum Data Assessment dated 12/20/13 indicated the resident was at risk for pressure ulcers. The resident's Brief Interview for Mental Status was a 10, which indicated the resident was moderately cognitively impaired. He was always incontinent of bladder and frequently incontinent of bowels. He required extensive assistance with two person assistance for bed mobility, transfers, toileting and personal hygiene. He required extensive assistance with one person assitance for dressing. A current document titled, "CNA Daily Assignments" provided by an unidentified CNA on 02/14/14 at 1:30 P.M., indicated the resident was alert, but confused, required extensive assistance of two person physical assist for transfers and bed mobility, the resident had a right heel pressure ulcer. The document did not indicate the resident's heels were to be elevated. The resident's Care Plan dated 09/27/12, addressed the problem the resident was at risk for skin breakdown related to decreased mobility and required		be in-serviced by Staff Development Coordinator on risk factors for skin breakdown and interventions to prevent pressure wound development. New Admissions with a diagnosis of hip fracture will be discussed during the weekly interdisciplinary meeting for appropriate interventions, care planning and implementation of preventative care. IV The facility will monitor the corrective action by implementing the following measures. DON or designee will conduct rounds on residents with care plan interventions for residents at high-risk for developing pressure wounds weekly for 4 weeks, then monthly 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the rounds will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	assistance. The interventions included, but were not limited to the following: 12/07/13-"Monitor skin for abnormal changes daily", 09/27/13-"Pressure reduction mattress, Weekly skin assessment, and Turn and repositon per staff." No Care Plan could be found that specifically addressed the problem with interventions that the resident resisted pressure ulcer interventions to prevent a pressure ulcer or to treat a pressure ulcer. The resident's Care Plan dated 02/04/14, addressed a problem the resident had a pressure ulcer to the right heel related to vitamin deficiency, anemia, and decreased mobility. The interventions included, but were not limited to the following: 02/12/14-"encourage resident to elevate heels while in bed" 02/04/14-"Apply dressings per MD order, Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue and epithelizatiion, and condition of surrounding skin at least weekly, Conduct a systematic skin inspection at least weekly. Report any signs of any further skin breakdown (sore, tender, red, or broken areas). Report signs of cellulitis (localized pain, redness,			

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	swelling, tenderness, drainage, fever); sepsis (fever, malaise, change in mental status, tachycardia, hypotension, N/V); osteomyelitis (pain, redness, swelling, muscle spasms in affected joint, fever), Turn and reposition at least every 2 hours." A document titled, "Skin--Pressure Ulcer Evaluation" dated 02/04/14 indicated the resident had an unstageable (unable to determine the stage of the ulcer due to it was covered with yellow or black tissue and the true depth of the ulcer cannot be determined) pressure ulcer to his right heel that he acquired in the facility. The date of onset for the ulcer was 02/03/14. The measurements of the pressure ulcer were 1.5 x 0.5 x 0 cm (centimeters). There was no undermining (lip of tissue around an area of the edge of the wound), odor or exudate (drainage). The wound bed was 100% yellow colored and the periwound (the skin surrounding the wound) was pink and bright red. The weekly skin assessments from 11/01/13 to 02/01/14 did not indicate the resident had any open areas or pressure ulcers. A document titled, "Skin--Pressure Ulcer Evaluation" dated 02/11/14 indicated the resident's right heel pressure ulcer was developed in the facility. The onset date was 02/03/14. The wound was			

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	unstageable. The wound was a yellow circular mushy area that measured 2 cm with a 1.0 x 1.5 x <0.1 cm open area inside the yellow area. The open area wound bed had a pink perimeter and a white center. The wound bed was red and the periwound was pink. The wound did not have any undermining, odor or exudate. No documentation was found that indicated the resident's right heel was elevated from 02/03/14 to 02/18/14 after the right pressure ulcer was discovered to prevent further pressure to the area. No documentation was found to indicate the resident's bilateral heels had been elevated prior to the development of the right pressure ulcer on 02/03/14. During an observation of the resident's pressure ulcer dressing change on 02/18/14 at 12:53 P.M., by LPN #2, the open area was measured at 1.0 x 0.4 x <0.1 cm. The wound bed was red and white and the periwound was pink. The back of the heel had a light brown colored hard flap of skin attached to it that could be lifted up. The old dressing had a dimed size amount of yellow colored drainage on it. LPN #2 completed the resident's dressing change to his right heel without applying the			

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	Santyl. She indicated before she began the dressing change, there was no Santyl available. She had to reorder it from the Pharmacy and when the medication was available she would have the resident's nurse change the dressing to apply the medication. After the dressing change, the resident was observed up in his wheelchair with black shoes on that had velcro closures and his bilateral feet were resting on the foot rests of the wheelchair. During an interview on 02/11/14 at 1:08 P.M., the Assistant Director of Nursing indicated the resident had an unstageable pressure ulcer to his right heel. She indicated he acquired the ulcer in the facility and the date of onset was 02/03/13. The resident had a significant weight loss from 177 on 12/22/13 to 158 on 12/29/13. The facility did not put any effective or timely weight loss interventions into place after the significant weight loss. The resident was not assessed by the Registered Dietician until 01/21/14. His current weight on 02/12/14 was 157 pounds. During an interview on 02/18/14 at 1:15 P.M., LPN #2 indicated the resident did not have a Heelz up pad or pillows to elevate his heels before the pressure area			

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	developed. She indicated she did not see an order for the resident's heels to be elevated when he was laying in the bed. LPN #2 indicated after the pressure ulcer was discovered the Physician was notified and a treatment order was obtained and that was Santyl with a dressing. She had no idea how the pressure ulcer had developed. She indicated she had not checked his shoes for the source of the cause. LPN #2 indicated the pressure ulcer was discovered when the CNA provided care for him on 02/03/14 and did not think his right heel looked right, so she notified his nurse regarding his heel. LPN # 2 and the resident's nurse assessed his right heel and discovered the pressure ulcer with yellow slough (dead tissue that covered the wound and the depth of the wound cannot be determined). A current document titled, "Skin Care And Pressure/Non Pressure Ulcer Management Program" dated April 2011, provided by the Clinical Nurse Specialist on 02/18/14 at 5:06 P.M., indicated "Risk Interventions: The following interventions may be considered if the resident is assessed at risk for pressure ulcer development:..6. Heel and elbow protection may be utilized as appropriate			

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	to reduce friction. 7. Utilize measures to reduce pressure on heels...9. Involve the dietician for assessment for proper nutrition and hydration. 10. Vitamin and mineral supplementation per physician order...14. Document efforts to provide preventative measures..." Information was requested from the Clinical Nurse Specialist on 02/18/14 at 4:45 P.M., to indicate any interventions the facility had implemented to prevent the resident's pressure ulcer to his heel. The Clinical Nurse Specialist provided a document titled, "Prevention 2000 Mattress 76" Length" on 02/19/14 at 11:15 A.M. She indicated the resident was on a pressure reducing mattress that had a special section at the end of the bed to help prevent pressure ulcers for the heels. At the end of the exit conference on 02/19/14 at 1:30 P.M., no further information had been provided by the facility to indicate any other interventions had been put into place before the resident's pressure ulcer developed. 3.1-40(a)(1) 3.1-40(a)(2)			

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F000323 SS=D	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 fall prevention interventions were implemented for 1 of 3 residents reviewed for accidents. (Resident #104) Findings include: Resident # 104's record was reviewed on 02/13/13 at 10:31 A.M. Diagnoses included, but were not limited to, constipation and paralysis agitans (Parkinson's). The Quarterly Review Minimum Data Set Assessment dated 01/04/14 indicated the resident's Brief Interview for Mental Status score was 14, which indicated the resident was cognitively intact. Resident had a Care Plan dated 08/11/13 that addressed a problem for at risk for falls related to poor safety awareness, mobility, self transfer deficit related to Parkinsons, muscle weakness and pain.	F000323	F323 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #104 has a mat next to his bed. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who are at risk for falls and have a care plan for a mat next to their bed could be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Residents who have a care plan for a mat next to the bed were reviewed for care planned intervention in place. Residents who have a care plan for a mat next to their bed have been reviewed for a physician order for mat next to the bed and updated as needed. Nursing staff re-educated on following care assignment sheets. IV The facility will monitor the corrective action by implementing the following measures. Unit manager/designee will conduct walking rounds to audit mats in place three times a week for 4	03/21/2014

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	Interventions included, but were not limited to the following, 01/18/14-"bed alarm", 09/23/13-"bed in lowest position with Mat", 08/15/13-"Therapy as ordered", 08/11/13- "Cue/remind resident to use call lights to seek assistance," 08/11/13- "Keep call light in reach at all times, Keep personal items and frequently used items within reach, non-skid footwear." A progress note dated 01/18/14 at 3:00 A.M., indicated the resident had an unwitnessed fall. He was kneeling beside the bed. The note indicated he had spilled water on the floor and was attempting to clean it up when he slid out of bed. The resident was not injured. A undated document titled, "CNA Daily Assignments" provided on 02/14/14 at 1:30 P.M., by an unidentified CNA indicated the resident's bed was to be in the low position with a mat. On the following dates, the resident was observed laying in bed without a mat on the floor next to the bed: On 02/14/14 at 1:20 P.M. On 02/14/14 at 2:30 P.M. On 02/18/14 at 4:18 P.M. During an interview on 02/18/14 at 4:15 P.M., the resident and a confidential		weeks, weekly for 4 weeks then monthly thereafter for a total of 12 months. Any identified concerns from the rounds will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	family member indicated he had never had a mat next to his bed when he was lying in bed. During an interview on 02/18/14 at 4:20 P.M., LPN #2 indicated the "CNA Daily Assignments" sheet and the resident's Care Plan for falls indicated he was to have a mat next to his bed, but he had not had one. She indicated she did not see a Physician's order written for the bed to be in a low position with a mat. 3.1-45(a)(2)			
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not			

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	possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to provide assessments and interventions to prevent the possibility of further weight loss for 1 of 3 residents reviewed for weight loss. (Resident #51) Findings include: Resident #51's record was reviewed on 02/17/14 at at 2:32 P.M. The diagnoses included, but were not limited to, fractured hip aftercare, muscle weakness, dysphagia, depressive disorder, constipation, vitamin B12 deficiency anemia, vitamin D deficiency, dementia and chronic pain syndrome. The resident had an 11.6% significant weight loss from 12/13/13 to 02/12/14, which was 60 days. The following were the resident's weights over the last 180 days: 08/11/13-174 09/08/13-169 09/15/13-172 09/22/13-173 10/06/13-178 10/13/13-170 11/01/13-169	F000325	F325 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Medical Record for Resident #51 and care plan were reviewed and current nutritional interventions remain in place. Resident #51 is within normal BMI, has good oral intake and weight has stabilized per RD visit on 2/14/14. We disagree with the findings. Physician for resident #51 was on site during survey and prepared to speak with ISDH surveyors. Survey team told physician they did not need to speak with him. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who have weight loss could potentially be affected. Current resident weights were evaluated to ensure that any losses were identified/ recognized. An interdisciplinary review was conducted for all residents with weight loss including the development of a nutritional care plan with individualized interventions. These residents will continue to be reviewed by the interdisciplinary team to ensure interventions are effective and nutritional goals have been met. III. The facility will put into place the following systematic changes	03/21/2014

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	12/01/13-169 12/13/13-174 12/22/13-177 12/29/13-158 01/01/14-158 01/29/14-161 02/04/14-154 02/12/14-157 A medication list for the February 2014 Physician's orders included, but were not limited to the following: 01/27/14-Weekly weights times four weeks on Mondays 01/27/14 to 02/17/14. A Significant Change Minimum Data Set Assessment dated 12/20/13, indicated the resident had a Brief Interview for Mental Status of 10, which indicated the resident was moderately cognitively impaired. He required extensive assistance with one person physical assist with eating. He had no swallowing or chewing problems. He had no dental problems. The resident had a Care Plan dated 01/22/14, that addressed the problem for weight loss after he had a significant weight gain since he was admitted to the facility. Interventions included, but were not limited to, 01/22/14-"Diet as ordered, Md and family aware weight loss, Registered Dietician as needed, Resident has weekly weights."		to ensure that the deficient practice does not recur. Any residents who experience a 5% or more weight loss in 30 days will be reviewed by the interdisciplinary team for current nutritional status and implementation of individualized interventions. An in-service will be provided by the Registered Dietitian and/or designee to the interdisciplinary team members regarding facility policy for reviewing residents with weight or nutritional concerns. IV The facility will monitor the corrective action by implementing the following measures. The Director of Nursing and/or designee will monitor weights weekly for 4weeks, monthly for 2 months, and quarterly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meetings and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	The resident had a Care Plan dated 02/07/14, that address the problem the resident required a mechanically altered diet related to dysphagia. Interventions included, but were not limited to, 02/07/14-"Diet as ordered, Followed by weekly IDT for weight until weight stabilizes, Monitor weights and intakes, Refer to ST as needed, Weekly weights X 4 r/t [related to] recent weight loss." The first Registered Dietary consult progress note found after the resident lost the significant amount of weight between 12/22/13 and 12/29/13 was on 01/21/14, 23 days after the noted weight loss. During a staff interview on 02/11/14 at 1:08 P.M., the Assistant Director of Nursing indicated the resident was not on a nutritional supplement defined as a prescribed high protein, high calorie, nutritional supplement between or with meals. During an interview on 02/18/14 at 1:35 P.M., LPN #2 indicated the intervention for the large amount of weight loss for the resident between 12/22/13 and 12/29/13 was a Registered Dietitician (RD) consult. She indicated the RD consulted on the resident's weight loss on 01/21/14 and she recommenced weekly			

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	weights for 4 weeks or until his weights were stable due to his weights had stabilized at this point in time. During an interview on 02/19/14 at 11:43 A.M., the Director of Nursing (DoN) indicated after the resident had the significant weight loss from 12/22/13 to 12/29/13 the interventions put into place was the RD consulted on the resident on 01/21/14 and she recommended his weights be monitored weekly until stable. The DoN indicated the RD assessed him again on 02/14/14 and indicated the resident had good oral intakes at that time and his Body Mass Index (relationship of a person's height and weight) was in normal range so she would continue to monitor him, but there were no new recommendations at that time. 3.1-46(a)(1)			
F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM			

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	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. 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. Based on interview and record review, the facility failed to monitor specific behaviors to support the use of psychoactive medications. In addition, the facility failed to initiate attempts for a GDR (Gradual Dose Reduction) of psychoactive medications, or provide specific detailed information discussing why an attempt might be clinically contra-indicated. In addition the facility failed to monitor for side effects or to monitor labs for specific medications. This deficiency impacted 4 of 6 resident	F000329	F329 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. We disagree with the findings due to there was erroneous information submitted in the 2567. Resident #234 antipsychotics medications were reviewed by attending physician. GDR was not recommended due to diagnosis of psychosis and reduction would cause psychiatric instability. Physician will consult with community psychiatrist for further recommendations. Resident #230 has been discharged from the community	03/21/2014

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	reviewed for Unnecessary Medication Use. (Residents #230, #114, #234, and #104) Findings include: 1. The record review for Resident # 230 was completed on 2/13/14 at 10:30 AM. Diagnoses included, but were not limited to, atrial fibrillation,coronary artery disease, congestive heart failure, GERD, diabetes, arthritis, anxiety disorder, depression, COPD, and Addison's disease. A physician's order dated 1/27/14, indicated the resident had received a medication of Cortef (a steroid) 20 milligrams (mg) in the morning and 10 mg. in afternoon. A hospital discharge summary report dated 1/27/14, indicated, "...2. Addison's disease/crisis-Pt c/o[complained of] generalized weakness over the course of this week, worse today and was unable to walk. Typically takes cortef 20 mg in morning and 10 mg in evening. Given intravenous Cortef 100 milligrams in the emergency department with resolution of weakness and hypotension. Will continue stress dose of Solu-Crotef every 8 hours. Monitor blood pressure closely...."		Resident #114 antipsychotics medication was reviewed and a GDR was ordered. Resident #104 has had labs ordered. New order received to discontinue testosterone injection. II. The facility will identify other residents that may potentially be affected by the deficient practice. New admissions currently receiving antipsychotics medications could be affected. Residents with physician orders for antipsychotics medications have the potential to be affected. These residents were reviewed by social service and their care plans were updated, as needed. Residents receiving a steroid medication have the potential to be affected. Residents currently on a steroid medication were reviewed by nursing and side effect monitoring has been initiated. Residents taking a testosterone or diuretic medication have the potential to be affected. Residents on testosterone or diuretic medication were reviewed by the consultant pharmacist to ensure appropriate lab test were ordered. Physicians were notified and orders obtained as appropriate. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nurses were educated on the monitoring of adverse side effects of antipsychotics or steroid medications. Residents	

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	The blood pressures monitored from admission on 1/27/14 through 2/17/14 indicated they had not been monitored daily. The resident had blood pressures on 2/6/14, 2/14/14, and 2/15/14 which were lower than her baseline blood pressure. There was no documentation in progress notes regarding monitoring of the blood pressures and any abnormal blood pressures On 2/17/14 at 10 A.M., the Director of Nursing indicated they did not have any documentation of side effect monitoring for the steroid medication. She indicated she would expect the nurses to know what side effects to look for. 2. The record review for Resident #114 was completed on 2/17/14 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, hyperlipidemia and dementia with delusions. The physician's recapitulation for February 2014 indicated the resident was on Zyprexa (an antipsychotic medication) 5 milligrams 1 tablet every evening at 5:00 P.M., and 2.5 milligrams in morning for dementia with delusions. There was no documentation found for monitoring of side effects of the		with orders for antipsychotics or steroid medications will have an order to monitor for adverse reactions to the medications and the nurse will sign off every shift. If the resident is experiencing possible adverse reactions, the physician will be notified and the residents plan of care will be updated, as needed. Residents admitted on antipsychotics medications will be reviewed within two weeks by the physician for a potential GDR. The Social Service Director and/or her designee will maintain a log of all antipsychotics medications being used within the facility with order date, diagnosis for use, and gradual dose reduction history. The log will be updated and discussed bi-monthly at facility behavior management meeting. The pharmacy consultant will review residents on antipsychotics drugs during monthly consultations and provide recommendations to the facility and attending physician. Education will be provided for licensed nurses and Social Service personnel regarding adequate indication for the use of antipsychotics medication. The Unit Manager or designee will notify the attending physician for a review of antipsychotics medication when a gradual dose reduction is due. D.O.N./designee will review new physician orders daily M-F to ensure appropriate labs are	

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	medication Zyprexa for Resident #114. The progress notes for nursing and the behavior symptom reports were reviewed for February 2013 through February 2014 and listed behaviors of: hoarding, wandering, anxiousness, agitation, and crying. There was no documentation of any delusional behavior. The pharmacy drug regimen review ,dated 5/28/13 indicated, "...psychiatric profile was due for review and potential gradual dose reduction. (GDR). Per nursing report no mood or behavioral disturbances have been documented for some time. She currently receives Risperidone 0.5 milligrams twice daily (August 2012-no attempts at reduction have been made)...does not receive routine psych-services...consider a trial reduction of the antipsychotic as it's current diagnosis may be considered inappropriate(Dementia with delusions...." The Nurse Practitioner note dated 6/10/13 indicated, "...Dementia with behaviors and insomnia increase resperdol (sic) to 0.5 milligrams twice daily...." There was no documentation or explanation following up on the pharmacy recommendation.		ordered for any resident beginning testosterone or diuretics regimen. Physicians will be notified and orders requested as appropriate. IV The facility will monitor the corrective action by implementing the following measures. The DON/Designee will audit residents with new orders for antipsychotics or steroid medications to determine side effects are monitored and care plans are updated as needed 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly times 2 months, then monthly thereafter totaling 12 months. The Social Service Director or designee will audit documentation on residents receiving antipsychotics medication, with emphasis on an adequate indication for the use of the medication weekly for 12 months. D.O.N./designee will review new physician orders daily M-F to ensure appropriate labs are ordered for any resident beginning testosterone or diuretics regimen weekly times 4 weeks, monthly for 2 months then quarterly thereafter totaling 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	The Interdisciplinary Team (IDT) note indicated on 9/18/13, "...Tremor, NP/Psych [Nurse Practitioner and Psychiatrist] suggest tremor with last increase of Risperdol [sic] , Risperdol [an antipsychotic medication] discontinued and Zyprexa stated, tremor reduced and no behaviors noted...." 9/25/13 IDT notes indicated, "...Tremor, NP/Psych suggest tremor with last increase of Risperdol, resident discharge from IDT...." 10/16/13 IDT notes indicated, "...resident had a fall...weight doing better...." 11/6/13 IDT notes indicated, "...psychoactive, root cause Monitoring for negative psychosocial behaviors related to resident altercations..resident had shown no negative behaviors since occurrence...." The Clinical Specialist indicated on 2/18/14 at 2:30 P.M., the facility had no gradual dose reduction, no tracking of behaviors to support use of an antipsychotic, and no side effects care plan for the antipsychotic for Resident #114. 3. Resident #104's record was reviewed on 02/13/13 at 10:31 A.M. Diagnoses			

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	included, but were not limited to, vitamin D deficiency, atrial fibrillation, edema, congestive heart failure, and diabetes mellitus type II. The medication list dated February 2014 indicated the resident's Physician's orders included, but were not limited to the following; 10/10/13-Furosemide (diuretic medication) 20 mg by mouth 1 tablet once daily on Sunday, Tuesday, Thursday and Saturday. 10/10/13-Furosemide 40 mg by mouth 1 tablet once daily on Monday, Wednesday and Friday. 10/10/13-Spironolactone (diuretic medication) 25 mg 1/2 tablet (12.5 mg) once daily. 10/17/13-Testosterone Cypionate Oil 200 mg/ml Intramuscular at bedtime every 14 days. 02/06/14-Lasix (Furosemide) 40 mg by mouth Special Instructions: For weight gain > (greater than) 2 pounds daily or > (greater than) 5 pounds weekly, once daily as needed. The resident had "Consults--Pharmacy Drug Regimen Reviews" on these following dates with the following recommendations: 08/16/13-Azilect an MAO type B (An antidepressant medication) and Cymbalta			

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	(SSNRI) (An antidepressant medication) would cause an interaction increasing risk of serotonin syndrome. Will monitor. No Recommendations. 9/11/13-No irregularities. No recommendations. 10/31/13-No irregularities. No recommendations. 11/22/13-No irregularities. No recommendations. 12/19/13-No irregularities. No recommendations. 01/31/14-No irregularities. No recommendations. The following laboratory tests were ordered by the Physician since the resident was admitted to the facility: 08/12/13-Hgb (hemoglobin) A1C. 10/22/13-CBC (complete blood count) w (with)Diff.(differential), UA C & S, (urinalysis with culture and sensitivity). 11/14/13-CBC w Diff, HgB A1C. 11/27/13-Vitamin B12. 01/18/14-U/A C & S. No further laboratory tests were found ordered by the Physician for this resident since he was admitted on 08/09/13. During an interview on 02/18/14 at 2:06 P.M., the Clinical Nurse Specialist indicated the resident would have had laboratory tests ordered to monitor the			

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	drugs Testosterone and diuretics. She indicated the Pharmacist would be the person who would be consulting and making the recommendations to the Physician to have these levels checked and have the laboratory tests ordered.			
	4. In an interview on 2/12/14 at 11:37 A.M., Resident #234 indicated she had been in the facility only a couple of weeks, but indicated she had just been moved to this room in the last day or two. The resident was laying in bed with a			

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	long robe and gown on, and indicated she was not feeling well. She indicated the nursing staff kept coming into her room to try to get her to eat something. She said "I'm not hungry--I ate a little, but didn't want very much." On 2/12/14 at 1:30 P.M., the resident was observed sitting up on her bed in her room. She was dressed in street clothes and had make-up on. She stated "The girls keep coming in my room and telling me things. They told me to put my gown on, but I'm not going to do that. They tell me I have to move to a lot of different rooms." She indicated her stomach was queasy, and that she had eaten only a little of her lunch. The resident's lunch meal tray was on an over-bed table in the room. About 1/2 of the entree and some vegetables were observed to have been consumed. In an interview on 2/12/14 at 1:40 P.M., an unidentified CNA indicated the resident was a new admit, and had not been in any other room. She indicated the resident had been in the facility about a year ago, and maybe remembered a different room from the previous admission. On 2/12/14 at 1:45 P.M., a nurse was heard to ask the resident where she was			

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	going as the resident was wheeling herself down the hallway. The resident responded that she was "going for lunch" because she was hungry. When she was told the lunch meal was already over, the resident said "Huh. I thought it was time." Several staff members offered to get her something to eat, but she refused. The staff offered to take her to the activity (Movie and Popcorn), and the resident responded "No, I've already seen that movie." The clinical record for Resident #234 was reviewed on 2/17/14 at 12:24 P.M. The resident was admitted on 1/28/14 with diagnoses which included, but were not limited to, muscle weakness, abnormal gait, difficulty walking, nonorganic psychosis--reactive confusion, anxiety state, and senile dementia without behavior disturbance. A Level 1 PASRR (Pre-Admission Screen for Resident Review), dated 1/28/14, indicated the resident had documentable diagnosis of senile or pre-senile dementia without a concurrent primary diagnosis of a major mental illness; and that there was no other diagnosis of a major mental illness. An Admission MDS (Minimum Data Set) assessment, dated 2/10/14, indicated			

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	the resident had a BIMS (Brief Interview for Mental Status) score of "03" (a score of 1-7 indicated severe cognitive impairment); no psychosis or behaviors; and receiving and antipsychotic medication. The February, 2014 physician order list included, but was not limited to, the following: 1/28/14--Quetiapine (Seroquel--an antipsychotic medication) 25 mg. 1 by mouth twice a day. A "Consults--Pharmacy Drug Regimen Review," dated 1/30/14, indicated "No irregularities," and "No recommendations." There was no other information documented. In an interview on 2/17/14 at 1:35 P.M., the Consultant Nurse Specialist indicated any behavior that was being monitored would be listed in the "Event" history. At 1:45 P.M., she indicated she had contacted the Consultant Pharmacist about his review form, and he responded that he had reviewed the order for the Seroquel and found no irregularities. The Pharmacist had also indicated he had reviewed the resident's past history, and that she had been receiving the Seroquel for a long time. The progress notes, behavior monitoring			

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	forms, and the "Observation" and "Event History" sections of the record, from the date of admission, had no behavior monitoring or documentation of specific behaviors required to justify the use of the antipsychotic medication. There was no documentation indicating the antipsychotic medication should be reviewed within the two weeks following admission for appropriateness. One Care Plan entry, carried forward from a previous admission in March of 2013 and dated 3/22/13, addressed a problem of "History of delusions/paranoia related to dementia as evidenced by claiming personal items are missing that do not exist (e.g.--eyeliner)--confirmed by [a family member]." 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(1) 3.1-48(b)(2)			
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any			

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	irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure the Consultant Pharmacist conducted accurate medication reviews related to requesting laboratory monitoring for diuretic and hormone medications; for 1 of 6 residents reviewed for Unnecessary Medications. (Resident #104) Findings include: Resident #104's record was reviewed on 02/13/13 at 10:31 A.M. Diagnoses included, but were not limited to, vitamin D deficiency, atrial fibrillation, edema, congestive heart failure, and diabetes mellitus type II. The medication list dated February 2014 indicated the resident's Physician's orders included, but were not limited to the following; 10/10/13-Furosemide (diuretic medication) 20 mg by mouth 1 tablet once daily on Sunday, Tuesday, Thursday and Saturday. 10/10/13-Furosemide 40 mg by mouth 1 tablet once daily on Monday, Wednesday and Friday. 10/10/13-Spironolactone (diuretic medication) 25 mg 1/2 tablet (12.5 mg) once daily.	F000428	F428 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #104 received lab testing and results were communicated to the physician. New order received to discontinue testosterone. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents receiving testosterone or diuretic medication could be affected. Residents receiving these medications were reviewed by the Pharmacist and recommendations to the MD were made as necessary. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The consulting Pharmacist will review all residents' testosterone or diuretic medications and make recommendations to the MD as needed during their monthly review. IV The facility will monitor the corrective action by implementing the following measures. DON or designee will audit residents with testosterone or diuretic medications for ordered labs five times per week for 4 weeks, then weekly for 4 weeks; then, monthly thereafter totaling 12 months. Pharmacy recommendations regarding	03/21/2014

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	10/17/13-Testosterone Cypionate Oil 200 mg/ml Intramuscular at bedtime every 14 days. 02/06/14-Lasix (Furosemide) 40 mg by mouth Special Instructions: For weight gain > (greater than) 2 pounds daily or > (greater than) 5 pounds weekly, once daily as needed The resident had "Consults--Pharmacy Drug Regimen Reviews" on these following dates with the following recommendations: 08/16/14-Azilect an MAO type B (An antidepressant medication) and Cymbalta (SSNRI) (An antidepressant medication) would cause an interaction increasing risk of serotonin syndrome. Will monitor. No Recommendations. 9/11/13-No irregularities. No recommendations. 10/31/13-No irregularities. No recommendations. 11/22/13-No irregularities. No recommendations. 12/19/13-No irregularities. No recommendations. 01/31/14-No irregularities. No recommendations. The following laboratory tests were ordered by the Physician since the resident was admitted to the facility: 08/12/13-Hgb (Hemoglobin) A1C.		testosterone or diuretic medications will be audited monthly by the DON or designee to ensure recommendations are followed through as needed with the resident's MD. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	10/22/13-CBC (complete blood count) w (with) Diff.(differential), UA C & S, Urine (urinalysis with culture and sensitivity). 11/14/13-CBC w Diff, HgB A1C. 11/27/13-Vitamin B12. 01/18/14-U/A C & S. No further laboratory tests were found ordered by the Physician for this resident since he was admitted on 08/09/13. During an interview on 02/18/14 at 2:06 P.M., the Clinical Nurse Specialist indicated the resident would have had laboratory tests ordered to monitor the drugs Testosterone and diuretics. She indicated the Pharmacist would be the person who would be consulting and making the recommendations to the Physician to have these levels checked and have the laboratory tests ordered to check the laboratory tests. 3.1-25(i)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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	(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review the facility failed to ensure 1 licensed nurse performed proper handwashing and proper sanitization of a glucometer to prevent the possibility of cross contamination during blood glucose testing for 1 of 2 residents reviewed for blood glucose testing. (Resident #239) Findings include: On 02/14/14 at 9:02 A.M., LPN #10 was	F000441	F441 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #239 clinical record was reviewed and no negative outcomes were noted. LPN #10 were re-educated regarding the proper procedure for hand hygiene and glucose blood monitoring equipment procedure guidelines. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents	03/21/2014

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	observed while checking Resident #239's blood sugar. LPN #10 gathered her supplies and glucometer and placed them on the bare top of her medication cart without a barrier. After she entered the resident's room she layed her supplies on the round table without a barrier. She donned clean gloves and gave him his pills, then she removed a glucometer strip and placed it into the glucometer. After she cleansed and stuck his right thumb, she obtained the sample of blood onto the glucometer strip. She sat the glucometer on the round table. She cleansed the resident's thumb and cleaned the area of trash and sharps. She removed her gloves and washed her hands for 10 seconds. On 02/14/14 at 9:42 A.M., LPN #10 was observed to sanitize the glucometer with a "Sani Bleach Wipe" then immediately placed it back into the medication cart. She took the glucometer out and sanitized it with the same "Sani Bleach Wipe" she had just used and placed the glucometer on top of the medication cart without a barrier. During an interview on 02/14/14 at 9:47 A.M., LPN #10 indicated she should wash her hands before she started a medication administration pass or a glucometer test. She indicated she had		who receive blood glucose monitoring could be affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nursing staff will be re-educated on hand hygiene and blood glucose monitoring equipment procedure guidelines to prevent cross contamination. Licensed nursing associated will continue to receive education on hand hygiene and blood glucose monitoring equipment procedure guidelines during initial orientation and as needed. IV The facility will monitor the corrective action by implementing the following measures. Staff Development Coordinator or designee will audit by observation of blood glucose testing rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed immediately. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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	not washed her hands before doing this resident's glucometer. The nurse indicated she should have used a barrier on the medication cart and the round table before she layed the glucometer down. She indicated she should have sanitized the glucometer with bleach wipes before and after she used it. She indicated the glucometer should have air dried and been placed on a Kleenex and not back into the cart until it was air dried. The directions for the "Sani Bleach Wipe" indicated the area to be cleansed was to be wiped down and then air dried. A current policy titled "Blood Sampling-Capillary (Finger Sticks)," dated October 2010, provided on 02/18/14 at 2:28 P.M., by the Clinical Nurse Specialist indicated the following: "Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees... Steps in the Procedure: 1. Wash hands. 2. Don gloves. 3. Place blood glucose monitoring device on clean field...7. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use...10. Replace blood glucose			

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	monitoring device in storage area after cleaning...." A current policy titled "Handwashing/Hand Hygiene," dated April 2010, provided on 02/18/14 at 2:28 P.M., by the Clinical Nurse Specialist indicated the following: "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections...When to Wash Hands:..5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following Conditions:..c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); d. Before and after performing any invasive procedure (e.g., fingerstick blood sampling);...." 3.1-18(l)			
R000000	The following residential findings were	R000000	March 7, 2014 Kim Rhoades,	

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	cited in accordance with 410 IAC 16.2-5.		Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on February 19, 2014. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on March 21, 2014. If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 19, 201. Please accept this plan of correction as Hamilton Trace of Fisher's credible allegation of	

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			compliance by March 21, 2014. This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure that a minimum of 1 staff person was available on-site at all times who had current certification in both CPR (Cardio-Pulmonary Resuscitation) and	R000117	R117 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected by the practice. II. The facility will identify other residents	03/21/2014

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	First Aid. This deficiency had the potential to impact 27 of 27 residents residing in the Residential facility. Findings include: Following the entrance conference on 2/10/14, the Administrator provided the completed "Employee Records" form, listing all employees working in the facility campus. Copies of the wallet cards issued for current certification in both CPR and First Aid were found in the License Log binder for only 4 employees--1 RN, 1 LPN, and 2 CNAs. In an interview on 2/18/14 at 3:30 P.M., the Administrator indicated she was not sure if the program for the CPR also included training in basic First Aid. She indicated she would need to contact someone to get clarification. At the exit conference on 2/19/14 at 1:00 P.M., the Administrator indicated she had no further information related to the current certifications in both CPR and First Aid.		that may potentially be affected by the deficient practice. Current residents could potentially be affected by the practice. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nursing personnel in the Assisted Living will become first aid and CPR certified. IV The facility will monitor the corrective action by implementing the following measures. Facility will offer first aid and CPR training and certification annually to licensed nursing personnel. Upon hire new licensed personnel will submit a copy of their first aid and CPR certification. If new employees have not received first aid training they will be signed up for earliest certification class upon hire. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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R000306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure the disposition of medications following discharge from the facility was documented, for 1 of 2 residents who were reviewed for the required discharge information. (Resident #275) Findings include: The clinical record for Resident #275 was reviewed on 2/18/14 at 2:34 P.M. The resident was discharged from the facility to an acute care hospital on 12/12/13. The physician's order sheet listed routine medications prior to discharge as: Aricept, Norvasc, Prilosec, Zocor, Fish	R000306	R306 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #275 has discharged from the community. II. The facility will identify other residents that may potentially be affected by the deficient practice. Any resident that discharges from the community has the potential to be affected by the alleged deficient practice. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The licensed nursing staff have been re-educated on the process of drug disposition when a resident discharges from the community. IV The facility will monitor the corrective action	03/21/2014

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	Oil capsules, Multi-Vitamin capsules, Ocuvite capsules, Lisinopril, Namenda, Peri-colace, Vitamin B-12 tablets, and Seroquel. A PRN ("as needed") order for Milk of Magnesia was also listed. Information related to the disposition of these medications following the resident's discharge from the facility was not found. In an interview on 2/19/14 at 11:30 A.M., LPN #1 indicated nursing staff filled out a paper form with the drug disposition information. The paper form was given to the Medical Records staff person to scan into the computer. She indicated she would continue to search the computer for any information about the disposition of the resident's medications. In an interview on 2/19/14 at 11:47 A.M., the Medical Records staff person indicated she had some forms yet to scan, and she would check to see if the one for Resident #275 was there. She later provided a copy of a medication that had been discontinued in February of 2013. In an interview on 2/19/14 at 11:59 A.M., LPN #1 indicated she was unable to find any information about the disposition of the medications in the computer.		by implementing the following measures. The unit manager/designee will audit the reconciliation of the resident's medication once the resident discharges. The medical records department will conduct an audit of the closed record for accurate drug disposition monthly. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to have complete and accurate documentation for a resident who transferred from the residential area of facility to the skilled nursing area for 1 of 2 residents closed records. (Resident #276) Findings include: The record review for Resident #276 was completed on 2/18/14 at 4:55 P.M. Diagnoses included, but were not limited to, anxiety, depressive disorder, malignant neoplasm and muscle weakness. The facility indicated the closed record was for a resident that had been transferred intrafacility to the skilled nursing area. The progress notes dated 1/2/14 indicated the resident had been eating in the main dining room, and was having no concerns. There were no other progress	R000349	R349 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #276 has discharged from the community. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who discharge from the community could potentially be affected. III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nursing personnel received education on discharge documentation. IV The facility will monitor the corrective action by implementing the following measures. The DON/designee will audit discharge documentation 1 business day following discharge for 3 months and then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and	03/21/2014

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	notes indicating the status of the resident. The skilled nursing progress notes had an entry dated 1/9/14 indicated the resident had transferred from the assisted living portion of the facility. There was no physician's orders indicating transfer or discharge. On 2/19/14 on 11:10 A.M., in an interview with LPN #1, she indicated the nurses should make an entry in the progress notes with the destination, who was with the resident upon transfer, and what was done with the resident's medication and belongings. She indicated there was no documentation found. LPN #1 also indicated there should be a physician's order for the transfer to the skilled unit. She indicated she could not find the physician's order or the disposal or transfer of the medications.		duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is March 21, 2014.	