

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2014
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NAME OF PROVIDER OR SUPPLIER WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the State Residential Survey.</p> <p>Survey dates: December 1, 2, 3, 4, 5, and 9, 2014.</p> <p>Facility number: 002724 Provider number: 155682 AIM number: 200309330</p> <p>Survey team: Sylvia Scales, RN-TC Terri Walters, RN Dorothy Watts, RN (12/1,12/2,12/3,12/5,12/9) Amy Winger, RN (12/1,12/2,12/3,12/5,12/9)</p> <p>Census bed type: SNF: 15 SNF/NF 35 Residential: 34 Total: 84</p> <p>Census payor type: Medicare: 14 Medicaid: 26 Other: 10 Total: 50</p>	F000000		

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

TITLE

(X6) DATE

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

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F000176 SS=D	<p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 16, 2014 by Jodi Meyer, RN</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were not self-administered unless ordered by the physician to self administer for 1 of 1 residents observed to have medications left in the room. (Resident #19)</p> <p>Findings include:</p> <p>During a random observation on 12/05/14 at 8:45 A.M., Resident #19 was observed to enter the hallway from her room and stated, "Who's pills are these?" Resident #19 was observed, at that time, to present a clear plastic medication cup to LPN #15. The cup was observed to contain a semi-dissolved oblong tablet.</p>	F000176	<p>Res#19 suffered no ill effects from the alleged deficiency and will ensure staff stay with her until she has swallowed it and then throw the cup away before leaving the room. No other residents were affected by the deficient practice and through alteration in med pass procedure will ensure staff verify residents have swallowed medicine before leaving the room. Licensed nursing employees will be inserviced on procedure of ensuring residents swallow or consume all of medicine and throw away cup before leaving their room. DHS/designee will perform 2 random observations of med administration daily x1 week, then 2 random observations weekly for 3</p>	01/08/2015

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	<p>During an interview on 12/05/14 at 8:46 A.M., LPN #15 indicated she had not administered medications to Resident #19 that morning and could not identify the pill.</p> <p>During an interview on 12/05/14 at 8:55 A.M., the DON (Director of Nursing) indicated the medication had been identified as the Norco [a narcotic pain medication] administered to Resident #19 on 12/05/14 at 6:00 A.M. The DON further indicated, at that time, Resident #19 had not been assessed to self-administer medication. The DON then indicated, at that time, the nurse should have stayed with Resident #19 until the medication was completely swallowed.</p> <p>The Policy and Procedure for Oral Medication Administration provided by the DON on 12/05/14 at 10:00 A.M. indicated, "...Procedures...C. Administer medication and remain with resident while medication is swallowed..."</p> <p>The clinical record of Resident #19 was reviewed on 12/05/14 at 10:30 A.M. The record indicated the diagnoses of Resident #19 included, but were not limited to, neuropathy (nerve pain).</p> <p>The most recent Quarterly MDS</p>		months, 2 observations monthly thereafter. Results of audits will be forwarded to QA monthly x6 and quarterly thereafter.				

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	<p>(Minimum Data Set) Assessment dated 09/08/14 indicated Resident #19 experienced moderate cognitive impairment.</p> <p>The most recent Physician's Order Recap dated 11/25/14 included, but was not limited to, an order for, "...Norco 7.5/325...tablet...1 tablet orally four times daily for pain...0600 [6:00 A.M.]..." The Recap lacked an order for Resident #19 to self-administer medication.</p> <p>A Monthly Nursing Assessment dated 11/14/14 indicated Resident #19 should not self-administer medication.</p> <p>An Investigation report dated 12/05/14 at 8:30 A.M., provided by the DON on 12/05/14 at 12:00 P.M., indicated, "...LPN #15 was administrating [sic] meds [medications] this am [morning], when [Resident #19]...brought her a pill that looked as if it was spit out into a medicine cup...deteremined [sic] that is [sic] was a Norco pill that would have been administered at 0600 [6:00 A.M.] on 12/5/14..."</p> <p>The Policy and Procedure for Oral Medication Administration dated 12/05/14 at 10:00 A.M. indicated, "...C. Administer medication and remain with resident while medication is</p>			

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F000242 SS=D	<p>swallowed..."</p> <p>3.1-11(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who had chosen shower as his preference bathing received showers for 1 of 1 resident reviewed for bathing choices. Resident #84</p> <p>Findings include:</p> <p>Resident #84 was observed on 12/4/14 at 8:35 A.M., sitting up in a wheel chair in the therapy department.</p> <p>Resident # 84's clinical record was reviewed on 12/2/14 at 10:00 A.M. His diagnoses included but were not limited to, congestive heart failure, mild dementia, hypertension, and cardiovascular accident. Resident #84 had been admitted to the facility on</p>	F000242	Resident #84 bathing preference has been shared with all that provide care to him. No other residents were affected by the alleged deficient practice and will verify all residents bathing preferences are updated. Nursing staff including CNA#3 will be inserviced on bathing preferences and proper documentation of refusals. SSD/designee will randomly interview 2 residents weekly for 2 months and 2 residents monthly thereafter to ensure their bathing preferences are being followed. Results of interviews will be forwarded to QA monthly for review.	01/08/2015

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	<p>11/8/14. His admission Minimum Data Set Assessment (MDS) indicated a cognition score of 3 (severe cognitive impairment).</p> <p>On 12/4/14 at 9:15 A.M., a life enrichment assessment form entitled, "Life Enrichment Assessment Home Again" dated 11/13/14 was reviewed. The form indicated per resident interview that Resident #84 preferred a shower. Other choices listed were tub bath, bed bath or a sponge bath. The shower choice was listed as a 1(very important). The life enrichment assessment had been completed by the Life Enrichment Director /Activity Director on 11/13/14 after Resident #84's admission to the facility on 11/8/14.</p> <p>On 12/3/14 at 9:20 A. M., the Minimum Data Set Assessment (MDS) Nurse was interviewed regarding Resident #84's ADL (activity of daily living) report in regard to bathing. Documentation was provided of Resident #84's type of bathing between 11/11/14 to 12/3/14. The MDS ADL report indicated a partial bath had been provided on 11/11/14, 11/12/14, 11/13/14, 11/14/14, 11/15/14, 11/16/14, 11/17/14, 11/19/14, 2 partials on 11/20/14, 11/22/14, 11/23/14, 2 partials on 11/24/14, 11/25/14, 11/26/14, 11/29/14, 11/30/14, 2 partials on 12/1/14,</p>			

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	<p>12/2/14, and 12/3/14. Showers were documented on 11/21/14 and 11/27/14 since admission to the facility. The MDS nurse indicated at that time if Resident #84 had refused a shower the Social Service Director (SSD) would be aware of the refusal behavior and would have documentation of the resident's refusal behavior.</p> <p>On 12/4/14 at 9:58 A.M., the SSD provided a behavior log for Resident #84 from 11/11/14 to 12/3/14. The behavior log lacked documentation of refusal of care or any type of behaviors for Resident #84. The SSD indicated documentation was lacking of any refusal of shower care since admission.</p> <p>On 12/5/14 at 10:15 A.M., CNAs #1, #2, and #3 were interviewed regarding bathing and shower schedules. The CNA's indicated residents shower lists were kept in the chart room at the nurses station. The CNA's indicated they check the shower list on their shift to see which residents were to receive showers. CNA #2 indicated if a resident refuses a shower the CNA's were to notify the resident's nurse and document the refusal on the computer. Resident #84's CNA, CNA #3 was interviewed, at that time, regarding showers. She indicated Resident #84 usually takes showers and</p>			

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	<p>doesn't refuse showers. CNA #3 indicated Resident #84 had refused a shower yesterday. She indicated she had told the Director of Nursing (DON) and had provided a partial bath.</p> <p>On 12/5/14 at 11:45 A.M., during interview the DON was made aware that Resident #84 had not been receiving showers as he had indicated was his choice for bathing. The DON was also made aware documentation was lacking of Resident #84 refusing showers.</p> <p>On 12/5/14 at 12:24 P.M., Resident #84's current care plan was reviewed. The ADL section dated 11/21/14 included but was not limited to, "... I would like to be showered at least two times a week and bathed on all other days..."</p> <p>On 12/9/14 at 8:20 A.M., the facility's policy for bathing entitled "GUIDELINES FOR BATHING PREFERENCE" (undated) was reviewed. The policy included but was not limited to, "PURPOSE: to establish a personal bathing routine. PROCEDURE: 2. The resident shall determine their preference for bathing upon admission. a. Day of the week. b. Time of day-morning or evening. c. Type of bathing-tub bath or shower..."</p>			

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F000258 SS=D	<p>3.1-3(u)(3)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels.</p> <p>Based on observation and interview, the facility failed to ensure a quiet, homelike environment for 1 of 2 residents reviewed for comfortable sound levels, in that, a resident was observed to be yelling loudly in 1 of the 3 halls of the facility during 3 of 5 survey days. (Resident #6)</p> <p>Findings include:</p> <p>During an interview with Resident #6 on 12/1/14 at 10:19 A.M., a resident across the hall was heard loudly and repeatedly yelling, "help me". At that time, Resident #6 indicated that Resident #38 was the resident who was yelling. Resident #6 said, "That resident hollers at night for an hour. You should hear it at ten o'clock at night. You can't get to sleep." Resident #6 indicated staying in the facility was not like staying at home because at home it was quiet.</p> <p>During an observation on 12/2/14 at 7:34 A.M., Resident #38 was heard yelling, "help me", for 3 minutes.</p>	F000258	Res #38 received inpatient care for her behaviors Res #6 stated that the noise level on the hallway is acceptable. SSD will randomly interview 2 residents per week x2 months and 2 monthly thereafter to determine if the noise level is acceptable. Through monthly resident council and quarterly resident care conferences will determine if anyone has experienced uncomfortable sound levels, with immediate interventions implemented to rectify noise levels. QA will review interviews and above documents in monthly meeting x12.	01/08/2015	

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	<p>During an observation on 12/5/14 at 2:45 P.M., Resident #38 was observed to be yelling, "help me", loudly and repeatedly for 3 minutes from across the hall.</p> <p>The clinical record for Resident #6 was reviewed 12/2/14 at 9:30 A.M., it included a Quarterly MDS (Minimum Data Set Assessment) dated 10/10/14 indicated Resident #6 experienced no cognitive impairment.</p> <p>During an interview on 12/5/14 at 11:31 A.M., RN #15 indicated Resident #38 did yell out sometimes during the day.</p> <p>During an interview on 12/5/14 at 11:33 A.M., CNA #18 indicated she was scheduled to work evening shifts (2:00P.M. to 10:00 P.M.) most of the time and Resident #38 yelled out frequently during the evening hours. CNA #18 further indicated Resident #38 could use the call light, but didn't. CNA #18 indicated Resident #38 would be toileted, given snacks and drinks, but once Resident #38 returned to bed the yelling would start again. CNA #18 indicated numerous residents in the vicinity of Resident #38's room had complained about Resident #38's yelling out, "help me." At that time, while standing in the hall outside of Resident</p>			

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F000314 SS=G	<p>#38's room, CNA #18 pointed to 4 rooms in the vicinity of Resident #38's room and indicated the residents living in those 4 rooms had complained about Resident #38's yelling keeping them awake.</p> <p>During an interview on 12/9/14 at 9:34 A.M., the DON indicated the facility did not have a policy for noise levels, but that it was the policy of the facility to maintain a quiet, homelike environment.</p> <p>3.1-32(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective interventions were provided for a dependent resident, in that, a resident admitted without a pressure ulcer developed a pressure ulcer and the ulcer deteriorated to a stage 3 for 1 of 1</p>	F000314	Resident #13 is a hospice resident with an unavoidable statement signed by physician and has treatment and careplan in place for wound on buttock. No other residents were affected by deficient practice. Nursing inserviced on residents at risk for skin breakdown and pressure ulcer treatment/prevention. DHS/	01/08/2015

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	<p>resident who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #13 experiencing a stage 3 pressure ulcer. (Resident #13)</p> <p>Findings include:</p> <p>During an observation on 12/03/14 at 1:19 P.M., Resident #13 was in the dining room sitting in her Geri Chair (Geriatric Reclining Chair) with her new positioning device in place.</p> <p>The clinical record of Resident #13 was reviewed on 12/05/14 at 9:55 A.M. The record indicated Resident #13 was admitted on 11/05/2008. The diagnoses of Resident #13 included, but were not limited to, depression, dementia and weakness.</p> <p>The Physician's Order dated 11/19/14 read as follows: "...cleanse buttocks with N/S [normal saline] Fill wound with Silvasorb cover with optifoam"</p> <p>An "Individual Care Plan Report" dated 10/6/14 read as follows' "...Provide me with pressure distribution products for my bed and chair."</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 09/22/14 indicated Resident #13 experienced severe</p>		<p>designee will conduct rounds to observe pressure reduction interventions on all residents and Resident #13 careplan interventions in place.Rounds will be conducted 2x daily for 6 months and daily thereafter.Results of rounds will be forwarded to QA committee monthly for review x6 months and quarterly thereafter.</p>				

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	<p>cognitive impairment and required the extensive assistance of two plus staff for bed mobility, positioning, and transferring.</p> <p>A</p> <p>"PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENTS" form dated 12/2/14 documented the wound was located on the left buttock of Resident #13 and was a Stage 3 pressure ulcer acquired on 3/25/14. The measurement on 12/2/14 of the pressure area was 1.7cm (centimeters) length, 1.2 cm width and 0.1 cm in depth. The color of the tissue was document as 80% red and 20% yellow. The wound margins were rolled and surrounding tissue was red. "Current preventive interventions: hospice provided new cushion for geri chair..."</p> <p>The</p> <p>"PRESSURE/STASIS/ARTERIAL/DIABETIC ULCER ASSESSMENTS" form indicated , "...Stage 3..., ...Full thickness tissue loss. Subcutaneous fat may be visible but bone tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss..."</p> <p>During an interview on 12/5/14 at 2:45 P.M., " OT #1 indicated a lateral support was added to Resident #13's wheelchair</p>			

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	<p>to help with her positioning. An "OT (Occupational Therapy) DAILY TREATMENT NOTE" was provided at that time and read as follows, "...8/28/13...W/C (wheel chair) modification including installing lateral support..."</p> <p>An "INTERDISCIPLINARY HOSPICE COMMUNICATION" form dated 11/20/14 indicated the following: "...Lateral supports have a bar @ [at] the coccyx area where supports secure to W/C [wheel chair]. Discussed removal of supports to see if wd [wound] will improve/heal with this intervention. Agree with this assessment et [and] they will have maintenance remove support. Will use 2 flow cushions for support..."</p> <p>During an observation with RN #11 on 12/5/14, Resident #13 had a wound area located on her left buttock slightly left of her coccyx. The wound was open with a red wound bed and yellow slough covering 30% of the wound bed. No drainage or odor was noted at the time of observation.</p> <p>During an interview on 12/5/14 at 09:58 A.M., the Assistant Director of Nursing (ADON) indicated Resident #13 had a padded positioning bar placed in her wheel chair in 2013. Over time, the</p>			

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F000323 SS=G	padding on the positioning bar wore out, leaving a piece of metal exposed. The exposed metal was believed to be the cause of a stage 3 pressure area on Resident #13's coccyx. The ADON further indicated that, since the time the positioning bar was removed from the chair and a new positioning device was installed, Resident #13's pressure area had improved. 3.1-40(a)(1) 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 a resident identified at risk for falls received adequate supervision and/or assistance to prevent further falls for 1 of 1 resident reviewed for falls. This deficient practice resulted in Resident #45 experiencing a hip fracture. (Resident#45) Findings include:	F000323	Resident #45 has current careplan and fall prevention interventions in place and staff that care for her have been inserviced on these. She has not had a fall since her 10/31/14 fall. No other residents were affected by the alleged deficient practice and through implementing medical record procedures will ensure that documentation is completed and filed appropriately and those residents who are at risk for falls have interventions implemented to provide adequate supervision to prevent falls. Nursing staff inserviced on fall	01/08/2015

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	<p>On 12/3/14 at 12:22 P.M., Resident #45 was observed sitting in her wheelchair in the main dining room. An alarm box was noted on the back of her wheelchair.</p> <p>Resident #45's clinical record was reviewed on 12/2/14 at 10:41 A.M. Resident #45 had been admitted to the facility on 10/13/11. Her diagnoses included but were not limited to, dementia, seizures, anxiety, and cardiovascular accident.</p> <p>Her quarterly Minimum Data Set Assessment (MDS) dated 7/8/14 indicated Resident #45 was always continent of urine.</p> <p>The assessment indicated supervision of 1 staff needed for bed mobility, transfers, and ambulation in her room and the corridor.</p> <p>The assessment indicated the limited assistance of 1 staff was needed for toileting. The 7/8/14 MDS indicated a cognitive score of 4 (severe cognitive impairment).</p> <p>A quarterly MDS dated 9/16/14, indicated Resident #45 was always continent of urine, needed limited assistance of 1 staff for bed mobility and transfers, and extensive assistance of 1 staff for toileting. Cognition score was 5 (severe cognitive impairment).</p> <p>A significant change MDS dated 11/11/14, indicated extensive assistance</p>		<p>documentation, interventions to prevent falls and appropriate documentation post fall. DHS/designee will conduct rounds to ensure fall prevention interventions and careplan items are observed in place. Rounds will be conducted 2x daily for 4 weeks and 2x weekly thereafter. Results of audits will be forwarded to QA committee monthly for review x12 months.</p>	

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	<p>of 2 staff needed for transfers, bed mobility, and toilet use. A cognition score of 3 indicated severe cognitive impairment.</p> <p>A fall care plan initiated 06/05/12 and last updated on 10/11/14, indicated the resident was at risk for falls related to antianxiety and antidepressant medications and unsteadiness related to position change from sit to stand. Interventions included but were not limited to, low bed, half rails as enabler, use of wheelchair as an adaptive device, educate and remind resident to request assistance before ambulating, and "...orange duct tape to walker as visual aid to use."</p> <p>On 12/3/14 at 10:30 A.M., the Assistant Director of Nursing (ADON) was made aware the fall assessment of Resident #45's 10/31/14 fall was missing from her clinical record. The ADON at that time was unable to locate in the clinical record the 10/31/14 fall assessment and circumstance or the documentation of the 10/31/14 fall in the nursing progress notes. She indicated at that time she would continue to look for the missing fall documentation.</p> <p>On 12/3/14 at 12:30 P.M., during interview with the Director of Nursing</p>			

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	<p>(DON) she indicated she was aware of the fall assessment for the 10/31/14 fall was not in Resident #45's clinical record. She indicated the facility's RN Consultant would continue to look for the missing fall assessment.</p> <p>On 12/3/14 at 1:40 P.M., the following fall assessments and care plans were reviewed with the Director of Nursing (DON).</p> <p>A "Fall Circumstance, Assessment and Intervention" form dated 7/18/14 indicated, Resident #45 had fallen and was found on the bathroom floor at 6:00 P.M. The section of the assessment regarding activity at the time of the fall was left blank. New interventions initiated were, "Lock bed wheels, Therapy evaluation, Frequently used items within reach, low bed, and PT [Physical Therapy] OT [Occupational Therapy] eval. [evaluation]." The fall assessment also indicated cognitive impairment had affected the resident's judgment in regard to safety and that assistance was needed for transfer and ambulation.</p> <p>The DON indicated at that time (12/3/14 at 1:40 P.M.) documentation was lacking that assistance had been provided for transfer to toilet in regard to the 7/18/14</p>			

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	<p>fall. The DON also indicated Occupational Therapy (OT) had picked up the resident for services after the 7/18/14 fall. The DON reviewed the OT notes (7/18/14) and indicated on OT discharge the resident had needed the assistance of 1 staff for ADLS (activities of daily living) and ambulation of short distances in her room.</p> <p>On 12/5/14 at 8:55 A. M., Occupational Therapist #1 was interviewed regarding the OT therapy provided after the 7/8/14 fall. She indicated OT therapy had started on 7/22/14 after the resident fell in her bathroom toileting herself on 7/18/14. OT Therapist #1 indicated at OT discharge on 8/20/14, Resident #45 had needed contact guard assistance for steadiness when dressing and toileting. She explained contact guard was "hand on" care/assistance that would be provided if needed. She explained on discharge 8/20/14, the resident needed contact guard assistance for transfers. OT Therapist #1 indicated at that time Resident #45 had needed contact guard and assistance to toilet and transfer before the fall of 9/25/14.</p> <p>Another fall assessment indicated a fall had occurred on 9/25/14. The documentation had indicated the fall had occurred in the resident's bathroom at</p>			

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	<p>1:50 P.M. The report indicated the activity at the time of the fall was "... ambulating s [without] device from toilet lost balance & slid down the wall..." The DON was made aware at that time the 9/16/14 MDS had indicated the resident needed assistance to toilet. The DON agreed staff assistance was lacking in regard to the 9/25/14 fall. The assessment lacked documentation of immediate interventions being initiated to prevent further falls until interventions were documented the next day on 9/26/14 by the Interdisciplinary team. The Interdisciplinary team interventions included: "balance loss r/t [related to] 0 [zero] utilizing adaptive device, apply orange duct tape to walker to act as visual cue and enabling to [arrow up symbol] [increase] compliance of utilizing walker... ", and a medication review.</p> <p>On 12/5/14 at 8:55 A.M., during interview with Occupational Therapist #1, she indicated Resident #45 had needed contact guard assistance by staff to toilet and transfer before the fall of 9/25/14. She indicated Resident #45 was not picked up for therapy after the 9/25/14 fall. She indicated Resident #45 had fallen in her bathroom on 10/31/14 and broke her hip and at present was receiving therapy.</p>			

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	<p>A "Resident Transfer Form" dated 10/31/14, indicated Resident #45 had been transferred to a hospital. The documentation indicated resident was up "... transferring self & fell in Br [bathroom] - usually uses w/c for locomotion transfers self for toileting needs. Res [resident] c/o [complaint] LT [left] knee, hip & shoulder pain..." The transfer form documented assistance was needed for the bed activity of turning and sitting and assistance was needed for transfer to tub and toilet. The transfer sheet also indicated Resident #45's mental status was documented as forgetful.</p> <p>A Hospital History and Physical dated 11/1/14 regarding Resident #45 indicated, "...This is a 95 year old female from a skilled nursing facility, who fell injuring her left hip. She was brought to [hospital name here] where she was found to have left intertrochanteric hip fracture [fracture of the upper femur]..."</p> <p>On 12/3/14 at 1:40 P.M., the DON was made aware that documentation was lacking of a facility assessment (Fall Circumstance Assessment and Intervention) of Resident #45's 10/31/14 fall. Documentation of the 10/31/14 fall was also lacking in the nursing notes of Resident #45. The DON indicated at that</p>			

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	<p>time she was aware the clinical record lacked the fall circumstance assessment. She indicated the facility had contacted the hospital for documentation that had been sent with the resident when she had been transferred to the hospital. She indicated the hospital had faxed the facility papers that had been sent during transfer. She indicated the facility fall assessment of the 10/31/14 fall had not been included. She indicated a facility incident report (internal facility documentation not part of the clinical record) of the 10/31/14 fall had been completed. The facility did not provide the 10/31/14 incident report. The facility did not provide any documentation in regard to the fall assessment of the 10/31/14 fall.</p> <p>On 12/5/14 at 10:10 A.M., the DON was made aware there was a problem with lack of adequate supervision and assistance being provided during transferring and toileting to prevent falls. The DON at that time provided no further information.</p> <p>On 12/5/14 at 10:30 A.M., the facility fall policy entitled "FALLS MANAGEMENT PROGRAM GUIDELINES (revision date 3/08) was received and reviewed. The policy included but was not limited to,</p>			

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F000334 SS=D	<p>"...Procedure: 3. Should the resident experience a fall the attending nurse shall complete the 'Fall circumstance and Reassessment Form' The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT [Interdisciplinary team] to evaluate thoroughness of the investigation and appropriateness of the interventions..."</p> <p>3.1-45(a)(2)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal</p>				

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	<p>representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure the facility immunization policy was correctly implemented for 2 of 5 residents reviewed for immunizations, in that, 2 of 5 residents reviewed did not have signed consent of refusal of flu vaccinations and/or documentation of vaccination available. (Resident # 19, Resident #63)</p> <p>Findings include:</p> <p>1. On 12/1/14 at 10:20 A.M., Resident #19 was observed sitting in a recliner in her room.</p> <p>The clinical record for Resident #19 was reviewed on 12/1/14 at 10:45 A.M. Documentation of current Influenza Immunization Education and Informed Consent was not included in the clinical record.</p> <p>2. On 12/2/14 at 11:40 A.M., Resident #63 was observed lying in bed with her eyes closed.</p> <p>The clinical record for Resident #63 was reviewed on 12/2/14 at 7:41 A.M., documentation of current Influenza Immunization Education and Informed Consent was not included in the clinical</p>	F000334	Resident #19 has been offered the flu vaccine and received it. Res #63 has been offered the flu vaccine and received it. There were no other residents affected by the alleged deficient practice and through the implementation of new tracking system will ensure that all residents have been offered and consent or refuse the influenza vaccine annually. Medical Records nurse was inserviced on the requirement of flu vaccines. Tracking sheet will be reviewed in QA during the months of September through November to ensure all residents have form on record and receive shot if wanted.	01/08/2015

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	<p>record.</p> <p>During an interview with the Director of Nursing (DON) 12/5/14 at 12:17 A.M., she indicated residents and/or families would be educated about and offered a yearly flu vaccination. She indicated that was done by the Medical Records Coordinator sending out the forms and than giving the vaccinations when consents were received. She indicated the current documentation for Resident #19 and Resident #63 was not in the chart.</p> <p>During an interview on 12/5/14 at 12:50 A.M., the Medical Records Coordinator indicated she had sent out the facility Influenza and Immunization Education and Consent forms in October and the Influenza Vaccinations had been administered in November. She indicated Resident #19 chart lacked documentation of Informed consent or refusal. She indicated the POA for Resident #19 was in frequently so she was not sure why it was not completed. The Medical Records Coordinator indicated Resident #63 did not have an informed consent in her chart. She further indicated Resident #63 was able to sign her own consents.</p> <p>An undated policy titled "Guidelines for Influenza and Pneumococcal Immunizations" was provided by the</p>						

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F000371 SS=F	<p>Administrator on 12/1/14 at 1:00 P.M., it included, "...1. Upon admission each resident/responsible party will be provided with information regarding the risk and benefits of influenza and pneumococcal immunization... 2. Upon admission and annually each resident/responsible party will sign an informed consent form indicating the acceptance/refusal of the immunization. A copy will be placed in the medical record. 7. It will be documented if the resident refuses immunization or did not receive the immunization as a result of a medical contraindication (including the nature of the resident's medical contraindication), unavailability, or a precaution that delayed the administration and a later date for administration has been planned..."</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy, in that, prepared food was not discarded after 72 hours, food stored in</p>	F000371	There were no residents affected by the alleged deficiency and all food items beyond the 72 hour window have been discarded. Steam table has been disassembled and	01/08/2015

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	<p>open bags and/or containers in the refrigerator lacked the date the packaging was opened or prepared, and sanitation was lacking. This had the potential to affect 50 of 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>During observations of the kitchen and dining room on 12/1/13 at 9:12 A.M. and 12/5/14 at 11:20 A.M., the following was observed.</p> <p>Located in the walk in refrigerator:</p> <ol style="list-style-type: none"> 1. One plastic storage container with diced ham had no date on the container documenting placement of the ham in the storage container. 2. One plastic storage container with diced ham dated 11/24/14. 3. One plastic storage container with chicken salad dated 11/24/14. 4. One plastic storage container with crushed pineapple dated 11/25/14. 5. One plastic storage container with tomato soup dated 11/26/13. 6. One opened bag of lettuce dated 		<p>cleaned, heat lamp has been cleaned and relocated, shelf under food prep tables have been cleaned, juice machine and water dispenser have been disassembled, delimed, and cleaned. Systemic change is that chemical storage has been designated away from food storage, new food labeling system for open containers, cleaning schedule has been revised. All dietary staff will be inserviced on sanitation requirements, food storage requirements, food labeling, cleaning schedule. DFS/designee will monitor cleaning schedule and sanitation daily times 6 months and 2 times weekly thereafter. Audits will be forwarded to QA monthly times 12.</p>	

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	<p>11/26/14.</p> <p>7. One opened quart carton of Liquid eggs dated 12/1/14.</p> <p>Located in the walk in freezer:</p> <p>8. One opened bag of biscuits not dated.</p> <p>9. One opened bag of French fries not dated.</p> <p>10. One opened bag of chicken tenders not dated.</p> <p>11. One opened bag of Onion Tangles not dated.</p> <p>During an interview on 12/01/14 at 9:20 A.M., the Dietary Manager (DM) indicated the facility's policy was to dispose all food after it was 72 hours old and foods should be labeled and dated after opening.</p> <p>The following was observed in the food preparation area:</p> <p>12. The convection oven had black grease running down the stainless steel leg where it dripped on the floor during both days of the observation.</p> <p>13. The storage shelf under the food prep</p>			

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	<p>table appeared greasy and had dried food debris and food smears during both days of the observation.</p> <p>14. The heat lamp located above the food steam table had extensive dust build up during both days of the observation.</p> <p>The following was observed in the storage room:</p> <p>15. Four cans of Butane Fuel stored beside 4 containers of prune juice and 8 containers of thickened lemon flavored water. At that time, the Dietary Manager indicated the Butane Fuel should not be stored with food items.</p> <p>The following was observed in the dining room:</p> <p>16. The Dining room steam serving table had dried food debris on the lids and on the sneeze guard. The temperature/control knobs were smeared with dried food during both days of the observation.</p> <p>17. The juice machine had a black build up inside the fountain heads.</p> <p>18. The water dispenser head had a white build up around the nozzle and a slimy substance covered the entire</p>			

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F000514 SS=D	<p>drainage/drip tray during both days of the observation.</p> <p>During an interview on 12/5/14 at 11:35 A.M., the Dietary Manager indicated she had just started working last week and she was aware that a lot of deep cleaning was needed.</p> <p>The facility's policy and procedure "Storage Procedures" was reviewed on 12/01/14 at 10:30 A.M. The policy and procedure read as follows: "...1...Chemical/poisonous items are not stored in food storage area...10. Leftovers are refrigerated immediately and used within 72 hours..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by</p>			

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	<p>the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the clinical record of a resident who had fallen was complete and accurate in regard to a fall assessment for 1 of 1 resident reviewed for falls. Resident # 45</p> <p>Findings include:</p> <p>Resident #45's clinical record was reviewed on 12/2/14 at 10:41 A.M. Resident #45 had been admitted to the facility on 10/13/11. Her diagnoses included, but were not limited to, dementia, seizures, anxiety, and cardiovascular accident.</p> <p>On 12/3/14 at 10:30 A.M., the Assistant Director of Nursing (ADON) was made aware the fall assessment of Resident #45's 10/31/14 fall was missing from the clinical record of resident #45. The ADON, at that time, was unable to locate in the clinical record the 10/31/14 fall assessment and circumstance or the documentation of the 10/31/14 fall in the nursing progress notes. She indicated, at that time, she would continue to look for the missing fall documentation.</p> <p>On 12/3/14 at 12:30 P.M., during interview with the Director of Nursing</p>	F000514	<p>Resident #45 has current careplan and fall prevention interventions in place and staff that care for her have been inserviced on these. She has not had a fall since her 10/31/14 fall. No other residents were affected by the alleged deficient practice and through implementing medical record procedures will ensure that documentation is completed and filed appropriately and those residents who are at risk for falls have interventions implemented to provide adequate supervision to prevent falls. Nursing staff inserviced on fall documentation, interventions to prevent falls and appropriate documentation post fall. DHS/designee will conduct rounds to ensure fall prevention interventions and careplan items are observed in place. Rounds will be conducted 2x daily for 4 weeks and 2x weekly thereafter. Results of audits will be forwarded to QA committee monthly for review x12 months.</p>	01/08/2015	

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	<p>(DON) she indicated she was aware the fall assessment of the 10/31/14 fall was not in Resident #45's clinical record. She indicated the facility's RN Consultant would continue to look for the missing fall assessment.</p> <p>A "Resident Transfer Form" dated 10/31/14, indicated Resident #45 had been transferred to a hospital. The documentation indicated resident was up "... transferring self & fell in Br (bathroom) - usually uses w/c for locomotion transfers self for toileting needs. Res (resident) c/o (complaint) LT (left) knee, hip & shoulder pain..."</p> <p>On 12/3/14 at 1:40 P.M., the DON was made aware that documentation was lacking of a facility assessment (Fall Circumstance Assessment and Intervention) of Resident #45's 10/31/14 fall. Documentation of the 10/31/14 fall was also lacking in the nursing notes of Resident #45. The DON indicated at that time she was aware the clinical record lacked the fall circumstance assessment. She indicated the facility had contacted the hospital for documentation that had been sent with the resident when she had been transferred to the hospital. She indicated the hospital had faxed the facility papers that had been sent during the hospital transfer. She indicated the</p>			

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F009999	<p>fall assessment of the 10/31/14 fall had not been included. She indicated a facility incident report of the 10/31/14 fall had been completed. The facility did not provide the incident report of the 10/31/14 fall.</p> <p>On 12/5/14 at 10:10 A.M., the DON was made aware there was a problem with Resident #45's clinical record being incomplete, in that, the clinical record lacked documentation of the 10/31/14 fall and assessment. At that time, the DON provided no further information.</p> <p>On 12/5/14 at 10:30 A.M., the facility fall policy entitled "FALLS MANAGEMENT PROGRAM GUIDELINES (revision date 3/08) was received and reviewed. The policy included but was not limited to, "...Procedure: 3. Should the resident experience a fall the attending nurse shall complete the 'Fall circumstance and Reassessment Form...'</p> <p>3.1-50(a)(1)</p> <p>Personnel 3.1-14 (s) Professional staff must be licensed, certified, or registered in accordance with</p>	F009999	LPN #16 license was reactivated and in good standing Systemic change is that licenses will be put into the payroll system and will	12/11/2014

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	<p>applicable state laws or rules.</p> <p>This state rule not met as evidence by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff were qualified to provide care, in that, an LPN provided nursing care for 9 days on the Health Care unit with an expired license. (LPN #16)</p> <p>Findings include:</p> <p>The nursing license of LPN #16 was reviewed on 12/09/14 at 10:00 A.M. The license included, but was not limited to, an expiration date of 10/31/14. A Payment Receipt indicated LPN #16 attempted to renew the license on 12/05/14 at 2:39 P.M.</p> <p>During an interview on 12/09/14 at 10:15 A.M., the Payroll Coordinator indicated the license of LPN #16 expired on 10/31/14, but was renewed on 12/05/14. The Payroll Coordinator further indicated, at that time, the active license could be verified online.</p> <p>The time sheets from 11/18/14 through 12/05/14 were provided by the Payroll Coordinator on 12/09/14 at 10:20 A.M. The time sheets indicated LPN #16 worked 9 shifts as a nurse on the Health</p>		<p>not be allowed to work when there is not a current one on file. ADHS/scheduler will validate licenses on month of expiration each year and remove employees if current license is not obtained. Peer review and QA will validate all licenses every 6 months.</p>				

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	<p>Care unit as follows:</p> <p>11/18/14 for 9.83 hours 11/19/14 for 13.00 hours 11/20/14 for 10.33 hours 11/21/14 for 17.00 hours 11/24/14 for 9.5 hours 11/26/14 for 8.50 hours 11/28/14 for 4.83 hours 12/02/14 for 9.17 hours 12/05/14 for 12.67 hours</p> <p>During an interview on 12/09/14 at 10:30 A.M., the Payroll Coordinator indicated online verification of LPN #16's license was attempted, but continued to show the license was expired.</p> <p>On 12/09/14 at 10:35 A.M., LPN #16 was observed standing at a medication cart near the 200 hallway of the Health Care unit.</p> <p>During an interview on 12/09/14 at 10:40 A.M., the DON (Director of Nursing) indicated LPN #16 performed common nursing duties on the Health Care unit during the shifts from 11/18/14 through 12/05/14. The DON stated, at that time, "... [LPN #16] is working as the nurse today..." The DON then indicated, at that time, she was not aware LPN #16 was working with an expired nursing license.</p>						

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R000000	<p>During an interview on 12/09/14 at 11:00 A.M., the ADON (Assistant Director of Nursing) indicated LPN #16 had provided verbal assurance of timely license renewal, but had not provided actual documentation. The ADON further indicated, at that time, the discrepancy had been identified on 12/05/14 and she had assisted LPN #16 to attempt license renewal on the same day. The ADON then indicated, at that time, she believed the payment receipt was adequate documentation to allow LPN #16 to continue working as a nurse.</p> <p>During an interview on 12/09/14 at 11:30 A.M., the DON indicated no specific policy could be provided, but it was the policy of the facility to only allow staff, with active licensure, to provide nursing care to the residents.</p> <p>3.1-14(s)</p>	R000000		
R000117	<p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance</p>			

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	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff were qualified to provide care, in that, an LPN provided nursing care for 13 days on the Assisted Living unit with an expired license. (LPN #16)</p> <p>Findings include:</p> <p>The nursing license of LPN #16 was reviewed on 12/09/14 at 10:00 A.M. The license included, but was not limited to, an expiration date of 10/31/14. A Payment Receipt indicated LPN #16</p>	R000117	<p>LPN #16 license was reactivated and in good standing Systemic change is that licenses will be put into the payroll system and will not be allowed to work when there is not a current one on file. ADHS/scheduler will validate licenses on month of expiration each year and remove employees if current license is not obtained. Peer review and QA will validate all licenses every 6 months.</p>	12/11/2014	

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	<p>attempted to renew the license on 12/05/14 at 2:39 P.M.</p> <p>During an interview 12/09/14 at 10:15 A.M., the Payroll Coordinator indicated the license of LPN #16 expired on 10/31/14, but was renewed on 12/05/14. The Payroll Coordinator further indicated, at that time, the active license could be verified online.</p> <p>The time sheets from 11/01/14 through 11/29/14 were provided by the Payroll Coordinator on 12/09/14 at 10:20 A.M. The time sheets indicated LPN #16 worked 13 shifts as a nurse on the Assisted Living Unit as follows:</p> <p>11/01/14 for 12.50 hours 11/02/14 for 8.67 hours 11/04/14 for 8.33 hours 11/05/14 for 10.67 hours 11/06/14 for 12.67 hours 11/07/14 for 10.33 hours 11/10/14 for 8.33 hours 11/11/14 for 8.17 hours 11/12/14 for 8.17 hours 11/13/14 for 11.00 hours 11/15/14 for 11.17 hours 11/16/14 for 13.17 hours 11/29/14 for 15.67 hours</p> <p>During an interview on 12/09/14 at 10:30 A.M., the Payroll Coordinator indicated</p>			

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	<p>online verification of LPN #16's license was attempted, but continued to show the license was expired.</p> <p>On 12/09/14 at 10:35 A.M., LPN #16 was observed standing at a medication cart near the 200 hallway of the Health Care Unit.</p> <p>During an interview on 12/09/14 at 10:40 A.M., the DON (Director of Nursing) indicated LPN #16 performed common nursing duties on the Assisted Living unit during the shifts from 11/01/14 through 11/29/14. The DON stated, at that time, "...[LPN #16] is working as the nurse today [on the Health Care unit]..." The DON then indicated, she was not aware LPN #16 was working with an expired nursing license.</p> <p>During an interview on 12/09/14 at 11:00 A.M., the ADON (Assistant Director of Nursing) indicated LPN #16 had provided verbal assurance of timely license renewal, but had not provided actual documentation. The ADON further indicated, at that time, the discrepancy had been identified on 12/05/14 and she had assisted LPN #16 to attempt license renewal on the same day. The ADON then indicated, she believed the payment receipt was adequate documentation to allow LPN</p>			

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R000216	<p>#16 to continue working as a nurse.</p> <p>During an interview on 12/09/14 at 11:30 A.M., the DON indicated no specific policy could be provided, but it was the policy of the facility to only allow staff, with active licensure, to provide nursing care to the residents.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who had orders for medications that may be kept at the bedside (MKAB) had been assessed to adequately administer their own medications for 1 of 1 resident observed to have MKAB medication orders which were reviewed after a medication pass (R</p>	R000216	Resident R#32 has updated self administration assessment No other residents were affected by the noncompliance AL manager inserviced on requirement for self administration assessment AL manager will assess during monthly recap of physician orders those who are self administering meds to ensure that a current assessment is in the chart for them all. QA committee will review all those who self	01/08/2015

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	<p>#32).</p> <p>Findings include:</p> <p>On 12/9/14 at 10:10 A.M., R #32's clinical record was reviewed. Documentation was lacking of an assessment regarding R #32's safety in regard to the self administration of medications.</p> <p>R #32's December 2014 medications orders included but were not limited to, "ARTIFICIAL TEARS SOL [solution] 15 ML INSTILL 1 DROP IN BOTH EYES FOUR TIMES A DAY FOR DRY EYES *MKAB [May Keep At Bedside]* " Another order dated 10/22/13, indicated, "DULERA INH [inhaler] 200 MCG [MICROGRAMS]/5 MCG GIVE 2 PUFFS ORALLY TWICE DAILY for allergies MKAB [May Keep At Bedside]." Documentation was lacking in the clinical record of a physician 's order for R #32 to administer his medication.</p> <p>On 12/9/14 at 11:20 A.M., a facility policy (dated December 2011) entitled, "GUIDELINES FOR SELF ADMINISTRATION OF MEDICATIONS was reviewed. The policy included but was not limited to, "PURPOSE: To ensure the safe administration of medication for</p>		<p>administer meds on the residential units quarterly for appropriate assessment x12 months.</p>				

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R000243	<p>residents who request to self-medicate or when self-medication is a part of their plan of care. PROCEDURE: 1. Residents requesting to self-medicate or has self medication as a part of their plan of care shall be assessed for safety by a licensed nurse. 2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of medication(s) the resident is able to self-medicate. i.e.: all oral meds, oral meds with the exception of, nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc..."</p> <p>On 12/9/14 at 11:58 A.M., the Director of Nursing (DON) was interviewed regarding an assessment for self medication administration for R #32. The DON indicated at that time documentation was lacking of an assessment for R #32's self medication administration.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and</p>			

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	<p>(D) name or initials of the person administering the drug or treatment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a transdermal drug patch was rotated from site to site when administered to prevent the same site administration for a 14 day administration period for 1 of 1 resident who had been administered a transdermal patch during a medication. 1 of 1 resident with orders for medications at bedside, the medications were not given to the resident and/or ensured the resident received the ordered medications stored at bedside. (R # 27).</p> <p>Findings include:</p> <p>1. On 12/9/14 at 9:15 A.M., R #27 was observed to have transdermal Exelon patch intact to an area of her upper left back. LPN #1 removed the patch before applying a new patch to the upper right back area. LPN #1 during interview, at that time, indicated she daily rotates the patch site areas but indicated there was no documentation of the site areas utilized in the clinical record. She indicated a site chart was needed for daily patch placement.</p> <p>On 12/9/14 at 9:15 A.M., R #27's December 2014 Medication Record</p>	R000243	Resident #27 suffered no ill effects from the deficiency and through implementation of the new administration record will ensure that 14 sites are in a rotating cycle. There were no other residents affected by the deficient practice. Licensed nursing staff inserviced on the site rotation form for the Exelon patches. DHS/designee will review MAR's for compliance and use of the form weekly x4 weeks and 2xmonthly x4 months and monthly thereafter. Pharmacist will review during monthly consultant visit for compliance. QA will review audits and pharmacist report monthly x3 months and quarterly thereafter.	01/08/2015

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	<p>(MAR) was reviewed. The MAR included but was not limited to, "Exelon 9.5 MG/24 HR (hour) PATCH APPLY 1 PATCH TOPICALLY ONCE DAILY FOR ALZHEIMER'S ****REMOVE OLD PATCH **** A section was included for the nurse's initials for A.M./morning placement of the patch. A section labeled "site" had been left blank the first 8 days of December 2014. A section was also included for removal of the patch and was labeled "off" for documentation of the nurses' initials when removing the patch. A section labeled "old" was for the patch already in place and had documentation of checkmarks on 12/1/14-12/5/14 and on 12/8/14.</p> <p>On 12/9/14 at 11:15 A.M., the facility's drug book entitled, "PDR (Physician's Desk Reference) 2015 EDITION NURSE'S DRUG HANDBOOK" was reviewed in regard to the drug patch Exelon. Nursing considerations included but were not limited to, "... (Patch) Instruct to rotate application site, not to use the same site within 14 days..."</p> <p>On 12/9/14 at 1:30 P.M., during interview with LPN #1 she indicated she had known to rotate the Exelon patch but she had not known about the need for a 14 day rotation site schedule.</p>			

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R000244	<p>2. On 12/9/14 at 10:10 A.M., R #32's physician's orders were reviewed after Resident #32 had received his upon rising (am) medications during a medication pass at 8:40 A.M. R #32's December 2014 medications orders included but were not limited to, " ARTIFICIAL TEARS SOL 15 ML INSTILL 1 DROP IN BOTH EYES FOUR TIMES A DAY FOR DRY EYES *MKAB [May Keep At Bedside]* [order date 11/5/14]" Another order dated 10/22/13, indicated, "DULERA INH [inhaler] 200 MCG [MICROGRAMS]/5 MCG GIVE 2 PUFFS ORALLY TWICE DAILY for allergies MKAB [May Keep At Bedside]." Documentation was lacking in the clinical record of a physician's order for R#32 to administer his medication. The current December 2014 Medication Administration Record (MAR) in regard to artificial tears and dulera inhaler lacked documentation by nursing staff that medications had been administered.</p> <p>410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted.</p> <p>Based on observation, interview, and</p>	R000244	Resident #32 suffered no ill effects from the noncompliance, has self administration	01/08/2015

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	<p>record review, the facility failed to ensure medications provided to the resident by the nursing staff, had been administered to the resident and not left at the bedside for 1 of 1 resident during the medication pass.</p> <p>(R #32)</p> <p>Findings include:</p> <p>On 12/9/14 at 10:10 A.M., R #32's physician's orders were reviewed after Resident #32 had received his upon rising (am) medications during a medication pass at 8:40 A.M.</p> <p>On 12/9/14 at 10:15 A.M., a stack of clear medication cups (approximately 3 inches high) with the resident's last name printed on them were observed in the cabinet and 1 clear medication cup (with his last name on it) contained 1 and 1/2 pills and a capsule. LPN #1 indicated the pills looked like they had been taken with the edges observed to be slightly dissolved. All of the above medications were removed from R #32's room by LPN #1 and given to the Assistant director of Nursing (ADN).</p> <p>12/9/14 at 11:20 A.M., during an interview with the administrator, she indicated the facility had no specific</p>		<p>assessment completed and physician orders for many meds to keep at bedside. MD had consultation with resident regarding orders. No other residents were affected by the noncompliance AL manager inserviced on self administration requirements and medication storage. AL manager will conduct rounds daily to ensure residents medications are properly stored x3 weeks, then weekly. Results of audits will be forwarded to QA committee monthly x3 months and quarterly thereafter.</p>	

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R000295	<p>policy for medications being left at bedside.</p> <p>On 12/9/14 at 1:30 P.M., LPN #1 was interviewed regarding the pills left in a medication cup and the opened medication bottles and inhaler left in a cabinet in R#32's room. LPN #1 indicated she thought the pills left in the medication cup were the resident's medications of Xanax and Colace. She indicated at that time the pills and opened bottles of medication should not have been left in R# 32's room.</p> <p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications that were ordered MKAB (May Keep At Bedside) were available/ and or stored safely for 1 of 1 resident reviewed for self medication administration. (R #32)</p> <p>Findings include:</p> <p>On 12/9/14 at 10:15 A.M., the following medications were observed with LPN #1</p>	R000295	Resident #32 suffered no ill effects from the noncompliance, has self administration assessment completed and physician orders for many meds to keep at bedside. MD had consultation with resident regarding orders. No other residents were affected by the noncompliance AL manager inserviced on self administration requirements and medication storage. AL manager will conduct rounds daily to ensure residents medications are properly stored x3 weeks, then weekly. Results of audits will be forwarded to QA	01/08/2015

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	<p>in R #32's unlocked room in an unlocked cabinet. The medications were: an opened antacid calcium tablets, an opened equate antacid bottle, an opened equate acetaminophen (500 mg) bottle, an opened equate gas relief (125 mg) bottle, an opened equate anti-diarrhea (2 mg) bottle, an opened Pepto-Bismol bottle, an opened equate stomach relief bottle, an opened MOM (milk of magnesia) Phillip's bottle, an opened equate allergy relief (Claritin) bottle, and an opened dulera 200 mg/5 mcg inhaler.</p> <p>On 12/9/14 at 11:20 A.M., a facility policy (dated December 2011) entitled, "GUIDELINES FOR SELF ADMINISTRATION OF MEDICATIONS was reviewed. The policy included but was not limited to, "PURPOSE: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. PROCEDURE: "... 4. The medication will be kept in a locked drawer in the resident's room. The resident will maintain the key, as well as, a key will be maintained by the licensed nurse and or QMA [Qualified Medication Aide]..."</p> <p>12/9/14 at 11:20 A.M., during an interview with the administrator, she</p>		committee regarding those who self administer and medication storage.				

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R000356	<p>indicated the facility had no specific policy for medications being left at bedside.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on observation, interview, and record review, the facility failed to ensure their policy for residential emergency files met minimum state requirement and/or medical records were complete and accurate, in that, the policy did not include the state requirement of a photograph and/or the residential emergency files did not contain complete and accurate information for 5 of 5 residents reviewed. (R #8, R #9, R #19, R</p>	R000356	R #9 had photograph and Advanced directives added to fileR #8 had photograph and Advanced directives added to the fileR #32 had photograph and Advanced directives added to fileR #20 had photograph and Advanced directives added to fileR #19 had Advanced directives added to fileSystemic change is the Emergency file policy updated to include photograph AL manager will update with each new admission	01/08/2015

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	<p>#20, R #32)</p> <p>Findings Include:</p> <p>1. The emergency file for R #9 was reviewed on 12/9/14 at 10:00 A.M., admission date was 7/26/14. The current emergency file for R #9 did not contain a photograph of the resident. The file lacked accurate Advance Directive information in that, the signed consent indicated resident was Do Not Resuscitate (DNR). The face sheet in the emergency file indicated resident had "no Advance directives."</p> <p>2. The emergency file for R #8 was reviewed on 12/9/14 at 10:00 A.M., admission date was 9/30/14. The current emergency file for R #8 did not contain a photograph of the resident. The file lacked accurate Advance Directive information, in that, the signed consent indicated resident was Do Not Resuscitate (DNR). The face sheet in the emergency file did not list a code status.</p> <p>3. The emergency file for R #32 was reviewed on 12/9/14 at 10:00 A.M., admission date was 9/5/13. The current emergency file for R #32 did not contain a photograph of the resident. The file lacked accurate Advance Directive information, in that, the signed consent</p>		and changes with current residents, all required items.QA committee will review Emergency binder monthly x3 and quarterly thereafter.				

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	<p>indicated resident was a Full Code. The face sheet in the emergency file indicated resident had "no Advance Directives."</p> <p>4. The emergency file for R #20 was reviewed on 12/9/14 at 10:00 A.M., admission date was 9/17/14. The current emergency file for R #20 did not contain a photograph of the resident. The file lacked accurate Advance Directive information, in that, the signed consent indicated resident was Do Not Resuscitate (DNR). The face sheet in the emergency file did not list a code status.</p> <p>5. The emergency file for R #19 was reviewed on 12/9/14 at 10:00 A.M., admission date was 9/16/11. The current emergency file for R #19 lacked accurate Advance Directive information, in that, the signed consent indicated resident was Do Not Resuscitate (DNR). The face sheet in the emergency file indicated resident had "no Advance directives."</p> <p>An undated facility policy titled " Emergency Information File " was provided on 12/9/14 at 1:30 P.M., by the DON. The policy included " ... 1.A current emergency information file shall be maintained for each resident. 2. The file shall contain the following information: g. a copy of advance directives ... " The policy lacked the state</p>						

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	requirement of a photograph for identification of residents.				