

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/30/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 22, 23, 24, 27, 28, 29, 30, 2014.</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Survey Team: Tom Stauss, RN, TC Beth Walsh, RN (January 22, 24, 27, 28, 29, 30, 2014) Karina Gates, Medical Surveyor Courtney Mujic, RN (January 22, 23, 24, 28, 29, 30, 2014)</p> <p>Census Bed Type: SNF/NF: 118 Residential: 0 Total: 118</p> <p>Census Payor Type Medicare: 9 Medicaid: 95 Other: 14 Total: 118</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</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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	Quality review completed on February 5, 2014 by Randy Fry RN.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a resident's Physician was notified related to a significant weight loss for 1 of 3 residents in a total of 4</p>	F000157	To accomplish corrective actions for residents affected by the practice, the physician for resident #106 was notified of the significant weight loss. To identify other residents having the	03/01/2014

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	<p>residents who met the criteria for nutrition review. (Resident #106)</p> <p>Findings include:</p> <p>A record review was performed for Resident #106 on 1/27/14 at 9:40am.</p> <p>Some of the clinical record reviewed included, but were not limited to: MDS data, assessments, progress notes, medication and treatment records, dietary and nutrition records, lab records, activities, and therapy services.</p> <p>Resident's diagnoses include, but were not limited to: acute, but ill defined, cerebrovascular disease, congestive heart failure, chronic kidney disease, atrial fibrillation, hypopotassemia, unspecified essential hypertension. Resident #106's admission assessment also indicated DVT (deep vein thrombosis) of LLE (left lower extremity). Admission assessment indicated no presence of edema.</p> <p>The clinical record indicated Resident #106's weight was 205 lbs on 9/24/13. A record entry dated 10/4/13 indicated Resident #106's</p>		<p>potential to be affected by the practice a record review was conducted for the residents meeting the criteria for significant weight loss and any absent notifications were communicated to the physician promptly. To ensure that the practice does not recur, the charge nurses and unit coordinators will be retrained on the notification requirements by the DNS and ADNS on February 20, 2014. To monitor the changes in practice and ensure that the practice does not recur, a copy of the weight variance report will be used to audit all resident records with significant weight losses to ensure that there is documentation of physician notification. These will be audited by the DNS, ADNS, and Unit Coordinators during the Clinical Startup. These will be conducted weekly X8, every other week x 4, and monthly ongoing. Any non compliance will be reported during the QAPI meeting for a formal action plan.</p>				

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	<p>weight was 176 lbs.</p> <p>The clinical record indicated, from a 10/4/13 progress note entry, that "resident has lost 21#(pounds) since admission".</p> <p>During an Interview with Registered Dietician (RD), on 1/27/14 at 10:08 a.m., She indicated Resident #106 was admitted with a problem of ascites (an accumulation of body fluid) which, as it resolved over time, contributed to the weight loss observed in clinical record. She indicated she observed Resident #106's weight to be 175.6 lbs on 9/30/13. She indicated the facility's policy was to reweigh a resident, within 24 hours, who lost more than 3 lbs at a given weighing. She indicated not knowing if Resident #106's physician was notified as "the Nurses would normally contact the Doctor."</p> <p>A follow up interview with the RD on 1/27/14 at 10:27 was conducted. She indicated she documented an issue of "ascites" for Resident #106, but she indicated those entries related to ascites were in error as no MD diagnosis of ascites was found in clinical record. She did indicate however, Resident #106 had a</p>						

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	<p>decreased appetite since admission.</p> <p>On 1/27/14 at 2:12 p.m., during an interview, the Director of Nursing (DON) indicated the clinical record does not show the MD (Medical Doctor) was notified about Resident #106's 21 lb weight loss. She indicated nurse's " should be documenting in progress notes when a Doctor is notified about weight changes." She also indicated physicians should be notified of weight changes as specified by facility policy.</p> <p>On 1/27/14 at 2:51 p.m., during an interview with the Nurse Practitioner for Resident #106's physician, she indicated she was unable to locate documentation prior to December, 2013 of Resident #106 having a 21 lb weight loss between 9/10/13 and 9/29/13. She indicated she would continue to look for the documentation.</p> <p>On 1/27/14 at 3:35 p.m., during an interview, the Nurse Practitioner indicated her office had no record of being notified of a 21 lb weight loss for Resident #106 prior to 1/27/14.</p> <p>A facility policy titled "Weight Monitoring" indicated the following:</p>			

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F000242 SS=D	<p>"...When weight change is significant or severe, the licensed nurse will notify the patient's physician..."</p> <p>A facility document titled "North Weekly Weights" indicated the following: "...Any gain or loss of 3lbs or more, reweigh x 24 hrs, call MD and Family..."</p> <p>3.1-5(a)(2)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to ensure a resident was getting up in the morning by choice for 1 of 3 residents reviewed of 3 who met the criteria for choices. (Resident #127)</p> <p>Findings include:</p>	F000242	To accomplish corrective actions for residents affected by the practice, resident 127 was removed from the "Get-up" list on 1/27/2014. To identify other residents having the potential to be affected by the practice, all residents will be interviewed to determine their desired awake	03/01/2014	

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	<p>The clinical record for Resident #127 was reviewed on 1/27/14 at 10:30 a.m.</p> <p>The diagnoses for Resident #127 included, but were not limited to: peripheral vascular disease.</p> <p>The 10/24/13 Quarterly MDS (minimum data set) assessment for Resident #127 indicated she required extensive assistance of 2 persons for bed mobility and transfers. It indicated she required extensive assistance of 1 person for dressing and toilet use. It indicated she required limited assistance of 1 person for personal hygiene. It also indicated she used a walker and a wheel chair as mobility devices.</p> <p>During an interview with Resident #127 on 1/23/14 at 10:58 a.m. regarding whether she chose when to get up in the morning she indicated, "Sometimes they get me up 5:00 in the morning. I'd like to get up around 8:00 (a.m.)"</p> <p>An interview was conducted with CNA (Certified Nursing Assistant) #12 on 1/27/14 at 11:24 a.m. regarding the time she helped Resident #127 get up that morning.</p>		<p>time. Any resident wanting to be on the "get-up" list, will be included and assisted to get up by the night shift. To ensure that the practice does not recur, all additions and subtractions to the "Get-up" list will be based on a written interview of the resident and only by the Unit Coordinators. Nurses will be in serviced on the need to give residents choices in their "Get-up" time by the DNS and ADNS on February 20, 2014. To monitor the changes in practice and ensure that the deficient practice does not recur, the Guardian Angels will interview the resident to ensure that the current schedule of "Get-ups" meets with their intent weekly x8. During the care plan conference the right to choice will be reviewed and any changes implemented at that time.</p>				

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	<p>CNA #12 indicated, "When I got to work this morning at 7 a.m., she was already up and dressed...I was told by the CNA I was relieving that the routine is to be to the dining room by 7 a.m. She (Resident #127) was sitting by her bed in her wheel chair when I got here."</p> <p>An interview was conducted with LPN #13 at 11:51 a.m. on 1/27/14 regarding the process for determining when to get a resident up in the morning. She indicated, "The New Wing Back (unit on which Resident #127 resides) residents get up on 3rd shift (11:00 p.m. to 7:00 a.m.) because they have to be to dining room by 7:30 (a.m.) Regarding whether a resident is ever asked when he or she would like to get up, she indicated, "When I do an admission packet, we ask what their routine was at home. We fill out that form by hand and it goes into their chart."</p> <p>The 10/25/13 Clinical Health Status assessment form was completed by LPN #10. Section G of the assessment indicated, "Sleep Patterns: Wake time-7 A (7:00 a.m.)"</p> <p>Another interview was conducted</p>						

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	<p>with Resident #127 on 1/27/14 at 11:40 a.m. regarding the above mentioned assessment indicating a 7:00 a.m. wake up time for her. She indicated, "7 a.m. is about right. As long as I'm not doing anything, I don't see why I have to get up that early (at 5 a.m.)...5 a.m. is a little too early to just be sitting here...I just think I'm a normal person who's still sleepy at 5 a.m." Regarding whether she was okay with the time she gets up in the morning, she stated, "If I could give my thoughts, I'd like to get up a little later."</p> <p>During an interview with LPN #15 on 1/27/14 at 2:41 p.m. regarding the times aides start getting residents up in the morning, she indicated, "They start getting residents up at 5:00 a.m." Regarding the time Resident #127 got up in the morning, she indicated there was a "Get Up List" hanging in the staff restroom at the nurses desk. At this time, an observation of the "Get Up List" hanging in the staff restroom was made with LPN #15. Resident #127 was on the list.</p> <p>An interview was conducted with LPN #16, the Unit Manager on Resident #127's unit, on 1/27/14 at 2:41 p.m. regarding whether she</p>			

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	<p>asked Resident #127 if she wanted to be on the "Get Up List" and whether her 10/25/13 Clinical Health Status assessment that indicated her wake up time was 7:00 a.m. was considered prior to putting her on the list. LPN #16 indicated, "I didn't ask (name of Resident #127) about being on that list. We don't use those clinical assessments to decide who gets put on the list." When informed Resident #127 indicated she preferred a later wake up time, LPN #16 stated, "I'll go have a conversation with her about it now."</p> <p>During another interview with LPN #16 on 1/27/14 at 2:57 p.m. after she finished speaking with Resident #127, she indicated, "I just spoke to her, and she said she'd really like to get up at 7:00, give or take 15 minutes. I'm going to change the get up list right now."</p> <p>3.1-3(u)(3)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan related to urinary incontinence for 1 of 3 residents reviewed out of a total of 5 who met the criteria for urinary incontinence. Resident # 28.</p> <p>Findings include:</p> <p>Resident #28's clinical record was reviewed on 1/29/2014 at 10:00 am. Diagnoses included but were not limited to; cerebral infarct (stroke),</p>	F000279	To accomplish corrective actions for residents affected by the practice, the care plan of Resident #28 was updated to include a plan to address his urinary incontinence. To identify other residents having the potential to be affected by the practice, the record will be reviewed for the residents identified as incontinent of bladder to insure that a care plan problem is included in their interdisciplinary care plan. To ensure that the practice does not recur, the Unit Coordinator and the MDS nurse will be inserviced	03/01/2014			

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	<p>diabetes, depressive disorder, hypothyroidism, anemia, dementia, and generalized pain.</p> <p>An MDS (Minimum Data Set) Admission Assessment, dated 9/08/2013, indicated, "Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)".</p> <p>A MDS (Minimum Data Set) Significant change in status assessment, dated 12/09/2013, indicated, "Always incontinent (no episodes of continent voiding)".</p> <p>An interview with LPN #16, on 1/29/2014 at 11:40 a.m., indicated every resident who lives on this locked dementia unit was checked and changed for urinary incontinence at least once in a.m., once at bedtime, and before/after meals, but could be more often such as every 2 hours, if necessary.</p> <p>An interview with the MDS Coordinator, on 1/29/2014 at 3:25 p.m. indicated she could not find a care plan addressing the resident's urinary incontinence.</p> <p>An interview with the DON, on 1/29/2014 at 3:27 p.m., indicated</p>		<p>by the DNS and ADNS on the need to develop Care Plan to address the resident's incontinence. This meeting will be held by 02/26/2014 To monitor the changes in practice and ensure that the practice does not recur, the MDS nurses will weekly times 8 generate a list of residents who are coded as incontinent and audit the record for a Care Plan addressing that problem. With each Assessment Reference Date, the Unit Coordinator and the MDS nurse will review the Clinical Health Status or the Quarterly Interdisciplinary Resident Review form for incontinence coding. A care plan problem for incontinence will be located, reviewed, and revised as indicated or if absent, created for that resident. Compliance will be discussed at the monthly QAPI meetings for Action Plan if indicated.</p>				

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F000280 SS=D	<p>she could not find any care plan related to the resident's urinary incontinence.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise a nutrition care plan for a resident with a history of weight loss. This affected 1 of 3 residents reviewed</p>	F000280	To accomplish corrective actions for residents affected by the practice, the Care Plan for Resident #71 was reviewed and revised on 01/27/2014. To identify other residents having the	03/01/2014

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	<p>for nutrition (Resident #71).</p> <p>Findings include:</p> <p>The clinical record for Resident #71 was reviewed 1/27/14 at 11:00 a.m. The diagnoses for Resident #71 included, but were not limited to: end stage renal disease, disorder of the esophagus, esophageal reflux, unspecified nutritional deficiency, and stricture and stenosis of esophagus.</p> <p>The clinical record indicated the following weights:  10/31/13=196.2 lbs (pounds)  11/7 /13=196 lbs  11/14/13=195.4 lbs  11/21/13= 181.3 lbs  11/28/13=184.4 lbs  12/1/13=171.18 lbs  12/5/13=178.4 lbs  12/12/13=171.8 lbs  12/19/13=174.3 lbs  1/2/14=173 lbs.</p> <p>A review of the current Physician's Orders indicated a diet order, initiated on 11/20/13, of regular small portion and an order of Ensure supplement with meals, initiated on 11/13/13.</p> <p>A review of a care plan titled,</p>		<p>potential to be affected by the practice, the nutritional care plans of all residents have been reviewed and revised to ensure that the diet is correct and the interventions are included. To ensure that the practice does not recur, the RD, DSM, and MDS will be re-instructed by the state dietician on the need to have all diets and interventions correct on the nutritional care plan. This re-instruction will be completed by February 20, 2014 To monitor the changes in practice and ensure that the practice does not recur, the nutritional care plans will be compared to new physician orders weekly x8 and then quarterly with the routine care plan review. Any non-compliance will be corrected and reviewed at the QAPI meetings for the need to develop an action plan.</p>		

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	<p>"Resident has dx (diagnosis) of stricture and stenosis of esophagus...Requires a diet of ConCHO mech (mechanical) soft..." indicated an intervention of "Diet as ordered:ConCHO mech soft." The care plan was dated 10/10/13. The Ensure supplement was not listed as an intervention.</p> <p>During an interview with the facility Registered Dietician (RD), on 1/27/14 at 12:29 p.m., the RD indicated she forgot to change the diet and add the Ensure supplement to the care plan above. The RD indicated she will update the care plans related to nutrition when she sees there has been an order added or changed. She also indicated she usually updates the care plans within a week, at the latest, since she was not at the facility daily.</p> <p>On 1/27/14, at 1:30 p.m., the RD indicated she updated the above care plan to have the correct diet on it, and she also added the Ensure supplement as a new intervention. A copy of the revised care plan was provided.</p> <p>3.1-35(d)(2)(B)</p>						

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure neurological assessments were completed after a fall for 2 of 3 residents out of a total of 6 who met the criteria for accidents. (Resident #28, Resident #31)</p> <p>Findings include:</p> <p>1. Resident #31's clinical record was reviewed on 1/28/2014 at 11:30 a.m. Diagnoses included but were not limited to; Alzheimer's dementia, osteoporosis.</p> <p>An interview with Resident #31, on 1/24/2014 at 10:29 am, indicated he did not verbally respond to a question.</p>	F000309	To accomplish corrective actions for residents affected by the practice, Residents 28 and 31 were observed and no issues were noted warranting neuro checks at this time. To identify other residents having the potential to be affected by the practice, any resident with an unwitnessed fall in the last 30 days has been observed for indications requiring neuro checks. To ensure that the practice does not recur, the DNS and ADNS will conduct one on one training with the licensed nurses re-stating the expectation that neuro checks are completed for any unwitnessed fall regardless of absence of physical evidence showing a blow to the head had occurred. This training will be completed by 02/20/2014. To monitor the changes in practice and ensure that the practice does not recur,	03/01/2014
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	<p>A "Change in condition" note, dated 1/18/2014 at 11:08 p.m., indicated, "Situation: Res. (resident) found sitting on floor on pad beside bed. Background: [sic] Diagnosis: dementia and transferring without assistance. Assessment:...Res. found sitting on floor on pad beside bed with all his covers under him. Res. slid to floor and no injuries noted. Asked resident what happened and he said "I don't know". Response:...Will monitor for pain or discomfort and ensure resident in center of bed while resting."</p> <p>A 'Verification of Investigation' document, dated 1/18/2014 at 4:10 p.m., indicated, "Provide a detailed description of event/allegation: Res. found sitting on top of pad on floor next to bed with all his covers under him per activity leader and called nurse. Resident Interview Summary: "I don't know" Witnesses's interview summary: Saw resident sitting on top of pad on floor next to bed with all his covers under him."</p> <p>A MDS (minimum data set) significant change in status assessment, dated 10/17/2013, indicated, "Section C-Cognitive Patterns C0100. Should Brief</p>		<p>during the daily morning communication meeting an audit of all falls will be conducted ongoing. Any occurrence requiring neuro checks will have a record review to ensure that the form is present and completed. Any non compliance will be addressed with the licensed nurse for completion. Continued non compliance will result in retraining and potentially disciplinary action. All non compliance will be reviewed at the monthly QAPI meeting for possibility of an action plan.</p>		

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	<p>Interview for Mental Status be Conducted? 0. No (resident is rarely/never understood)" was checkmarked.</p> <p>An interview with CNA #17, on 1/29/2014 at 2:55 p.m., indicated, "I don't remember this fall, but It is typical for (Resident #31) to fall."</p> <p>An interview with the Assistant Director of Nursing, on 1/28/2014 at 2:50 p.m., indicated the staff should do neuro checks anytime a fall is unwitnessed, unless the resident is alert and oriented and able to say they didn't hit their head.</p> <p>2. Resident #28's clinical record was reviewed on 1/29/2014 at 10:00 am. Diagnoses included but were not limited to; cerebral infarct (stroke), diabetes, depressive disorder, hypothyroidism, anemia, dementia, and generalized pain.</p> <p>An interview with Resident #28, on 1/24/2014 at 10:20 am, indicated he did not verbally respond to a question.</p> <p>A nurses note, dated 12/27/2013 at 2:51 pm, indicated, "Situation: found on floor. Background: history of falls. Assessment...Found on floor on rt</p>				

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	<p>side. No s/s (signs/symptoms) of hitting head...No distress noted at this time. Response: Dr.'s office notified of fall without injury. Son notified of fall without injury."</p> <p>A "verification of investigation" document, provided by the DON on 1/28/2014 at 1:20 pm, indicated, "Resident name: (Resident #28's name) Location event occurred: resident's room. Provide a detailed description of event/allegation: Found on floor on rt (right) side. Assessment of resident/describe injury: Assessed for injury...No red, open or discolored areas noted. Denies hitting head. Resident interview summary: I lost my balance...Witnesses: Interview summary: I had toileted him before lunch. He left the dining room and I walked by and saw him on the floor. I called for the nurse."</p> <p>An interview with the Director of Nursing, on 1/28/2014 at 2:10 p.m., indicated Resident #28 had no neurological checks for this fall because, "he denied hitting his head, and there were no indications he had hit his head."</p> <p>A MDS (minimum data set) significant change in status</p>			

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	<p>assessment, dated 12/9/2013, indicated, "Section C-Cognitive Patterns C0100. Should Brief Interview for Mental Status be Conducted? 0. No (resident is rarely/never understood)" was checkmarked.</p> <p>An interview with the Assistant Director of Nursing, on 1/28/2014 at 2:50 p.m., indicated the staff should do neuro checks anytime a fall is unwitnessed, unless the resident is alert and oriented and able to say they didn't hit their head.</p> <p>A policy, provided by the D.O.N., on 1/29/2014 at 10:00 am, indicated, "Documentation guidelines: Neurological checks will be done with any fall if the resident states they hit their head or if a visible or palpable area (example but not limited to read or discolored area, raised area, laceration) is noted during the assessment. Neurological checks are to be done every 15 minutes times one hour, every 30 minutes times one hour, every 60 minutes times two hours, every two hours times two hours, then every four hours times 72 hours."</p> <p>3.1-37(a)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide a resident with showers as scheduled for 1 of 3 residents reviewed of 3 who met the criteria for choices. (Resident #86)</p> <p>Findings include:</p> <p>The clinical record for Resident #86 was reviewed on 1/27/14 at 10:45 a.m.</p> <p>The diagnoses for Resident #86 included, but were not limited to: heart failure.</p> <p>The 10/17/13 Quarterly MDS (minimum data set) assessment for Resident #86 indicated she required physical help in part of bathing.</p> <p>The 6/18/13 ADL (activities of daily living) care plan for Resident #86 indicated, "I have a deficit related to: Self care impairment." An</p>	F000312	To accomplish corrective actions for residents affected by the practice, Resident #86 has had her shower schedule reviewed and on interview has stated that she is getting her showers as scheduled. To identify other residents having the potential to be affected by the practice all residents have been interviewed to determine their preference for showers or sponge bathing to meet their bathing needs. Any change in the shower schedule will be reviewed with the resident and documented in the medical record. To ensure that the practice does not recur, shower sheets will be used when each resident is to receive a shower. If a resident refuses the shower, the CNA is to document the refusal on the shower sheet and alert the licensed nurse. The licensed nurse will approach the resident in attempts to achieve acceptance of the shower. Refusal of the shower will trigger the CNA to give a partial bath in the bathroom or at bedside or a full bed bath. By 02/20/2014 the	03/01/2014			

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	<p>intervention was to, "Encourage choices with care."</p> <p>An interview was conducted with Resident #86 on 1/23/14 at 10:34 a.m. regarding whether she chose how many times a week she took a bath or a shower. She indicated she was supposed to have showers twice a week, "but they just come and get you whenever they feel like it. I'd like to get the showers as scheduled."</p> <p>The South Unit Day Shift Shower Schedule indicated Resident #86 was to receive a shower during day shift on Wednesdays and Saturdays.</p> <p>An interview was conducted with CNA #17 on 1/27/14 at 2:00 p.m. regarding showers for Resident #86 and whether she documented somewhere after she gave a resident a shower. She indicated, "I always work first shift...I haven't given her (Resident #86) a shower in a while. Her days are Wednesdays and Saturdays. I document on the kiosk (Caretracker database) afterwards."</p> <p>The Bathing Type Weekly Report printed from Care Tracker on</p>		<p>DNS, ADNS, and Unit Coordinators will inservice the nursing staff on the documentation method to ensure that all residents are assisted to bath per schedule. Documentation of bathing and/or refusal will be entered by the CNA into the Care Tracker kiosk daily. To monitor the changes in practice and ensure that the practice does not recur, the Unit Coordinator will print and compare shower sheets to the Care Tracker document daily times 4 weeks to ensure that showers are being documented, twice weekly times 4 weeks and them weekly ongoing after that. Any refusals of bathing will trigger the Unit Coordinator to conduct an interview with the resident to verify that their bathing needs are being met. Non compliance with the documentation method will result in retraining of the CNA and Licensed Nurse. Repeated non compliance will be brought to the QAPI meeting for action planning.</p>		

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	<p>1/27/14 at 2:19 p.m. indicated Resident #86 received a total of 5 showers and refused a total of 4 showers/baths from 11/28/13 to 1/27/14, 2:19 p.m.</p> <p>During another interview with Resident #86 on 1/28/14 at 11:29 a.m. regarding the bathing report, she stated, "Yes, 5 sounds about right...I want 2 a week. They will tell me "We're getting in the shower today, (name of Resident #86), and they never come. It makes me mad."</p> <p>The Bathing Type Weekly Report printed from Care Tracker on 1/27/14 at 2:19 p.m. also indicated Resident #86 did not receive a shower or bath on Saturday, 1/25/14, as scheduled, nor did she refuse it.</p> <p>During another interview with Resident #86 on Monday, 1/27/14, at 11:21 p.m. regarding whether she received a shower the previous Saturday, 1/25/14, she stated, "I can't remember the last time I've had a shower. I don't think I've had one in the last week. They say they're gonna do it, but they don't."</p> <p>During an interview with LPN #15 on</p>			

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	<p>1/28/14 at 11:12 a.m. regarding whether Resident #86 received a shower on Saturday, 1/25/14, she indicated, "It looks like she should have had a shower on 1/25 (1/25/14), Saturday. I'll look and see what happened."</p> <p>On 1/28/14 at 11:45 a.m., an interview was conducted with CNA #18 (CNA assigned to Resident #86 on Saturday, 1/25/14, day shift and Sunday, 1/26/14, day shift) a.m. regarding whether she gave Resident #86 a shower on Saturday, 1/25/14. She indicated, "She refused on Saturday, and we talked about doing it Sunday, but I didn't do it on Sunday, and don't remember asking her. I worked days on Saturday and Sunday...I try not to make promises as far as rescheduling, because something might happen, and I may not be able to do it, and they get agitated."</p> <p>During an interview with the MDS Coordinator on 1/28/14 at 11:20 a.m., she indicated, "The daughter said she wanted her (Resident #86) to have a basin so she could wash up instead of just using the sink." She indicated Resident #86's daughter wanted the basin in addition to her twice weekly</p>						

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	<p>showers.</p> <p>An interview was conducted with LPN #13 on 1/27/14 at 2:07 p.m. regarding how she monitored to ensure residents were receiving showers as scheduled. She indicated, "I can ask the CNA if they gave the shower." Regarding whether she asked CNA's every shift, she stated, "I honestly don't ask every shift I work." Regarding how she would know, if she didn't ask, she stated, "There's no way for me to know a resident didn't get a shower, if I don't ask, and the CNA doesn't tell me."</p> <p>3.1-38(a)(2)(A)</p>			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure non-medicinal interventions were provided prior to administration of PRN (as needed) anti-anxiety medication. The facility also failed to ensure adequate monitoring was in place for an antipsychotic medication. This affected 2 of 5 residents reviewed for unnecessary medications. (Resident #101 &amp; Resident #3)</p>	F000329	To accomplish corrective actions for residents affected by the practice, the medical record for Resident #3 was updated to include the side effect monitoring. The medical record of resident # 101 was updated to include the sheet for documenting non medical interventions prior to administering PRN psychoactive medications. To identify other residents having the potential to be affected by the practice, the medical record of all residents receiving antipsychotics has been reviewed to ensure that the side	03/01/2014

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	<p>Findings include:</p> <p>The clinical record for Resident #101 was reviewed 1/29/14 at 1:30 p.m. The diagnoses for Resident #101 included, but were not limited to: dementia with behavioral disturbances, unspecified psychosis, and senile dementia with delusional features.</p> <p>A review of the current Physician's Orders indicated an order for lorazepam (anti-anxiety medication) 0.25 mg (milligrams) every 12 hours and an order for lorazepam intensol 0.25 mg, every 6 hours, as needed.</p> <p>A review of the January MAR (Medication Administration Record) indicated Resident #101 received PRN lorazepam Intensol 0.25 mg on the following dates: 1/3/14, 1/12/14, 1/18/14, and 1/21/14.</p> <p>A review of the clinical record, including the form, "Interventions attempted before PRN (as needed) anti-psychotic, anti-anxiety, and/or hypnotic [sic]," did not indicate any non-medicinal interventions were tried on the above dates, prior to the</p>		<p>effect monitoring is in place. The medical record of all residents receiving PRN psychoactive medications has been reviewed to ensure that the non-medical intervention sheet is present and completed prior to administering the medication. To ensure that the practice does not recur, the Unit Coordinators were been re-instructed by the ADNS to audit the monthly physician order sheet to ensure that the side effect monitoring is still present for residents receiving antipsychotic medications. Additionally, the Unit Coordinators were re-instructed on the completion of the documentation showing non medical interventions attempted prior to administration of the psychoactive medication. These meetings were held on February 10, 2014 by the ADNS and DNS. To monitor the changes in practice and ensure that the practice does not recur, the Health Information Manager will review at least a 10% sample of records monthly ongoing from residents receiving antipsychotic medications to ensure that the side effect monitoring is in place. Non-compliance will be referred to the DNS or ADNS for immediate correction. The Unit Coordinators monitor the administration of PRN psychoactive medications for the documentation of non-medical interventions prior to</p>		

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	<p>medication administration.</p> <p>During an interview with the Director of Nursing, on 1/29/14 at 2:55 p.m., she indicated nursing staff were supposed to try non-medicinal interventions prior to the PRN lorazepam administrations for Resident #101. She indicated she will further look into this and try to locate non-medicinal interventions for the medication administration dates listed above.</p> <p>On 1/30/14 at 10:35 a.m., RN #1 indicated the facility staff was unable to locate non-medicinal interventions used prior to the administration of the PRN lorazepam on the above dates. He also indicated nursing staff were supposed to try non-medicinal interventions prior to the administration of PRN anti-anxiety medication.</p> <p>A review of policy, no title/date, received from the Assistant Director of Nursing on 1/30/14 at 11:51 a.m., indicated "...If PRN medications [sic], the interventions need to be in place [sic] to be [sic] tried prior to giving medication. Interventions need to be numbered."</p> <p>2. A record review for Resident #3 was conducted on 1/28/14 at</p>		<p>administering the medication. These will be shared during daily Communication Meeting for ongoing compliance. Any non compliance will be corrected immediately and reviewed at the monthly QAPI meeting to determine if an action plan is warranted.</p>				

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	<p>10:02am. Care plans, medication and treatment administration records, progress notes, MDS and other assessment information, social service, therapy, lab records, among other pertinent records, were reviewed.</p> <p>Diagnoses for Resident #3 included, but were not limited to, the following: hypertension, congestive heart failure, osteoporosis, anemia, senile dementia, depression, dementia, asthma.</p> <p>Medications for Resident #3 included, but were not limited to, the following: Zyprexa 2.5mg, classified as an atypical antipsychotic medication, and it is a medication used to manage antipsychotic behaviors, among other uses. A care plan, dated 3/29/13 was observed in place for antidepressant and antipsychotic medication usage. It indicated the following: "...Observe for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth...tachycardia...agitation..." and "...Observe for the following side effects while receiving anti-psychotic medications: abnormal facial, oral extremity or trunk movements..." It also directed nursing to evaluate</p>						

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	<p>risks and benefits of psychotropic medication usage.</p> <p>On 1/28/14 at 2:25 p.m., during an interview, the DON indicated Resident #3 should have an electronic medication administration record (EMAR) assessment, related to her Zyprexa use, completed each shift by licensed nurse staff. She indicated no such assessment had been completed for Resident #3 related to her antipsychotic medication usage, but they should have been done.</p> <p>On 1/28/14 at 2:32 pm, LPN #3 indicated nurses usually complete an antipsychotic medication monitoring assessment each shift and it is documented in the electronic medication administration record (EMAR). She indicated Resident #3 did not have an antipsychotic medication monitoring assessment form currently in the EMAR. She indicated Resident #3 should have one of these completed each shift related to her Zyprexa usage.</p> <p>On 1/29/14 at 10:05 a.m., the DON indicated the antipsychotic medication side effect monitoring assessment was not completed by</p>			

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	<p>nursing staff, but should have been, since Resident #3 had been on Zyprexa at the facility.</p> <p>On 1/29/14 at 3:07 p.m., during an interview, the DON indicated Resident #3 had a physician's order for daily Zyprexa use since 5/2/13. She indicated the appropriate side effect assessment tool nursing staff should use related to antipsychotic medication usage was not completed by nursing staff between the dates of 5/2/13 and 1/28/14. She indicated adequate monitoring of the Zyprexa side effects was not being properly performed by the licensed staff who were responsible for monitoring side effects of Resident #3's Zyprexa usage.</p> <p>The electronic medication administration records from November and December 2013, and January 1st through January 27th 2014 indicated an assessment was not completed for antipsychotic medication side effects for Resident #3.</p> <p>On 1/27/14 at 2:26 p.m., during an observation. Resident #3 was sitting in her wheelchair in her room watching television. She did not exhibit any abnormal movements</p>			

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	<p>and was in no apparent distress.</p> <p>On 1/28/14 at 10:22 a.m., during an observation, Resident #3 was in her room, in her wheelchair, watching television. She was not exhibiting distress or abnormal body movements.</p> <p>A facility policy titled "Behavior Management Guideline" indicated the following: "...Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used:...Without adequate monitoring..."</p> <p>3.1-48(a)(6)</p>						

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F000371 SS=F	<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 ensure the dishwasher's chemical test strips were available as necessary to ensure dishes were clean which had the potential to affect 116 residents who were served food out of the kitchen out of a total of 118 residents.</p> <p>Findings include:</p> <p>An observation of the dishwasher, on 1/29/2014 at 3:35 pm, indicated there were no chemical test strips available to test the dishwasher effectiveness. An interview with the Assistant Dietary Manager indicated she was unaware the staff had run out of test strips. She indicated the dishwasher was a low temperature machine, and needed chemicals to ensure sanitization of dishes.</p> <p>An interview with dietary aide #19,</p>	F000371	To accomplish corrective actions for residents affected by the practice, there were no residents directly affected by this practice. The chemical test strips were immediately placed into use on 01/30/2013. The log sheet has been completed daily per instructions. There is only one dishwasher so no other residents could be affected. To ensure that the practice does not recur, the Dining Services Director has established a back up supply to ensure that the strips are always available. All of the dining services staff who use the dishwasher will be retrained in the use of test strips and recording on the log by the Dining Services Director by 02/20/2014. To monitor the changes in practice and ensure that the deficient practice does not recur, the DSD, RD and the ED will inspect the supply and the log sheet daily times 4 weeks. If compliance is achieved, the inspection will be reduced to 3 times per week for 8 weeks. Then it will be weekly ongoing.	03/01/2014			

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	<p>on 1/29/2014 at 3:36 pm, indicated, "I told you (the Assistant Dietary Manager) 3 days ago that we ran out of test strips." The dietary aide also indicated he normally checks the dishwasher with the chemical strips three times a day, after each meal service.</p> <p>A "Dish Machine Temperature Log", provided by the Assistant Dietary Manager, on 1/30/2014 at 10:35 am, indicated there were blank spaces for the "PPM (parts per million: the unit of measure of the chemical) low temp (temperature) only column for the breakfast meal and the evening meal on the following dates in January; the 25th, 26th, 27th, 28th, and 29th". The document also indicated, "Instructions: Observe and record chemical concentration in ppm BEFORE beginning the dishwashing procedures. Low temp machines- Observe and record actual wash and final rinse temperature and chemical concentration in ppm."</p> <p>3.1-21(i)(3)</p>				

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Pre-Admission Screening / Resident Review (PASRR) level II services were delivered to 1 of 1 residents reviewed for PASRR level II services. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's clinical record was reviewed on 1/27/14 at 3:32 pm. The review included assessments, MDS data, progress notes, medication and treatment records, activities, care plans, social services, therapy services, dietary, and other pertinent interdisciplinary records. Diagnoses for Resident #1 included, but were not limited to; mental retardation.</p>	F000406	<p>To accomplish corrective actions for residents affected by the practice, Resident # 1 has been screened by physical and speech therapy and screened and evaluated by occupational therapy and a care plan has been established and implemented.</p> <p>To identify other residents having the potential to be affected by the practice the other resident identified by PASRR as needing Level II services has been screened by PT/OT/ST for the need to receive skilled therapy services. To ensure that the practice does not recur, the residents who require level II services will be screened by PT/OT/and ST quarterly to determine the need for skilled therapy services. If the next PASRR Level II makes more specific recommendations, those directives will be incorporated into the total plan of care. To monitor the changes in practice and</p>	03/01/2014			

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	<p>A care plan, dated 6/25/13, was reviewed for Resident #106 and indicated the following "...Resident has a...DX (diagnosis of ) Mental Retardation..."</p> <p>A care plan for Resident #1 indicated the following: "Resident has had Seizures through out her life, almost daily; DX MR and Depression; (Resident #1) is not a morning person (and neither is her twin); Some difficulty with making decisions in unfamiliar settings, Vagal Stimulator placed June 2013..." Interventions for the focus are of Mental Retardation included, but were not limited to: "...Incorporate Level II D&amp;E recommendations (State agency recommendations) (sic) into POC as indicated by review w/IDT (interdisciplinary) team..."</p> <p>A Pre admission screening and resident review (PASRR) indicated a recommendation of "... (Resident #1) may continue to benefit from PT/ST/OT(Physical Therapy/Speech Therapy/Occupational Therapy) screenings and treatment as needed..."</p> <p>On 1/29/14 at 11:14 a.m., the Social</p>		<p>ensure that the practice does not recur, the Social Services Director will audit quarterly and during the OBRA meetings for presence of the screen forms and follow through on any recommended skilled services. Any non-compliance with the screens will be referred to the Director of Rehab for immediate completion of the missing screen.</p>				

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	<p>Services Director indicated Resident #1's care plans did not include a therapy services care plan. She indicated a resident, from the PASRR recommendations, who may benefit from therapy services would "at least be screened for therapy services quarterly."</p> <p>On 1/29/14 at 11:27 a.m., during an interview the Director of Rehabilitation (DOR) indicated Resident #1 received an evaluation on 9/18/12 and recommendations were conveyed to nursing.</p> <p>On 1/29/14 at 11:39 a.m., during an interview, the DOR indicated no speech therapy screenings, evaluations, or services were documented by therapy staff for Resident #1.</p> <p>On 1/29/14 at 12:18 p.m., during an interview, the DOR indicated Resident #1 did not receive therapy services related to Physical Therapy or Speech Therapy services during the year of 2013.</p> <p>On 1/29/14 at 12:52 p.m., during an interview with the DOR, she indicated therapy services staff "should be documenting all</p>						

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	<p>screenings and evaluations" of residents in the electronic record. She indicated there was no documentation in the clinical record of screenings or evaluations related to physical therapy and speech therapy for Resident #1 between the dates of January 1st 2013 and January 29th, 2014.</p> <p>On 1/29/14 at 1:42 p.m., during an interview, the Administrator indicated the facility guidelines for implementing PASRR recommendations are to create a care plan based on the recommendations from the PASRR. She also indicated it is the Social Services Director's responsibility to implement, and follow up on, such care plan items based on the PASRR recommendations.</p> <p>Resident #1 was not observed in therapy services at the facility between the dates of 1/27/14 and 1/30/14.</p> <p>3.1-23(a) 3.1-23(a)(1) 3.1-23(a)(2)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to properly dispose of an expired medication. This had the potential</p>	F000431	To accomplish corrective actions for residents affected by the practice, the medications for Residents #105, #109, and #151 that lacked a "date open" on	03/01/2014			

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	<p>to affect 1 of 2 residents that received inhaled medication from the ACU medication cart. The facility also failed to ensure all medications had an open date on them. This had the potential to affect 2 of 3 residents that receive inhaled medication and insulin from the North medication cart. (Residents #109, #151, &amp; #105)</p> <p>Findings include:</p> <p>1. During a random observation, with LPN #10 on 1/30/14 at 10:50 a.m., Advair 500/50 (inhaler) for Resident #109 was observed with a dispensed date of 12/14/13 on the packaging. There was no open date of when the medication was removed from the foil packaging.</p> <p>During an interview with LPN #10, on 1/30/14 at 10:52 a.m., she indicated she did not see an open date for the above medication. She also indicated the medication should have had an open date on it, since it could have been opened after the dispense date and might not be in the expiration date range, as it was during the observation.</p> <p>On 1/30/14 at 11:05 a.m., the</p>		<p>the product, were discarded and replaced immediately To identify other residents having the potential to be affected by the practice, the Unit Coordinators an inspection of all medication carts and any medication identified as lacking date open or outside of the expiration range were removed, discarded, and replaced. To ensure that the practice does not recur, all licensed nurses will be re-trained through one on one meetings on the practice of entering a date when medications are opened. Additionally the night shift licensed nurse will be responsible to inspect the cart to monitor compliance with affixing "date opened" notation on the medication and take necessary steps to discard and replace out dated medications. To monitor the changes in practice and ensure that the practice does not recur, the Unit Coordinator will inspect the cart twice weekly times 8 weeks for proper storage of medications. The DNS and the ADNS will inspect the cart weekly times 12 weeks and then randomly ongoing. Non compliance will be addressed and corrected immediately. Results of the inspections will be shared with the QAPI team and the consultant pharmacist during monthly meetings and visits.</p>		

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	<p>Administrator indicated during an interview, all medication needed to have an open date on them.</p> <p>2. During a random observation, with LPN #11 on 1/30/14 at 10:57 a.m., Lantus (insulin) 100 u/mL (units/milliliter) for Resident #151, was observed without an open date on the vial or packaging. It was dispensed on 1/25/14. During the same observation, with LPN #11, Advair 250/50 for Resident #105, was observed with a dispense date of 1/18/14, but no open date when the medication was removed from the foil packaging.</p> <p>During an interview, with LPN #11 on 1/30/14 at 11:00 a.m., LPN #11 indicated she was unsure when either medications was opened.</p> <p>A policy titled, "Medication to Date when Opened," was received from the Assistant Director of Nursing (ADON) on 1/30/14 at 11:17 a.m. The policy indicated Advair expires after 30 days, when it is removed the foil packaging. The policy also indicated insulin expires 28 days after it is opened. The policy further indicated, "The opened date should be noted on each container/vial of medication known to have a</p>			

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	shortened beyond use date or expiration date."  3.1-25 (k)(6) 3.1-25(o)			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed</p>	F000441	To accomplish corrective actions for residents affected by the	03/01/2014			

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	<p>to properly sanitize the New Wing and Front Hall glucometers (blood test performed for readings of blood glucose/sugar) during random observations. This had the potential to affect 13 residents that required glucometer readings on New Wing and Front Hall. (Residents #19, #119, #95, #60, #9, #61, #37, #32, #97, #90, #71, #20, &amp; #36)</p> <p>Findings include:</p> <p>1. During a random observation of blood glucose testing with LPN #4, on 1/27/14 at 11:37 a.m. for Resident #119, LPN #4 completed the test and then brought the glucometer to the medication cart. LPN #4 then proceeded to wipe the glucometer with a (name of bleach wipe) wipe for 37 seconds and proceeded to throw the wipe away when she was done cleaning the machine.</p> <p>During an interview with LPN #4, on 1/27/14 at 11:39 a.m., she indicated the same glucometer was used for the entire New Wing Hall.</p> <p>2. On 1/27/14 at 4:05 p.m., LPN #5 was observed performing blood glucose testing for Resident #90. Before LPN #5 administered the</p>		<p>practice the glucometer for the front hall and the new wing were re-sanitized ensuring that they achieved the 1 minute "wet" time. To identify other residents having the potential to be affected by the practice all glucometers in the building were re-sanitized ensuring that they achieved the 1 minute "wet" time. To ensure that the practice does not recur, the DNS, ADNS, and DCE will be re-training all licensed nurses on the practice of cleaning and decontaminating the blood glucose meters. All licensed nurses will complete a return demonstration to demonstrate that they understand the practice and can complete it after all uses of the glucometer. This training will be completed by February 26, 2014 To monitor the changes in practice and ensure that the deficient practice does not recur, the Unit Coordinators, the DNS, the ADNS, and the DCE will weekly times 4 weeks randomly select a licensed nurse to give a return demonstration of the cleaning and decontamination of the blood glucose meter. Following that the DCE will observe at least 1 licensed nurse on every shift complete a return demonstration weekly times 8 weeks. The licensed nurses will be re-trained annually during their nurse competencies to ensure that the practice is maintained.</p>		

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	<p>test, she wiped the glucometer with a (name of bleach wipe) wipe for 20 seconds and threw away the wipe after she was done cleaning the machine. After she performed the test, she wiped the glucometer with a (name of bleach wipe) wipe for 5 seconds and threw away the wipe when she was done cleaning the machine.</p> <p>At 4:10 p.m., on 1/27/14, LPN #5 indicated during an interview, the glucometer was used for the entire Front Hall.</p> <p>A document titled, Interoffice Memo, "...Subject: Product change from (name of previous bleach wipe) to (name of current bleach wipe) wipes for cleaning blood glucose meters..." was reviewed. The document was dated 6/12/12 and was received from the Director of Nursing (DoN) on 1/27/14 at 4:30 p.m. The document indicated "(name of bleach wipe) wipes require a 1 minute wet contact time to kill bloodborne pathogens on the blood glucose meters..." The phrase, 1 minute, was in bold typeface.</p> <p>3. At 12:10 p.m., on 1/29/14, LPN #6 was observed performing a blood glucose test on Resident #20. LPN</p>			

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	<p>#6 wiped the glucometer with a (name of bleach wipe) wipe for 5 seconds before she administered the test. She threw away the wipe after she cleaned the machine.</p> <p>After LPN #6 performed the blood glucose test, she wiped the glucometer with a (name of bleach wipe) wipe for 6 seconds and threw away the wipe after she cleaned the machine.</p> <p>During an interview with the DoN, on 1/29/14 at 2:35 p.m., she indicated the nursing staff was supposed to follow the protocol above and wipe the glucometer for 1 minute with a (name of bleach wipe) wipe. The DoN indicated there was an inservice done on how long the "wet contact" time was for glucometers with (name of bleach wipe) wipes, but she was unable to recall when that inservice was.</p> <p>At 3:10 p.m., on 1/29/14, the DoN provided a list of residents on the halls above that receive blood glucose testing with the New Wing and Front Hall glucometers. There were 13 residents listed.</p> <p>3.1-18(b)(4)</p>				

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F000514 SS=D	<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 the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation of communication and collaboration with hospice to ensure that patient needs were addressed 24 hours a day per their hospice contract for 1 of 1 resident reviewed for hospice. (Resident #48)</p> <p>Findings include:</p>	F000514	To accomplish corrective actions for residents affected by the practice, all chart information for resident #48 was obtained from Hospice and entered into the unit record. To identify other residents having the potential to be affected by the practice, the chart information for all residents receiving hospice care has been obtained and placed in the unit record. To ensure that the practice does not recur, the hospice workers sign in on the log sheet, document the care and	03/01/2014

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	<p>The clinical record for Resident #48 was reviewed on 1/30/14 at 9:00 a.m.</p> <p>The diagnoses for Resident #48 included, but were not limited to: Alzheimer's dementia.</p> <p>The 12/23/13 Hospice Rectification form indicated Resident #48 was certified for hospice from 1/3/14 to 3/3/14.</p> <p>The Hospice Visitation Log found in Resident #48's clinical record indicated the last hospice visit was on 1/14/14. No information was found in the clinical record regarding this visit or any subsequent visits by hospice.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) and LPN #16, the Unit Manager for Resident #48, on 1/30/14 at 9:40 a.m. regarding when hospice staff visits Resident #48, the lack of documentation of hospice visits, and the communication and collaboration of care between the facility and hospice. LPN #16 indicated, "We sign their tablet before they leave. They ask me all kinds of questions (sic) to how are they doing, last bowel movement..."</p>		<p>services delivered into an electronic tablet, and have a facility staff member co-sign the tablet. . The paper copy of the notes is generated at their Indianapolis office and placed in the unit record by the Case Manager. All documentation from February 6, 2014 forward will be scanned and electronically transmitted to the facility to ensure that the facility has current notes while the paper documents are in transit. Nursing and social services staff was instructed on the new procedure by the Executive Director on February 7, 2014 To monitor the changes in practice and ensure that the practice does not recur, the Hospice Case Manager will audit the unit record weekly to ensure that all hospice paper documents are in the record. The Health Information Manager will audit the record every week for 4 weeks, every other week for 4 weeks, and monthly ongoing. Any missing documents will be printed from the electronic version and a message sent to hospice regarding the non-compliance. The compliance level will be reviewed in QAPI for the possibility that an action plan is required.</p>				

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	Regarding verification of this communication or any recommendations from hospice, the ADON indicated, "I know they do everything on the tablet, so I'm not sure about an actual hard copy of a complete assessment." LPN #16 indicated, "The nurse is coming once a week. I know I saw the nurse this week, but I'm not sure what day it was." LPN #16 looked at a calendar on the wall and stated, "He was last here on Tuesday, 1/28/14." Regarding what was discussed with the hospice nurse prior to him leaving, she indicated, "I don't know who talked to him before he left. I didn't sign his tablet that day. I assume it was (name of LPN #13), but she's not here." Regarding how she ensured nursing staff was communicating with hospice, the ADON stated, "It is the hospice nurse's responsibility. We don't have a system in place to track to make sure nursing is reviewing the hospice visit and signing off on the tablet before they leave. My expectation is that nursing review hospice's visit and sign the tablet before they leave...I think it would be a good idea to have a system in place to ensure nursing staff is reviewing with hospice before they leave and signing off." LPN #16			

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	<p>stated, "It's also our expectation that they come to us...They do not leave us a hard copy of our signature or summary of visit."</p> <p>Another interview was conducted with the ADON on 1/30/14 at 11:10 a.m. She stated, "As far as how we're tracking for signing off, there is a collaborative meeting with hospice every other week with the DON (Director of Nursing) and hospice nurse. The DON reviews at that time whether the floor nurse signed off on the tablet. I know we had a meeting with hospice on 1/8/14 at 10:30 about issues we were having with hospice, about them not coming to sign off before they left. The aides would go to give a bath, and the resident would say they already had one. They were coming during lunch. Also, they would want nursing to sign off without showing what they'd done." Regarding how long these collaborative meetings had been taking place between hospice and the DON, she indicated, "I asked (name of Administrator), and she doesn't know, and neither do I." Regarding whether there was any written verification of any of these meetings, the ADON indicated, "We don't have anything that I know of." Regarding the</p>			

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	<p>process now since they identified issues with hospice, she indicated, There is no protocol because on our part the nursing staff is providing the care we expect and hospice is just enhancing the care." Regarding a policy on hospice care, she indicated, Our only policy is our contract with hospice.</p> <p>The ADON provided a copy of their contract with Resident #48's hospice company on 1/30/14 at 12:34 p.m. It indicated a section of the contracted titled, "Comparison of SNF(Skilled Nursing Facility)/Hospice Responsibilities." A responsibility under this section was, "Documentation of communication between hospice and SNF to ensure that patient needs are addressed 24 hours a day." It indicated this was the responsibility of both the SNF and hospice.</p> <p>During a review of and interview with the ADON on 1/30/14 at 12:34 p.m. regarding the above responsibility indicated as theirs in the hospice contract, the ADON stated, "We are not doing the addressed 24 hours a day. I see that now."</p> <p>3.1-50(a)(2)</p>						

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