STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE NURSING AND REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey date: May 9, 10, 11, 14, 15, 16, 2012 Facility number: 000169 Provider number: 155269 AIM number: 100267100 Survey team: Carol Miller, RN, TC Honey Kuhn, RN (May 9, 10, 11, 14, 15, 2012) Shelly Vice, RN Census bed type: SNF: 6 SNF/NF: 128 Total: 134 Census payor type: Medicare: 22 Medicaid: 87 Other: 25 Total: 134 Sample: 24 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 15, 2012.**	

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

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

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	Quality review completed on May 23, 2012 by Bev Faulkner, RN			

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F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observations and interviews, the facility failed to provide privacy during a shower for Resident #124. This affected 1 of 24 residents in a sample of 24. Findings include: On 5/15/12 from 1:00 p.m. to 2:00 p.m., an observation was made of Resident	F0164	It is the practice of this provider that all residents have the right to privacy and confidentiality of his or her personal and clinical records and care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the***	06/15/2012

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	#124 during her Occupational Therapy session with Staff #2. During the observation of the activity of showering, it was noted that Therapy Staff #2 did not close the door to provide privacy for Resident #124 during the resident's activity of unclothing. On 5/15/12 at 1:10 p.m., an interview was conducted with Therapy Staff #2. It was noted, "...let me shut the door..." after Resident #124 had begun to remove her clothing. On 5/15/12 at 1:24 p.m., it was noted that halfway through the activity, the staff member left the room to retrieve an assistive device, the hand grabber, without shutting the door for the second time. On 5/15/12 at 1:25 p.m., an interview with Resident #124 was conducted. The resident indicated, "... the door is open, would you please close that (the door as she pointed)..." Resident #124 was observed to be naked from head to toe, sitting on a metal folding chair with a towel draped across her shoulders. On 5/16/12 at 9:30 a.m., an interview was conducted with the Director of Nursing Services (DNS), Administrator and the Manager of the Therapy Services		***deficient practice:*** Resident #124 has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents requiring assistance for bathing have the potential to be affected by this finding. The facility will continue to ensure privacy and dignity while providing assistance during ADLs and bathing. Facility care rounds will be conducted on all units. Any resident dignity or privacy issues noted during the facility rounds will be corrected immediately. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be conducted on or before 6/15/12. This in-service will be conducted by the DNS/SDC and will include review of procedures related to showers and bathing. It will also include review of privacy practices such as use of privacy curtains and closed doors during personal care and bathing/showers. A member of the Nurse Management Team will ensure privacy and dignity is	

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	concerning the observation. It was noted that this was not the expected practice of the facility. 3.1-3(o) 3.1-3(p)(4)		maintained for residents during bathing/showers and personal care while conducting routine rounds on the units. Customer care rounds will be conducted no less than 5x per week for 3 weeks by the DNS/designee. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tool titled, "Customer Care Rounds" no less than 5x week for 3 weeks, bi-weekly for 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance date = 6/15/12.	

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F0253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, record review and interview, the facility failed to ensure floors in 3 of 24 resident rooms were clean. This potentially affected 3 of 24 residents. (Residents #1, 19, and #23.) Findings include: 1. On 5/11/12 at 11:00 a.m., an observation was made of the bathroom floor in Room 201 (Resident #1's room). The floor was dull, sticky and overall dirty to the observation. A musty smell was noted. 2. On 5/13/12 at 9:00 a.m., an observation was made on Unit 1 of Room 211 (Resident 19's room.) The floor was filthy with left over food items: potato chips, patches of dried liquids and littered dirt. On 5/13/12 at 9:15 a.m., an interview was conducted with the Assistant Director of Nursing Services (ADNS). It was noted, "I saw it too... I've already contacted the housekeeping...I have no idea why it's so dirty..." This was in reference to the condition of Resident 19's	F0253	It is the practice of this provider to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #1, #19 and #23's rooms have been deep cleaned including thorough floor care in each room. None of these residents experienced any negative outcome as a result of this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All resident rooms have been thoroughly cleaned and checked to ensure a sanitary, orderly and comfortable interior including thorough floor care in each room. ***What measures will be put into place or what systemic changes will be made to ensure that the***	06/15/2012

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	floor. On 5/15/12 at 2:00 p.m., an observation was made of Room 211 (Resident # 19's room.) Again, it was littered with spilled food that had been dried, dirty patches and was sticky underfoot. 3. On 5/14/12 at 1:00 p.m., an observation was made of Room 215 (Resident #23's room.) It was noted to be filthy. The floor was littered with debris and patches of old food. The floor was sticky when walked upon. During a confidential interview with resident's family member on 5/14/12 at 4:45 p.m., the family member stated, "I've noticed the floors to be very dirty... I know this may be a small thing, but it's unsettling..." 3.1-19(f)(5)		***deficient practice does not recur:*** A mandatory all staff in-service will be conducted on or before 6/15/12 by the SDC/designee. This in-service will include review of procedures related to daily cleaning of resident rooms, keeping floors free of debris and spillage and daily cleaning/inspecting of floor in all resident rooms. In addition, the ED/designee will make daily rounds on various shifts using an environmental checklist tool to observe for any housekeeping issues. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the ED/designee will be responsible for completion of the CQI Audit Tool related to environmental rounds daily x 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance date = 6/15/12.	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interviews and record reviews, the facility failed to	F0441	It is the practice of this provider to	06/15/2012

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	ensure soiled linens were handled correctly for Resident #134 and gloves were worn during Resident #124 perineal care. This affected 2 of 8 residents observed for infection control practices in the sample of 24. Findings include: 1) On 5/14/12 at 2:00 p.m., an observation was made upon entering the Resident #134's room of a wet wash rag lying at the end of the Residents bed. There were no other noted items to be lying on the floor. On 5/14/12 at 2:00 p.m., an interview was conducted with Resident #134. The resident stated, "... they (facility) told me to put my dirty clothes at the end of my bed on the floor, that's why that's laying there; it's dirty... I used it." On 5/14/12 at 2:40 p.m., an interview was conducted with the Director of Nursing Services (DNS). It was noted that dirty linen was to be placed in a dirty linen bag per policy. On 5/16/12 at 8:30 a.m., a review was conducted of the "Laundry/Linen Policy Procedure." Under the heading "Components:" of the policy/ procedure it was stated: "Note: All linen is contaminated... 1.		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. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #134 – has been instructed on where to place soiled linen in her room. This resident experienced no negative outcome as a result of this finding. Resident #124 – This resident experienced no negative outcome as a result of this finding. Resident discharged to home. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by this finding. The facility will continue to educate all staff regarding facility infection control practices and procedures. A nursing in-service will be conducted by the SDC on or before 6/15/12. This in-service will include review of the facility practices regarding safe handling and proper disposal of	

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	Resident care areas: Soiled linen... d. Soiled linen: ... ii. Place in container in soiled linen room for holding until picked up by laundry..." 2) On 5/14/12 from 1:00 p.m. to 1:35 p.m., an observation was conducted of Resident #124 during the Occupational Therapy session with the Occupational Therapist. Therapy Staff #2 was observed to perform perineal care during the residents' shower. Staff #2 did not wear gloves during this task. On 5/15/12 at 9:30 a.m., an interview was conducted with the Rehabilitative Service Manager (RSM). It was noted that the staff of the therapy department follow Universal Precautions guidelines and wear gloves "...at all times..." when handling "...all body fluids..." On 5/15/12 at 9:45 a.m., a record review of the "Perineal Care" policy/ procedure was conducted. It noted under the heading "Procedure Steps: ...4. Put on gloves." On 5/15/12 at 9:45 a.m., a record review was conducted of the "Standard Precaution Usage Guidelines." It was noted under the heading "Personal Protective Equipment (PPE): Gloves; Used for touching or possible contact		soiled linens in hampers. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** An all staff in-service will be conducted by the SDC on or before 6/15/12. This in-service will include review of the facility practices regarding safe handling and proper disposal of soiled linens in hampers. This in-service will also include review of proper hand washing and use of gloves during personal care. The Charge Nurses and Nurse Management Team will monitor proper infection control practices and procedures through routine and random walking rounds on the units observing for compliance. DNS/SDC/designee to perform skills validation with nursing and therapy staff regarding hand washing and peri care proper techniques. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The CQI Audit Tool titled, "Customer Care Rounds" will be completed by the DNS/designee no less than 5x week for 3 weeks, bi-weekly for 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed.	

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	with blood, body fluids, secretions, excretions, contaminated items; for touching or possible contact with mucous membranes ..." On 5/15/12 at 9:45 a.m., an interview was conducted with the DNS. It was noted that "... all staff are trained on these..." in reference to the policy/ procedures of "Standard Precaution Usage Guidelines." 3.1-19(g)(1) 3.1-18(j)		Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance date = 6/15/12.	

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F0465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F0465	It is the practice of this provider to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The kitchen has been cleaned and sanitized and all spillage and debris has been removed from the kitchen floor, tray passageway, food prep, food service and cold storage area. The wall behind the fryer has been thoroughly cleaned. The Housekeeping Storage closet floor and the Oxygen Storage room have been thoroughly cleaned and are free of spillage and debris. No residents were adversely affected by this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** The entire kitchen floor has been deep cleaned with the use of a scrubber and power washer. The	06/15/2012

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			entire kitchen was thoroughly deep cleaned. The food prep table was moved to provide more room for service carts resulting in a more sanitary environment. The housekeeping storage closets and both oxygen rooms have been thoroughly cleaned with thorough floor care. A facility inspection will be completed to ensure all resident rooms, storage areas, common areas and kitchen and dining areas are clean and sanitary. Any identified concerns or issues will be addressed at the time noted. The kitchen floor was added to a monthly deep clean schedule. Cleaning and inspecting the walls behind equipment was added to the daily cleaning schedule in the kitchen. The Environmental Supervisor will perform regular sanitation and housekeeping audits. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A mandatory all staff in-service will be conducted on or before 6/15/12 by the SDC/designee. This in-service will include review of policies related to kitchen sanitary procedures and keeping walls free of spillage and splatters. This in-service will also include review of procedures for deep cleaning of storage closets and oxygen storage rooms. In addition, the ED/designee will make daily rounds using an environmental	

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			checklist tool to observe for any housekeeping or sanitation issues. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the ED/designee will be responsible for completion of the CQI Audit Tool related to environmental rounds daily x 4 weeks and monthly for 6 months. In addition, the Dietary Manager/designee will perform sanitation audits in the kitchen no less than five times weekly. The Environmental Supervisor will perform sanitation and housekeeping audits no less than five times weekly x 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date = 6/15/12.	
	Based on observations, record review and interview, the facility failed to maintain a clean and sanitary kitchen as evidenced by spillage and debris on the floor, dirty dishes and tableware from resident trays,			

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	and splatters of unidentifiable food debris behind the fryer on 2 of 2 observations. The facility also failed to ensure the floors of the 1 housekeeping storage closets and 2 of 2 oxygen rooms were free from litter and debris. This deficiency had the potential to effect dietary staff working in the kitchen and residents who received food from the kitchen. Findings include: 1. The initial kitchen tour was completed on 05/09/12 between 9:00 a.m. and 9:30 a.m., while accompanied by the CDM (Certified Dietary Manager), the following observations were made: a. The tiled and grouted kitchen floor was observed to have scattered debris of condiment wrappers, crumbs, shredded cheese, and unidentifiable dried splatters of various colors and ranging from approximately 2 cm (centimeters) to 4 cm in circumference. The debris was noted throughout the kitchen in the tray passageway, food prep, food service, and cold storage area. b. The white wall area directly behind the fryer was noted to have splatters of dark brown and reddish brown of unidentifiable matter.			

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	The food service preparation and service observation, on 05/09/12 between 11:00 a.m., and 11:45 a.m., included the following: There was no change in the kitchen floor from the previous observation. An open food service cart, which contained 6 resident's breakfast trays, abutted the food prep table where staff had removed baked chicken from the oven to steam table containers. The breakfast trays contained plates with the food covers haphazardly skewed over the plates and food debris visible. The trays also contained open milk cartons with the used straws sitting on the edge of the trays. The CDM was interviewed on 05/09/12 at 11:25 a.m. The CDM indicated the kitchen floors are swept and mopped twice daily, between the day and evening shift, and before the evening dietary shift leaves. The CDM indicated the facility had no P&P (Policy & Procedure) that addressed deep cleaning of the floors. Review of the kitchen "Daily Cleaning Schedule", provided by the CDM at the time, did not indicate cleaning behind the fryer.			

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	The CDM indicated the open tray cart containing the soiled trays should not have been sitting next to the food prep table. 2. On 5/10/12 from 9:50 a.m. to 11:30 a.m., an environmental tour was completed with the Maintenance Manager, the Housekeeping/Laundry Manager and the Administrator. Upon the tour the following observations were made: a. The Housekeeping Storage closet located on Unit 2 was dirty. The floor had spots of old debris and was littered with dust throughout. b. The Oxygen Storage room located on Unit 1 at the Nurses Station was dirty. The floor has spots of old debris and littered dust throughout. On 5/10/12 at 1:25 p.m., an observation was made of the oxygen room located on Unit 2. Littered papers and dust were observed on the floor 3.1-19(f)			

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F0504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure a laboratory test was done. This deficiency affected 1 of 24 residents whose laboratory tests were reviewed (Resident #91). Findings include: Review of the clinical record of Resident #91 on 5/15/12 at 9:00 a.m., indicated Resident #91's diagnosis included, but were not limited to, cirrhosis of the liver with alcoholism. The Physician's Order, dated 11/23/11, indicated to draw a Blood Alcohol Level Laboratory test in 4 weeks between the hours of 3:00 p.m. to 4:00 p.m. The Laboratory tests for December 2011 were reviewed and did not indicate the Blood Alcohol Level Laboratory test had been drawn. On 5/16/12 at 8:00 a.m., the Director Nursing Service (DNS) was interviewed in regard to the resident's laboratory test for a Blood Alcohol Level. The DNS	F0504	It is the practice of this provider to provide or obtain laboratory services only when ordered by the attending physician. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #91 – laboratory orders have been clarified with the physician. This resident experienced no negative outcome as a result of this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents with lab orders have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will review all residents with lab orders to ensure all labs are obtained as ordered. Any discrepancies will be corrected and/or clarified when noted. Physician's orders are reviewed daily by the Nurse	06/15/2012

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	indicated the laboratory had been contacted and had the order for the Blood Alcohol level ordered on 11/23/11. The DNS indicated she was unsure why the Blood Alcohol Level Laboratory test got missed. 3.1-49(f)(1)		Management Team. All physician orders related to labs will be cross referenced to the Lab Requisition Form to ensure labs are obtained as ordered. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be conducted on or before 6/15/12. This in-service will include review of the facility procedure related to Lab Tracking. The in-service will emphasize the importance of following physician orders related to lab monitoring and obtaining labs per physician order. The DNS/SDC will be responsible for conducting this in-service. Physician's orders are reviewed daily by the Nurse Management Team. All physician orders related to labs will be cross referenced to the Lab Requisition Form to ensure labs are obtained as ordered. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** Ongoing compliance with this corrective action will be monitored through the facility CQI Program. The DNS/designee will be responsible for completion of the	

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			CQI Audit Tool related to Lab Services weekly x3 weeks, then monthly x 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance date = 6/15/12.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on record reviews, observations and interviews, the facility failed to provide up to date information in the clinical charting of Resident #42 in regards to the lumbar spine steroid injection. This affected 1 of 1 resident charts reviewed in a sample of 24. Findings include: On 5/9/12 at 4:37 p.m., an interview with Resident #42 indicated an appointment with Orthopedic Surgical Medicine Corporation (OSMC) on this date had been attended and a "shot for pain" had been given into "... my back..." On 5/9/12 at 4:45 p.m., a record review was conducted of Resident #42's clinical record. There were no discharge instructions of the appointment with	F0514	It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized and that contain sufficient information to identify the resident. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #42's clinical record has been clarified and updated related to the lumbar spine injection. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***	06/15/2012

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	OSMC. A Physician's Progress Note was reviewed that stated, "dictated note to follow" with 2 (two) sets of initials located at the end of the statement. This was not dated. There was not a resident name or identifier noted on the Physicians Progress Note. On 5/9/12 at 4:50 p.m., an interview was conducted with the Unit Manager of the 400 Hall on Unit 2. It was indicated upon review of the clinical record with the Unit Manager of the 400 Hall of Unit 2 that there were no notes of the OSMC visit/appointment or the shots received by Resident #42. "No, I haven't seen anything from them for her (Resident #42)." When asked what the normal procedure was for assuring communication happen between visits to an outside appointment and the staff caring for the Resident it was noted,"the appointments notes are often times given to the families if they take the residents, but a note is usually made somewhere in the chart(clinical)..." On 5/9/12 at 4:59 p.m., a record review was conducted alongside of the Unit 2 Manager of the "last progress notes made by the off going nursing staff" for Resident #42. It was noted as below: "05/09/21012, 1:34 p.m. ...PT (patient)		All residents with out of facility specialty and follow up appointments have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will review all residents with out of facility specialty and follow up appointments dating back to 5/16/12. This audit will ensure that all progress notes, physician orders and clinical notes related to outside visits and appointments have been obtained and placed accordingly in the clinical record. Any discrepancies noted during this audit will be corrected and/or clarified at the time noted. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be conducted on or before 6/15/12 by the DNS/designee. This in-service will include review of the facility documentation procedures related to out of facility specialty and follow up appointments. The importance of obtaining progress notes, clarifying physician orders and obtaining clinical notes related to outside tests and procedures will be stressed. ***How the corrective action(s) will be monitored to ensure the deficient***	

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	had appointment with OSMC. No new orders. PT visiting with family at this time." This entry was electronically signed by Nurse #6. No discharge instructions in regards to the 5/9/12 appointment was found in the clinical records of Resident #42. On 5/9/12 at 5:00 p.m., an interview was conducted with Unit Manager of Unit 2. It was noted that there was no identifying the Physicians Progress Notes located within Resident #42's clinical record as to be Resident #42's or to whom the Physicians Progress Note was referring. "I know because I've worked here a long time, but, no, there isn't anything on this note telling me (facility) anything about today's appointment..." for Resident #42 with OSMC. On 5/10/12 at 1:30 p.m., an interview was conducted with the DNS noting the above interviews and observations. No information was provided. On 5/11/12 at 9:15 a.m., an interview was conducted with the DNS. The following piece of paper was provided for review: "(Pain Clinic Name). Patient Instructions. Epidural Steroid Injection. Label: (Resident's name, date of birth, Surgeon, Medical Record Number and Date of Service [DOS]). Lumbar..." DOS was		***practice will not recur, i.e., what quality assurance program will be put into place:*** Ongoing compliance with this corrective action will be monitored through the facility CQI Program. The DNS/designee will be responsible for completion of the CQI Audit Tool related to Lab Services weekly x3 weeks, then monthly x 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date = 6/15/12.	

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	noted as "5/9/12." This was hand signed by Resident #42. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(1)			