

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER  IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE ROAD SOUTH BEND, IN46614
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 3, 4, 5, 6 and 7, 2011</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Sandra Haws, RN TC Vicki Manuwal, RN Bobbie Costigan, RN - October 4, 5, 6, and 7, 2011</p> <p>Census bed type: SNF/NF: 133 Total: 133</p> <p>Census payor type: Medicare: 21 Medicaid: 97 Other: 15 Total: 133</p> <p>Sample: 24 Supplemental sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p>	F0000		

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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F0157 SS=D	<p>Quality review completed on October 12, 2011 by Bev Faulkner, RN</p> <p>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</p>	F0157	Resident #67, 69, and 115 charts were reviewed and care plans	10/31/2011

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	<p>facility failed to notify the physician of blood sugar results that fell within call parameters for 3 of 11 diabetic residents reviewed for diabetic call orders in a sample of 24.</p> <p>Resident # 67, # 69, # 115</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 67, reviewed on 10/4/11 at 10:20 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hyperlipidemia.</p> <p>A Physician Order, dated 7/29/11, indicated, "...Accu Checks (blood sugar test)...Call MD if BSL (blood sugar level) &lt; (less than) 60..."</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the following blood sugar that fell within call parameters:</p> <p>9/5/11 9:00 P.M. - Accu Check - 55</p> <p>The clinical record lacked documentation of physician notification.</p> <p>Resident # 67's care plan, dated 3/30/11, updated last on 8/2/11, indicated, "...Diabetes Plan of Care...Potential for</p>		<p>were updated as necessary. No negative outcomes noted by this practice.</p> <p>100% audit of all blood sugar parameters, sliding scales, and MD notification were completed with no other residents affected.</p> <p>All nursing staff were re-educated on blood sugars, documentation, review of sliding scale, legibility, and notifying the MD timely.</p> <p>UM or ADON will monitor MARs daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly. This is to ensure that blood sugars are being completed, legible documentation, blood sugar parameters are being followed, sliding scale is being followed and MD is being notified as ordered. DON to do spot checks weekly for 1 month. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>		

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	<p>Alteration/Alteration in Blood Glucose Levels related to Diagnosis of IDDM (Insulin Dependent Diabetes Mellitus) - Adult Onset...Follow up with physician as needed...."</p> <p>During interview on 10/6/11 at 4:20 P.M., the DON (Director of Nursing) indicated the MAR included a blood sugar that was not called to the physician.</p> <p>2. The clinical record for Resident # 69, reviewed on 10/5/11 at 3:20 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hypothyroidism.</p> <p>A Physician Order, dated 8/25/09, indicated, "...Accu Checks...Notify MD if &lt; 60..."</p> <p>Review of the September 2011, MAR, indicated the following blood sugar that fell within call parameters:</p> <p>9/20/11 11:00 A.M. - Accu Check - 38</p> <p>The clinical record lacked documentation of physician notification.</p> <p>Resident # 69's care plan, dated 3/29/11, updated 6/9/11 &amp; 9/12/11, indicated, "...Diabetes Plan of Care...Potential for Alteration/Alteration in Blood Glucose</p>			

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	<p>Levels related to Insulin dependent diabetes...Document actions taken for hyper (high)/hypoglycemia (low)...Follow up with physician as needed...."</p> <p>During interview on 10/6/11 at 4:20 P.M., the DON (Director of Nursing) indicated the MAR included a blood sugar of 38 on 9/20/11 at 11:00 A.M.</p> <p>3. The clinical record for Resident # 115, reviewed on 10/6/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and schizophrenia.</p> <p>A Physician Order, dated 9/18/09, indicated, "...Accu Checks (blood sugar test)...Notify MD if B.S. (blood sugar) &lt; (less than) 60..."</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the following blood sugar that fell within call parameters:</p> <p>9/12/11 7:00 A.M. - Accu Check - 40</p> <p>The clinical record lacked documentation of physician notification.</p> <p>Resident # 115's care plan, dated 7/31/11, updated 9/26/11, indicated, "...Diabetes Plan of Care...Document actions taken for</p>			

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F0168 SS=C	<p>hyper/hypoglycemia...Follow up with physician as needed...."</p> <p>During interview on 10/6/11 at 4:20 P.M., the DON (Director of Nursing) indicated the MAR included a blood sugar that was not called to the physician.</p> <p>A facility policy titled, "Med (Medication) Administration", dated January 2001, revised October 2008 &amp; July 2010, provided by the DON on 10/6/11 at 9:00 A.M., indicated, "...22. Notify physician/provider of changes in condition related to medication regimen (improvement of decline)...."</p> <p>3.1-5(a)(2)</p> <p>A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.</p> <p>Based on interviews and observation, the facility failed to ensure residents had access to information regarding contacting agencies for client advocates for 133 of 133 residents in the facility who may wish to contact an advocate.</p> <p>Findings include:</p>	F0168	<p>The client advocates posting was edited and the phone numbers are now in bold faced, dark black writing. Additionally, the client advocate numbers were framed and posted in large, bold font at wheelchair height on every unit next to the meal menus. Administrator was invited to resident council meeting held 10-20-2011 in which residents</p>	10/31/2011

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F0282 SS=E	<p>During a resident group meeting on 10/4/11 at 10:00 a.m., 8 of 10 alert and oriented residents indicated they were not aware of any posted information available to be able to call a resident advocate if they needed to. The residents did not know where in the facility they could find this information. The residents indicated they did not see any information on any of their units and would like to have this available to them.</p> <p>During a tour of the facility on 10/6/11 at 9:30 a.m., an observation was made of a framed paper containing information regarding contacting the Ombudsman (a resident advocate). The framed information was observed hanging 5 feet from the ground and located near the entrance of the facility. The print on the form was very small and had to be read close up. The information would not be available to any resident in a wheelchair.</p> <p>The facility contains 5 units; a 100, 200, 300, 400 and 500 unit.</p> <p>3.1-3(b)(2)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>		were informed of the new locations of the postings. Administrator will ensure during rounds that the ombudsman and client advocate numbers remain in place on each unit and are legible.	

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	<p>Based on interview and record review, the facility failed to ensure physician orders and plan of care were followed related to blood sugars and administration of insulin coverage for 5 of 11 residents (Resident # 46, # 67, # 69, # 101, # 108) in a sample of 24 reviewed with diabetes.</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 67, reviewed on 10/4/11 at 10:20 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hyperlipidemia.</p> <p>A Physician Order, dated 5/31/11, indicated, "...Novolin R...sliding scale before meals and at bedtime; 151-200=1 units, 201-250=2 units, 251-300=3 units, 301-350=5 units, 351-400=10 units; 7 A.M., 11 A.M., 4 P.M., 9 P.M...."</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the following 4 incorrect sliding scale coverage's:</p> <p>9/3/11 11:00 A.M. - Accu Check - 181. The clinical record indicated 2 units given. The next available Accu Check at 4:00 P.M. was 308.</p> <p>9/15/11 11:00 A.M. - Accu Check - 328. The clinical record indicated 4 units</p>	F0282	<p>Resident #46, 67, 69, 108 and 101 charts were reviewed and care plans were updated as necessary. No negative outcomes noted by this practice. 100% audit of sliding scales and accurate coverage were completed with no other residents affected. All nursing staff were re-educated on following physicians orders, review of sliding scale and notifying the MD timely. UM or ADON will monitor MARs daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly. This is to ensure that the sliding scale is being followed accurately and MD is being notified as ordered. DON to do spot checks weekly for 1 month. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p> <p>Addendum F282: Resident #108 was added in this plan of correction on 10/28/11.</p>	10/31/2011	

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	<p>given. The next available Accu Check at 4:00 P.M. was 62.</p> <p>9/21/11 9:00 P.M. - Accu Check - 302. The clinical record lacked documentation of coverage given. The next available Accu Check on 9/22/11 at 7:00 A.M. was 130.</p> <p>9/24/11 7:00 A.M. - Accu Check - 175. The clinical record indicated 0 units given. The next available Accu Check at 11:00 A.M. was 166.</p> <p>Resident # 67's Care Plan, dated 3/30/11, updated last on 8/2/11, indicated, "...Diabetes Plan of Care...Administer insulin per MD order..."</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she was aware there are blood sugar issues related to wrong sliding scale coverage.</p> <p>2. The clinical record for Resident # 108, reviewed on 10/5/11 at 10:25 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and dementia.</p> <p>A Physician Order, dated 4/15/10, indicated, "...Novolin R...sliding scale A.C. (before meals) and HS (bedtime); 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=10 units...7 A.M., 11 A.M., 4</p>				

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	<p>P.M., 9 P.M...."</p> <p>Review of the August 2011, MAR (Medication Administration Record), indicated the following incorrect sliding scale coverage:</p> <p>8/2/11 11:00 A.M. - Accu Check - 158. The clinical record indicated 0 units given. The next available Accu Check at 4:00 P.M. was not completed due to the resident on leave of absence.</p> <p>Resident # 108's Care Plan, dated 2/16/11, updated last on 7/19/11, indicated, "...Diabetes Plan of Care...Administer insulin per MD order..."</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she was aware there are blood sugar issues related to wrong sliding scale coverage.</p> <p>3. The clinical record for Resident # 69, reviewed on 10/5/11 at 3:20 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hypertension.</p> <p>A Physician Order, dated 8/18/09, indicated, "...Novolin R...sliding scale...; 0-149=0 units, 150-200=3 units, 201-250=6 units, 251-300=9 units, 301-350=11 units, 351-400=13 units, &gt;</p>				

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	<p>400=15 units; 7 A.M., 11 A.M., 4 P.M., 9 P.M...."</p> <p>Review of the July 2011, MAR (Medication Administration Record), indicated the following 2 incorrect sliding scale coverage's:</p> <p>7/2/11 11:00 A.M. - Accu Check - 214. The clinical record indicated 3 units given. The next available Accu Check at 4:00 P.M. was 128.</p> <p>7/18/11 11:00 A.M. - Accu Check - 219. The clinical record indicated 3 units given. The next available Accu Check at 4:00 P.M. was 87.</p> <p>Review of the September 2011, MAR, indicated the following incorrect sliding scale coverage:</p> <p>9/2/11 9:00 P.M. - Accu Check - 187. The clinical record indicated 0 units given. The next available Accu Check on 9/3/11 at 7:00 A.M. was 68.</p> <p>Resident # 69's Care Plan, dated 3/29/11, updated last on 9/12/11, indicated, "...Diabetes Plan of Care...Administer insulin per MD order..."</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she was aware there are blood sugar issues</p>				

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	<p>related to wrong sliding scale coverage.</p> <p>4. The clinical record for Resident # 101, reviewed on 10/6/11 at 9:30 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hyperlipidemia.</p> <p>A Physician Order, dated 1/9/09, indicated, "...Novolog...0-150=0 units, 151-199=3 units, 200-249=6 units, 250-299=9 units, 300-349=12 units, &gt; 350=15 units; 7 A.M., 11 A.M., 4 P.M., 9 P.M...."</p> <p>Review of the July 2011, MAR, indicated the following incorrect sliding scale coverage:</p> <p>7/17/11 9:00 P.M. - Accu Check - 253. The clinical record indicated 6 units given. The next available Accu Check on 7/18/11 at 7:00 A.M. was 178.</p> <p>Review of the August 2011, MAR, indicated the following 2 incorrect sliding scale coverage's:</p> <p>8/9/11 11:00 A.M. - Accu Check - 164. The clinical record indicated 0 units given. The next available Accu Check at 4:00 P.M. was 133.</p> <p>8/21/11 4:00 P.M. - Accu Check - 189.</p>				

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	<p>The clinical record indicated 2 units given. The next available Accu Check at 9:00 P.M. was 165.</p> <p>Review of the September 2011, MAR, indicated the following incorrect sliding scale coverage:</p> <p>9/9/11 7:00 A.M. - Accu Check - 360. The clinical record indicated 12 units given. The next available Accu Check at 11:00 A.M. was 293.</p> <p>Resident # 101's Care Plan, dated 2/4/11, updated last on 9/13/11, indicated, "...Diabetes Plan of Care...Administer insulin per MD order..."</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she was aware there are blood sugar issues related to wrong sliding scale coverage.</p> <p>5. The clinical record for Resident # 46, reviewed on 10/6/11 at 1:10 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and depression.</p> <p>A Physician Order, dated 7/26/11, indicated, "...Novolog...151-199=1 units, 200-249=2 units, 250-299=3 units, 300-350=4 units, 351-400=5 units...7 A.M., 11 A.M., 4 P.M., 9 P.M...."</p>				

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F0315 SS=D	<p>Review of the September 2011, MAR, indicated the following 1 incorrect sliding scale coverage:</p> <p>9/18/11 9:00 P.M. - Accu Check - 350. The clinical record indicated 5 units given. The next available Accu Check on 9/19/11 at 7:00 A.M. was 385.</p> <p>Resident # 46's Care Plan, dated 3/2211, updated 7/26/11, indicated, "...Diabetes Plan of Care...Administer insulin per MD order..."</p> <p>Interview with the DON on 10/6/11 at 4:20 P.M., she indicated she was aware there are issues with sliding scale coverage not being taken as ordered.</p> <p>3.1-35(g)(2)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was free from the risk of</p>	F0315	<p>Resident # 51 no longer resides in facility.</p> <p>100% audit of all residents with a</p>	10/31/2011

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	<p>developing urinary complications related to having a Foley catheter without a medical need or justification for its use for 1 of 5 residents reviewed with a Foley catheter in a sample of 24. (Resident # 51)</p> <p>Findings include:</p> <p>During a tour of the 300 unit on 10/3/11 at 11:00 a.m., accompanied by LPN #2, an observation was made of Resident # 51 in bed., A Foley catheter was observed hanging on the lower bedside frame.</p> <p>During an interview with LPN #2 at this time, she indicated the resident has a history of bariatric surgery and came to the facility with the catheter in place. She indicated the resident was working with therapy and would be able to transfer to a commode. LPN # 2 indicated there wasn't a medical diagnosis for the use of the catheter other than the resident wanted it.</p> <p>Resident # 51's record was reviewed on 10/4/11 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; status post gastric bypass surgery, and hypertension. The resident's record indicated she was admitted to the facility on 8/15/11.</p> <p>A physician's order, dated 8/30/11, indicated "16 FR (french) Foley catheter</p>		<p>Foley catheter were completed with all other residents having proper diagnosis's.</p> <p>All nursing staff were re-educated on appropriate diagnosis for Foley catheters.</p> <p>UM or ADON will monitor all new orders and 24 hour report sheets for appropriate diagnosis for all Foley catheters. The DON or designee will monitor this daily during the Daily Clinical Review Meeting to ensure proper diagnosis. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>		

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	<p>10cc (cubic centimeter) bulb. Cath care q (every) shift, change Foley UD (urinary drainage) bag monthly and date and prn (as needed) soilage."</p> <p>Review of a urinalysis report, dated 8/27/11, indicated " Blood; large, nitrates; positive, leukocyte screen; large, bacteria; present, wbc (white blood cells) innum (innumerable)...."</p> <p>A physician's order, dated 9/2/11, indicated "Bactrim DS (antibiotic) one po (by mouth) bid (two times a day) x (times) 10 d (days)."</p> <p>Nurses note, dated 9/3/11 at 11:50 a.m., indicated "Foley draining dark colored/amber urine...continue ATB (antibiotic/UTI) (urinary tract infection) ...."</p> <p>Nurse note, dated 9/5/11 at 12:10 p.m., "...Remains of abt for uti, skin is warm to touch continues to mention pressure toward (arrow down) abdomen...current temp is 96.8"</p> <p>Nurse note, dated 10/3/11 at 5 a.m., indicated "Foley cath patent/intact...."</p> <p>During an interview with the Director of Nursing on 10/4/11 at 10:30 a.m., she indicated there was not a medical or</p>				

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	<p>justified reason the resident had the catheter other than she wanted it. She further indicated the physician was called and he gave an order to discontinue the Foley catheter.</p> <p>A physician's order dated 10/3/11 indicated "DC (discontinue) Foley cath."</p> <p>The facility's policy and procedure titled "Indwelling Urinary Catheters" revised 1/2009 indicated " ...All residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use...."</p> <p>3.1-41(a)(1)</p>				

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F0329 SS=D	<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 residents taking medications requiring monitoring were monitored prior to the administration of the medication for 2 of 2 residents ( Residents # 46 and # 2) with medication requiring monitoring in a sample of 24 and for 1 of 1 in a supplemental sample of 1 (Resident # 6)</p> <p>Findings include:</p> <p>1. Resident # 6's record was reviewed on 10/6/11 at 1:00 p.m. The resident's record indicated diagnoses of, but not limited to; dementia, anemia, coronary artery disease,</p>	F0329	<p>Resident #46, 2, and 6 charts were reviewed and care plans were updated as necessary. No negative outcomes noted by this practice.</p> <p>100% audit of all residents with blood pressure medication requiring pulse and blood pressure to be taken prior to administration of medication. No other residents were affected.</p> <p>All nursing staff were re-educated on following physicians orders, taking the residents blood pressure and pulse prior to medication administration, following the blood pressure and pulse parameters,</p>	10/31/2011			

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	<p>heart failure and congestive heart failure.</p> <p>A physician's order, dated 8/20/11, indicated "Amlodipine Besylate (blood pressure medication) 10 mg (milligram) may cause dizziness give 1 tablet orally once a day (hold for SBP (systolic blood pressure) &lt; (less than) 100 or HR (heart rate) 50."</p> <p>The resident's September 2011 MAR Medication Administration Record) indicated the resident's pulse was not taken and the medication initialed it was given on the following dates at 8:00 a.m.: September 11, 20, 21, 22, and 29.</p> <p>According to the Nursing Drug Handbook 2010 edition for Amlodipine Besylate indicated "...use cautiously in elderly patients...monitor heart rate and rhythm and blood pressure..."</p> <p>A physician's order, dated 8/20/11, indicated "Carvedilol (blood pressure medication, and used to treat heart failure) 25 mg one p.o. bid hold if SBP &lt; 100 or HR &lt;50 and notify Dr. (doctor). The resident's September 2011 MAR indicated a pulse was not documented and the medication initialed it was given on the following dates at 9:00 a.m.: September 6, 19, 20 (no pulse or blood pressure), 21,22,23, and 29. The 5 p.m. dose</p>		<p>documentation, legibility, and notifying the MD timely.</p> <p>UM or ADON will monitor the MARs daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly. This is to ensure that blood pressures and pulses are being taken prior to medication administration. Also that the results are being transcribed, legibly, in the MAR/flow sheet and MD is being notified as ordered. DON to do spot checks weekly for 1 month. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>		

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	<p>indicated no pulse was taken on September 21 and 22.</p> <p>During an interview with RN # 3 on 10/6/11 at 1:20 p.m., regarding the lack of documentation on the MAR to indicate if a pulse was monitored prior to giving the blood pressure medication, she indicated it was not, if it was it would be recorded on the MAR. No further documentation was provided.</p> <p>According to the Nursing Drug Handbook 2010 edition for Carvedilol indicated "...use cautiously in elderly patients... when drug is used to treat heart failure , check apical pulse before administering, be aware that addition of diuretic may cause additive effects and my worsen orthostatic hypotension..." Resident # 6's record indicated she takes Lasix (a diuretic) 40 mg every morning.</p> <p>2. Resident # 2's record was reviewed on 10/4/11 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; gastrocutaneous fistula, jejunostomy, protein calorie malnutrition, and TPN (total parental nutrition).</p> <p>A physician's order, dated 9/12/11, indicated "Lopressor (blood pressure medication) 12.5 mg per (by) J (jejunostomy) tube bid, hold if SBP&lt; 105</p>				

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	<p>or pulse &lt; 65."</p> <p>The resident's September 2011 MAR at 9:00 a.m., indicated no pulse was recorded on the following dates: September 18, 19, 20 ,21, 23, 24, 25, 26, and 30. The 5 p.m. dose the MAR indicated no pulse recorded on September 25, 26, and 27.</p> <p>During an interview with RN # 3 on 10/4/11 at 9:30 a.m. regarding the lack of the resident's pulse being documented on the MAR, she indicated if it was done it would be recorded on the MAR. She further indicated the pulse should have been taken before the gave the medication.</p> <p>According to the Nursing Drug Handbook 2010 edition for Lopressor indicated "...Watch for orthostatic hypotension in at-risk patients, particularly the elderly...."</p> <p>3. The clinical record for Resident # 46, reviewed on 10/6/11 at 1:10 P.M., indicated diagnoses of, but not limited to: hypertension, diabetes mellitus, and hypothyroidism.</p> <p>A Physician Order, dated 7/26/11, indicated, "...Clonidine (high blood pressure medication) 0.3 mg (milligram)/day patch...apply 1 patch</p>				

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	<p>topically, change every week - hold for SBP (systolic blood pressure) &lt; (less than) 120..."</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated a Clonidine patch was applied on 9/26/11, scheduled at 8:00 A.M.</p> <p>The clinical record indicated a blood pressure reading of 110/78 on 9/26/11 at 8:00 A.M.</p> <p>According to the 2010 Nursing Drug Handbook for Clonidine indicated "...Monitor patient for signs and symptoms of adverse cardiovascular reactions, frequently assess vital signs, especially blood pressure and pulse...."</p> <p>Further Physician Orders, dated 7/26/11, indicated, "...Isosorbide DN (heart medication) 30 mg tablet...give 1 tablet orally once a day, hold if SBP &lt; 100 or HR (heart rate) &lt; 50...; Metoprolol Tart (high blood pressure medication)...give 1 tablet orally 2 times a day, hold if SBP &lt; 100 or HR &lt; 50...; Amlodipine Besylate (high blood pressure medication) 10 mg tablet...give 1 tablet orally once a day, hold if SBP &lt; 100 or HR &lt; 50..."</p> <p>Review of the August 2011, MAR, indicated 32 of 60 scheduled doses that</p>				

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	<p>were not evaluated for the need of the medications related to lack of heart rate results.</p> <p>Review of the September 2011, MAR, indicated 49 of 60 scheduled doses that were not evaluated for the need of the medications related to lack of heart rate results.</p> <p>According to the 2010 Nursing Drug Handbook for Isosorbide indicated "...Precautions: use cautiously in:...elderly patients...Patient monitoring: monitor vital signs closely, especially blood pressure...."</p> <p>According to the 2010 Nursing Drug Handbook for Metoprolol indicated "...Measure blood pressure closely when starting therapy and titrating dosage...watch for orthostatic hypotension in at-risk patients, particularly the elderly...."</p> <p>According to the Nursing Drug Handbook 2010 edition for Amlodipine Besylate indicated "...use cautiously in elderly patients...monitor heart rate and rhythm and blood pressure..."</p> <p>Resident # 46's clinical record indicated, "...N.O. (new order) to hold Lopressor (Metoprolol Tart) and Norvasc</p>			

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	<p>(Amlodipine Besylate) if SBP &lt; 100 or HR &lt; 50..."</p> <p>Review of Resident # 46's care plan, dated 3/22/11, updated 6/13/11 &amp; 7/26/11, indicated, "...Cardiovascular/Circulatory: Plan of Care...HTN (hypertension)...Meds/Tx (treatment) as ordered... Vital signs per protocol and prn (as needed)..."</p> <p>Interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware of the pulses not being taken as ordered.</p> <p>A facility policy titled, "Medication Administration", received on 10/6/11 at 9:00 A.M., dated January 2001, revised October 2008 &amp; July 2010, indicated, "...6. Perform necessary assessments prior to administering specific medications which may include, but is not limited to: pulse, blood pressure..."</p> <p>3.1-48(a)(3)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food preparation and serving dishes were clean and sanitary and that dishes were stored correctly. This deficient practice had the potential to effect 128 of 133 residents who receive meals prepared in 1 of 1 facility kitchen.</p> <p>Findings include:</p> <p>During initial tour of the facility's kitchen conducted with the Dietary Manager on 10/3/11 at 10:40 A.M., observations were made of the following dishes that had been washed and ready to be used:</p> <p>Dried on particles were noted on:</p> <ul style="list-style-type: none"> <li>2 of 2 serving pitcher lids</li> <li>4 of 6 plate covers</li> <li>5 of 5 clear plastic serving pitchers</li> <li>1 of 1 Tupperware cereal bowl</li> <li>3 of 3 white plastic pitchers</li> <li>4 of 4 small juice glasses</li> <li>2 of 2 steam table pans</li> <li>1 of 1 puree blade</li> <li>4 of 4 burgundy colored soup bowls</li> <li>2 of 2 small fruit bowls</li> </ul>	F0371	<p>Dietary Manager spot checked all dry and stored dishware, glasses, and utensils for any dried particles, stains and residue. All items found with particles, stains or residue were washed and restored properly 10/3/11. All items found stored wet ready to use were washed and dried properly prior to storage.</p> <p>Staff re-educated on proper washing, drying, and dish storage procedures on 10/4/11-10/5/11.</p> <p>Dietary Manager or designee to spot check compliance of proper dishware cleanliness and storage daily for 1 week, weekly for 1 month using Quick Sanitation Rounds Form. This is to ensure that dishware is being washed, dried, and stored properly. RD to monitor dishware cleanliness and storage monthly for 5 months using Quality Validation Sanitation form. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any</p>	10/31/2011	

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	<p>5 of 10 dinner plates</p> <p>1 of 1 "lid off" utensil with a dried on sticky, yellowish brown substance</p> <p>1 of 1 white plastic scoop with dark brown stains</p> <p>Wet dishes:</p> <p>2 of 2 plate covers</p> <p>The soiled pitchers, plastic lids and scoops were observed on a rack ready for use. The plates and soup bowls were on the serving line ready to be used. The four soiled juice glasses were observed on a serving cart as staff prepared to fill them. The steam table pans were on a rack ready for use.</p> <p>During interview on 10/3/11 at 10:50 A.M., the Dietary Manager indicated the dishwasher was serviced within the last couple months because it was down. She further indicated the dish machine may need to be looked at again since the dishes were not getting completely clean.</p> <p>Review of a (Name) "Service Report", dated 8/3/11, indicated, "...Customer wants machine checked over...Inspected machine and found wash arm o-rings and drain o-ring wore out. Also found</p>		<p>identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>		

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F0514 SS=E	<p>machine not shutting off in auto. Found motor on/off switch stuck in the on position rather than a momentary operation. Changed out switch &amp; o-rings. Cleaned off floats and tested wash tank heater current. Heater element drawing proper current. Machine operational and in good condition...."</p> <p>A facility policy provided on 10/6/11 at 9:00 A.M., titled "Cleaning and Sanitizing", dated November 2000, revised July 2008 &amp; July 2010, indicated, "...The entire Nutrition Services team maintains clean and sanitary kitchen centers and equipment. Walls, floors, ceilings, equipment, and utensils are clean, sanitized, and in good working order...."</p> <p>3.1-21(i)(2)</p> <p>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</p>	F0514	Resident # 72, 6, 2, 30, 67, 108, 69, 101, 46, charts were reviewed	10/31/2011	

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	<p>facility failed to ensure resident records were complete, accurately documented, and legible for 9 of 24 residents reviewed for proper medical record documentation in a sample of 24.</p> <p>Residents: #72, #6, #2, #30, #67, #108, #69, #101, #46</p> <p>Findings include:</p> <p>1. Resident #72's record was reviewed on 10/5/2011 at 3:20 p.m. Resident #72's diagnoses include, but were not limited to, Diabetes Mellitus, Neuroleptic Malignant Syndrome, Failure to thrive, Schizophrenia, chronic dysphagia, Chronic Obstructive Pulmonary Disease (COPD), and gastrostomy tube for feeding and medication administration.</p> <p>The "Medication Administration Record" (MAR) for the month of September 2011 indicated, "...Resident is NPO (nothing by mouth)...Hydrocodone-APAP 5-325 mg...Give 1 tablet orally as directed as needed...Lorazepam 0.5 mg...Give 1 tablet orally as directed as needed..." The MAR indicated both medications orders were placed on 7/28/11.</p> <p>The "Questionnaire History" for 8/10/2011 stated, "...NPO, meds (medications) only via G-tube...."</p>		<p>and care plans were updated as necessary. No negative outcomes noted by this practice.</p> <p>100% audit of all residents with accu checks, legible documentation of the results, and MD notification were completed with no other residents affected. 100% audit of all MARs and POSs completed for accurate medication administration time parameters and route.</p> <p>All nursing staff were re-educated on legible documentation, following physicians orders and taking the residents accu checks as ordered. Also, on transcription of physicians orders to reflect medication administration time parameters and proper route.</p> <p>UM or ADON will monitor the MARs daily times 2 weeks then, 3 times a week for two weeks, weekly for 1 month, then monthly. This is to ensure that accu checks and being done, and that the results are being transcribed, legibly, in the MAR/flow sheet and MD is being notified as ordered. Also, to monitor 2 nd checks of the POSs are getting done and signed by the nurse doing them. DON to do spot checks weekly for 1 month. Identified trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs.</p>		

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	<p>The "Nutritional Risks Plan of Care" last updated 9/21/11 stated, "...Tube feeding r/t (related to) NPO...swallowing difficulties...Med administration via G-tube...."</p> <p>During an interview with the DON (Director of Nursing) on 10/5/2011 at 3:40 p.m., she indicated that the order for Lorazepam (anti-anxiety medication) and Hydrocodone-APAP (pain medication, brand name Norco) should have included the frequency instead of "...as directed as needed...." and that the route should not be oral but rather via g-tube (gastro tube).</p> <p>The "Physician Telephone Orders" for 10/6/2011 at 3:30 p.m., stated, "...order clarification 1) Norco 5-325 tab (mg) 1 tab (tablet) q4 hours (every 4 hours) PRN pain (as needed for pain) 2) Lorazepam 0.5 mg 1 tab q 4 hours PRN anxiety via g-tube...."</p> <p>2. Resident # 6's record was reviewed on 10/6/11 at 1:00 p.m. The resident's record indicated diagnoses of, but not limited to; dementia, anemia, coronary artery disease, heart failure and congestive heart failure.</p> <p>A physician's order, dated 8/20/11, indicated "Amlodipine Besylate (blood</p>		<p>Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>	

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	<p>pressure medication) 10 mg (milligram) may cause dizziness give 1 tablet orally once a day (hold for SBP (systolic blood pressure) &lt; (less than) 100 or HR (heart rate) 50."</p> <p>The resident's September 2011 MAR (Medication Administration Record) indicated the blood pressure entries on the MAR were not legible to read.</p> <p>During an interview with RN # 3 on 10/6/11 at 1:20 p.m., regarding not being able to read many of the blood pressure entries, she indicated they need to come up with something bigger for staff to document on. She agreed much of what was documented was not legible.</p> <p>3. Resident # 2's record was reviewed on 10/4/11 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; gastrocutaneous fistula, jejunostomy, protein calorie malnutrition, and TPN (total parental nutrition).</p> <p>A physician's order dated 9/12/11 indicated "Lopressor (blood pressure medication) 12.5 mg per (by) J (jejunostomy) tube bid, hold if SBP&lt; 105 or pulse &lt; 65."</p> <p>The resident's September 2011 MAR indicated he blood pressures recorded for</p>			

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	<p>5 p.m. on the 23rd through the 29th were not legible.</p> <p>During an interview with RN # 3 on 10/4/11 at 9:30 a.m., RN # 3 indicated she was not able to tell what the resident's blood pressure readings were that were documented on the MAR.</p> <p>4. Resident # 30's record was reviewed on 10/5/11 at 10:00 a.m. The resident's record indicated diagnoses of, but not limited to; diabetes.</p> <p>The residents September 2011 MAR indicated the resident received glucose monitoring daily at 6:00 a.m., 11:00 a.m. 4:00 p.m. and 8:00 p.m. The record indicated he received sliding scale insulin coverage.</p> <p>The 4:00 p.m. and 8:00 p.m. glucose reading and coverage documentation was not legible. The documentation was overlapped and not able to be read.</p> <p>During an interview with the Director of Nursing on 10/5/11 at 2:45 p.m., after review of the resident's MAR, she indicated she was not able to read most of it and will need to put something different in place as the tiny squares on the MAR are too small to document what is needed.</p>				

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	<p>5. The clinical record for Resident # 67, reviewed on 10/4/11 at 10:20 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hyperlipidemia.</p> <p>A Physician Order, dated 7/29/11, indicated, "...Accu Checks before meals and bedtime...7 A.M., 11 A.M., 4 P.M., 9 P.M...."</p> <p>Review of the August 2011, MAR (Medication Administration Record), indicated the lack of testing on: 8/18/11 11:00 A.M.</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the lack of testing on:</p> <p>9/14/11 9:00 P.M. 9/16/11 9:00 P.M.</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware there are blood sugar issues related to lack of testing.</p> <p>6. The clinical record for Resident # 108, reviewed on 10/5/11 at 10:25 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and dementia.</p>			

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	<p>A Physician Order, dated 4/15/10, indicated, "...Accu Checks AC and HS...7 AM, 11 A.M., 4 P.M., 9 P.M..."</p> <p>Review of the August 2011, MAR (Medication Administration Record), indicated the lack of testing on: 8/8/11 9:00 P.M.</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the lack of testing on: 9/26/11 11:00 A.M.</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware there are blood sugar issues related to lack of testing.</p> <p>7. The clinical record for Resident # 69, reviewed on 10/5/11 at 3:20 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hypertension.</p> <p>A Physician Order, dated 8/25/09, indicated, "...Accu Checks 4 x (times) daily...7 AM, 11 A.M., 4 P.M., 9 P.M..."</p> <p>Review of the August 2011, MAR (Medication Administration Record), indicated the lack of testing on: 8/17/11 11:00 A.M.</p>				

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	<p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware there are blood sugar issues related to lack of testing.</p> <p>8. The clinical record for Resident # 101, reviewed on 10/6/11 at 9:30 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hyperlipidemia.</p> <p>A Physician Order, dated 9/18/09, indicated, "...Accu Checks 4 x (times) daily...7 AM, 11 A.M., 4 P.M., 9 P.M...."</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the lack of testing on: 9/26/11 9:00 P.M.</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware there are blood sugar issues related to lack of testing.</p> <p>9. The clinical record for Resident # 46, reviewed on 10/6/11 at 1:10 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and depression.</p> <p>A Physician Order, dated 7/27/11, indicated, "...Accu Checks before meals and at HS...7 AM, 11 A.M., 4 P.M., 9</p>			

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	<p>P.M...."</p> <p>Review of the August 2011, MAR (Medication Administration Record), indicated the lack of testing on:</p> <p>8/20/11 9:00 P.M. 8/21/11 9:00 P.M. 8/24/11 9:00 P.M. 8/25/11 9:00 P.M.</p> <p>Review of the September 2011, MAR (Medication Administration Record), indicated the lack of testing on:</p> <p>9/16/11 11:00 A.M.</p> <p>During interview with the DON on 10/6/11 at 4:20 P.M., she indicated she is aware there are blood sugar issues related to lack of testing.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				