STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155459		05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT NEW CASTLE	901 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00193414. Complaint IN00193414 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F279, F280, F309, F329, F502, and F514. Survey dates: May 2, 4, and 5, 2016 Facility number: 000341 Provider number: 155459 AIM number: 100286550 Census bed type: SNF/NF: 29 Total: 29 Census payor type: Medicare: 3 Medicaid: 21 Other: 5 Total: 29 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on	F 0000	This Plan of Correction constitutes the writtenallegation of compliance for the deficiencies cited. However, submission ofthis Plan of Correction is not an admission that a deficiency exists or thatone was cited correctly. This Plan of Correction is submitted to meetrequirements established by state and federal law. ·Hickory Creek at New Castle desires this Plan ofCorrection to be considered the facility's Allegation of Compliance. Compliance is effective on June 4, 2016.	

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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	May 13, 2016			
F 0157 SS=D Bldg. 00	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). 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.			

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	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician was notified of two failed attempts to collect urine and that a collected urine specimen had been discarded (Resident #A) and failed to notify 2 resident's families of new medication orders (Resident #A and Resident #B). This affected 2 of 3 residents reviewed for notification. Findings include: 1. A. Resident #A's record was reviewed on 5/2/16 at 11:52 a.m. Resident #A's diagnoses documented on her January 2016 physician's recapitulation orders indicated, but were not limited to, dementia, muscle weakness, osteoarthritis, and malaise. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/27/15, indicated she rarely/never understood others. She was severely impaired in her cognitive skills for daily decision making. A physician's order for Resident #A dated 2/11/16 at 6:00 p.m., indicated a urine	F 0157	Itis the policy of this facility to ensure that the physician is notified of anychange in a resident's condition or treatment, including failed attempts tocollect a specimen ordered by the physician. It is also the policy of thisfacility to notify residents' families/legal representatives when medicationorders are changed. what corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #A no longer resides atthe facility. Resident #B's family was notified on May 24, 2016, of theresident's change in condition that prompted the physician to order painmedication, including adverse side effects of the pain medication and the resulting decrease of pain medication. how other residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this practice. An audit of all nurses'notes since May 2, 2016 will be completed by June 3, 2016, to ensure that theresidents' physician and their legal representatives have been notified of anychanges in condition. Any issues noted	06/04/2016

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	specimen would be collected for urinalysis and culture and sensitivity. A "Progress Note" for Resident #A, dated 2/12/16 at 1:32 a.m., indicated two failed attempts were made to collect urine using a straight catheter technique. A "Progress Note" for Resident #A, dated 2/13/16 at 6:10 a.m., indicated cloudy tan urine had been obtained using a straight catheter technique. A "Progress Note" for Resident #A dated 2/14/16 at 6:09 a.m., indicated the urine specimen collected on 2/13/16, had not been sent to the laboratory and had been thrown away. No explanation was documented why the urine specimen had been thrown away. A "Physician Progress Note" for Resident #A dated 2/16/16, indicated a urine specimen collection had been attempted on Friday 2/12/16, without any return and the physician had not been notified. An interview with the Director of Nursing (DON) on 5/2/16 at 5:40 p.m., indicated she did not know why the urine specimen collected from Resident #A on 2/13/16, had been thrown away and the staff involved in collecting and disposing the urine specimen were no longer		where notifications have not been madewill be promptly corrected by the DON or designee by notifying the physician orfamily at that time. Once that is done, the DON will re-train the nurse(s)involved regarding the facility policy for notification and will render writtencounseling as indicated by the situation. what measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; An inservice will be conducted with licensed nursing staff related to the policyand procedure for physician, and family notification of any change of condition. On regular business days, the IDT teamwill review the previous day's nurses' notes and new orders during the morningclinical meeting, to ensure that all needed notifications have been completed. Nurses' notes and new orders from the weekendswill be reviewed on the first following business day. Any identified issueswill be addressed by the DON as indicated in the prior section. (See Attachment #1) how the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place. The DON or designee will bring results of the audit to the monthly QA&ACommittee meeting for review and recommendations. Any recommendations made by	

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	employed at the facility. An interview with Resident #A's physician on 5/3/16 at 12:15 p.m., indicated he had not been notified by the facility of the two failed attempts to collect a urine specimen on 2/12/16, and had not been notified the urine specimen collected on 2/13/16, had been thrown away until Resident # A had become more ill. 1. B. A physician's order for Resident #A, initiated 1/5/16, indicated she would receive Norco 10-325 milligrams (mg) by mouth every 8 hours as needed for pain related to osteoarthritis. No documentation was available in Resident #A's record that her son had been notified of the Norco 10-325 mg order dated 1/5/16. An interview with the Nurse Consultant on 5/2/16 at 5:38 p.m., indicated she was unable to locate any documentation Resident #A's son had been notified of the Norco 10-325 mg order dated 1/5/16. 2. Resident #B's record was reviewed on 5/2/16 at 1:05 p.m. Current physician's orders, dated 3/27/16, indicated Resident #B had diagnosis that included, but were not limited to, atrial fibrillation, dementia, high blood pressure, peptic		the committee willbe followed through by DON or designee, the results of those recommendationswill then be reviewed again at the next QA&A Committee meeting. At the endof 2 months, and once the audits show 100% compliance, the QA&A Committeemay decide to stop the written audits; however, the process of review and followup will continue on an ongoing basis.	

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	ulcer, high blood fats, joint pain, and peripheral vascular disease. A quarterly Minimum Data Set assessment (MDS), dated 3/11/16, indicated Resident #B was severely impaired in cognitive skills for daily decision making and required total assist of one for all activities of daily living. A document faxed to the resident's physician on 2/19/16 indicated: "Resident experiencing quite a bit more pain lately. Tylenol [not] effective. May we have an order for Tramadol 50 mg (milligrams) 1 PO (by mouth) BID (twice a day) QD (every day)." The physician responded with this order: "Tramadol 50 mg 1 PO BID QD with food." There was also a note to pick up the written prescription order. There was no documentation in the clinical record that indicated the resident's family had been notified of the new order for a pain medication. On 5/2/16, at 8:00 p.m., the Director of Nurses indicated they could find no documentation the family was notified of the physician's order for Tramadol. A policy and procedure for "Change of Condition", with a review date of			

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	3/10/16, was provided by the Director of Nurses on 5/2/16 at 8:30 p.m. The policy indicated, but was not limited to, "Policy...The resident's primary physician or designated alternate will be notified immediately of any change in the resident's physical or mental condition. The resident's designated family/legal representative will also be notified...Examples of significant change include, but are not limited to...Change in level of consciousness...Drug reactions...Bleeding, signs and symptoms of infection...Procedure...4. Physician and family will be notified, with the notification documented in the nurses' notes...." This Federal tag relates to Complaint IN00193414. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive			

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	care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review, the facility failed to develop a plan of care for narcotic use, pain, and vaginal or bladder area bleeding, for 1 of 3 residents reviewed for care plans. (Resident #A) Findings include: Resident #A's record was reviewed on 5/2/16 at 11:52 a.m. Resident #A's diagnoses documented on her January 2016 physician's recapitulation orders indicated but were not limited to, dementia, muscle weakness, osteoarthritis, and malaise. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/2715, indicated she rarely/never understood others. She was severely impaired in her cognitive skills for daily decision	F 0279	Itis the policy of this facility to develop plans of care for each resident thatreflects the services being offered to the residents, including narcotic useand change in condition, such as vagina or bladder area bleeding. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #A no longer resides inthe facility. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents had the potentialto be affected by this practice. A CarePlan audit of all active residents will be conducted by the IDT team by June 3,2016. Care Plans will be updated asneeded	06/04/2016

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	making. A physician's order for Resident #A initiated 1/5/16, indicated she would receive Norco 10-325 milligrams (mg) by mouth every 8 hours as needed (PRN) for pain related to osteoarthritis. A physician's order for Resident #A initiated 2/11/16, indicated she would receive Norco 5-325 mg by mouth every 4 hours PRN for pain related to osteoarthritis. Resident #A's January 2016 Medication Administration Record (MAR) indicated she received Norco 10-325 mg PRN's 14 times. Resident #A's February MAR indicated she received Norco 10-325 mg PRN's 10 times and Norco 5-325 mg PRN 1 time. No plan of care was available in Resident #A's record related to her use of a narcotic or pain. "Progress Notes" for Resident #A indicated the following: 12/29/16 at 10:44 a.m. - She had large amounts of bright red blood from her vaginal or bladder area. 2/8/16 at 2:39 p.m. - She had bright red blood and several large clots in her brief. 2/10/16 at 2:31 p.m. - She had reddish brown drainage observed		to reflect each resident's current status, to maintain the residents'highest practicable physical, mental, and psychosocial well-being. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; On regular business days, duringthe morning clinical meeting, the previous day's nurses' notes and orders willbe reviewed by the IDT members. Nurses' notes and new orders from the weekendswill be reviewed on the next business day. The resident's plan of care will be promptly updated with any newpertinent information, by the MDS coordinator, or another designee. Once the care plan is updated, the DON orAdministrator will review the facility policy on care plan accuracy andupdating with the nurse or other discipline's team member to make sure thatthey understand the process for prompt updating of residents' care plans at thetime a change occurs. Continued noncompliance will be addressed through thefacility counseling/disciplinary process as warranted by the situation. (See Attachment #2) howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what	

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	when she urinated. 2/11/16 at 8:13 p.m. - She had blood clots observed in her brief. 2/12/16 at 4:27 a.m. - She had blood clots observed in her brief. 2/14/16 at 2:11 p.m. - She had a small amount of blood observed in her brief. 2/15/16 at 10:28 p.m. - She had a minimal amount of blood observed in her brief. No plan of care was available in Resident #A's record related to her vaginal or bladder area bleeding. An interview with the Director of Nursing (DON) on 5/2/16 at 8:30 p.m., indicated Resident #A did not have a plan of care for the use of a narcotic, pain, or bleeding in the vaginal or bladder area. A policy and procedure for "Care Planning", with a last review date of 3/10/16, was provided by the DON on 5/2/16 at 8:30 p.m. The policy indicated, but was not limited to, "Policy: A care plan is initiated upon the admission/readmission of each resident to the facility, reviewed, and updated at intervals throughout the resident's length of stay. Purpose: To identify problems and developmental solutions for the coordination of resident care. To provide interdisciplinary, resident, and family input into the resident's plan of care. Procedure: 1. A care plan is initiated		quality assurance program will be put into place;and TheMDS Nurse or designee will bring results of the care plan audit to the monthly QA&ACommittee meeting for review and recommendations. Any recommendations made by the committeewill be followed through by MDS Nurse or designee, the results of thoserecommendations will then be reviewed again at the next QA&A Committeemeeting. At the end of 2 months, and once the audits show 100% compliance, theQA&A Committee may decide to stop the written audits; however, the processof review and follow up will continue on an ongoing basis.	

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	upon admission/readmission by the admitting nurse. It should reflect immediate assessed needs...6. Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and the Resident Assessment Instrument (MDS)...." This federal tag relates to Complaint IN00193414. 3.1-35(a) 3.1-35(a)(1)			
F 0280 SS=D Bldg. 00	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. 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,			

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	the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise a care plan for pain, that included side effects, when the resident's pain medication was changed to a stronger pain medication, for 1 of 3 resident reviewed for pain. (Resident #B) Findings include: Resident #B's record was reviewed on 5/2/16 at 1:05 p.m. Current physician's orders, dated 3/27/16, indicated Resident #B had diagnosis that included, but were not limited to, atrial fibrillation, dementia, high blood pressure, peptic ulcer, high blood fats, joint pain, and peripheral vascular disease. A quarterly Minimum Data Set assessment (MDS), dated 3/11/16, indicated Resident #B was severely impaired in cognitive skills for daily decision making and required total assist of one for all activities of daily living. A document faxed to the resident's physician, on 2/19/16, indicated: "Resident experiencing quite a bit more pain lately. Tylenol [not] effective. May	F 0280	Itis the policy of this facility to develop a comprehensive care plan for eachresident and to revise that care plan as the condition of the resident changes,including addressing residents' pain and the medication they are receiving forit. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #B Care Plan for painhas been updated to match existing orders. howother residents having the potential to be affected by the same deficientpractice will be identifiedand what corrective action(s) will be taken; All residents who receive painmedication have the potential to be affected by this practice. A Care Planaudit of all active residents who receive pain medications will be conducted bythe IDT team and completed June 3, 2016 Any care plans found to be lacking updated information on residents'pain management issues will be updated as needed to reflect each resident'scurrent status related to pain, medication being received for the pain,	06/04/2016

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	we have an order for Tramadol 50 mg (milligrams) 1 PO (by mouth) BID (twice a day) QD (every day)." The physician responded with this order: "Tramadol 50 mg 1 PO BID QD with food." A "Controlled Drug Use Record" had documentation that the first dose of tramadol, 50 mg, was given on 2/20/16 at 12:00 p.m. "Progress Notes", dated 2/20/16 at 3:13 p.m., indicated: "CNA brought pt (patient) up to nursing station and pt was cold and non responsive, sternal rub done and pt started to arouse, pt started new med of Tramadol. Pt was helped back to bed with feet elevated." "Progress Notes", dated 2/20/16 at 4:26 p.m., indicated: "First dose of tramodol (sic) given to resident. made her very lethargic low bp (blood pressure) and plulse (sic). Dr Miller in house and lowered dose. pharmacy notified of new order." "Progress Notes", dated 2/20/16 at 7:18 p.m., indicated: "PT refused supper, but drank glass of O.J. and now is alert and talking. Dr Miller in earlier and changed Tramadol to 25 mg BID." Current physician's orders, dated 3/27/16,		andmonitoring for side effects of pain medications. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; On regular business days, duringthe morning clinical meeting, the previous day's nurses' notes and orders willbe reviewed by the IDT members. Nurses' notes and new orders from the weekendswill be reviewed on the next business day, including those that relate to theresident's pain management. Theresident's plan of care will be promptly updated with any new pertinentinformation, by the MDS coordinator, or another designee. Once the care plan is updated, the DON willreview the facility policy on care plan accuracy and updating with the nurse(s)to make sure that they understand the process for prompt updating of residents'care plans at the time a change occurs. Continued noncompliance will beaddressed through the facility counseling/disciplinary process as warranted bythe situation (See Attachment #2) howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheMDS Nurse or designee will	

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	indicated the current dose of tramadol was 50 mg, 1 tablet - give 1/2 tablet to equal 25 mg by mouth, two times a day related to pain. A care plan, dated 2/22/16, indicated: "I complain of having pain at times. Goal: I will be free from pain within 30 minutes of pain relief intervention through next review. Interventions: I need my medications administered as ordered. I need pain assessments done quarterly, yearly, with any significant change and as needed. I need staff to monitor me for constipation due to pain medications. I need staff to monitor me for signs and symptoms of non-verbal pain. I need staff to report to MD if I have new or worsening pain." The care plan did not include the stronger pain medications and any side effects of the pain medications. During an interview, on 5/2/16 at 1:40 p.m., the MDS Coordinator indicated they would care plan for the side effects of the stonger pain medications. A policy and procedure for "Care Planning", with a review date of 310/16, was provided by the Director of Nurses on 5/2/16 at 8:30 p.m. The policy indicated, but was not limited to, "Policy:		bring results of the care plan audit to the monthlyQA&A Committee meeting for review and recommendations. Any recommendations made by the committee willbe followed through by MDS Nurse or designee, the results of thoserecommendations will then be reviewed again at the next QA&A Committeemeeting. At the end of 2 months, and once the audits show 100% compliance, theQA&A Committee may decide to stop the written audits; however, the processof review and follow up will continue on an ongoing basis.	

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	155459		05/05/2016

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	A care plan is initiated upon the admission/readmission of each resident to the facility, reviewed, and updated at intervals throughout the resident's length of stay. Purpose: To identify problems and developmental solutions for the coordination of resident care. To provide interdisciplinary, resident, and family input into the resident's plan of care. Procedure...Additions to care plans are to be preceded by the date...." This Federal tag relates to Complaint IN00193414. 3.1-35(d)(2)(B)			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a urine specimen was transported to the laboratory, notify the physician timely of the failure to transport the urine	F 0309	Itis the policy of this facility to receive care and services in accordance withthe plan of care, including the obtaining and transport of laboratory specimensas ordered by the physician, notification of the physician when the	06/04/2016

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	specimen, and develop a thorough plan of care for a resident with vaginal or bladder area bleeding and an increased white blood cell (WBC) count, resulting in sepsis, for 1 of 3 residents reviewed. (Resident #A) Findings include: Resident #A's record was reviewed on 5/2/16 at 11:52 a.m. Resident #A's diagnoses documented on her January 2016 physician's recapitulation orders indicated, but were not limited to, dementia, muscle weakness, osteoarthritis, and malaise. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/2715, indicated she rarely/never understood others. She was severely impaired in her cognitive skills for daily decision making. "Progress Notes" for Resident #A indicated the following: 12/29/16 at 10:44 a.m. - She had large amounts of bright red blood from her vaginal or bladder area when staff toileted her. She also had 2 bed changes from large amounts of blood. 2/8/16 at 2:39 p.m. - She had bright red blood and several large clots in her brief. 2/10/16 at 2:31 p.m. - She had reddish brown drainage		specimencannot be obtained or is not transported, and updating the resident's care planto accurately reflect the current condition of the resident. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #A is no longer aresident of the facility. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents had the potentialto be affected by this practice. Anaudit of all active residents' lab orders will be conducted and completed June3, 2016.The physician will be notified of any lab work that has not beencompleted as per previous orders, and follow through will occur with any neworders, as well as notification of any affected residents' families/legalrepresentatives. A Care Plan audit ofall active residents will be conducted by the IDT team June 3, 2016 Care Plans will be updated as needed toreflect each resident's current status, to maintain the residents' highestpracticable physical, mental, and psychosocial well-being at the time ofreview, including change of condition, pain management, and laboratory	

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	observed when she urinated. A physician's order for Resident #A dated 2/11/16 at 6:00 p.m., indicated a urine specimen would be collected for urinalysis and culture and sensitivity for blood in urine/vaginal area and increased white blood cells. A "Progress Note" for Resident #A dated 2/11/16 at 8:13 p.m., indicated she had blood clots observed in her brief. A "Progress Note" for Resident #A dated 2/12/16 at 1:32 a.m., indicated two failed attempts were made to collect urine using a straight catheter technique. A "Progress Note" for Resident #A dated 2/12/16 at 4:27 a.m., indicated she had blood clots observed in her brief. A "Progress Note" for Resident #A, dated 2/13/16 at 6:10 a.m., indicated cloudy tan urine had been obtained using a straight catheter technique. A "Progress Note" for Resident #A dated 2/14/16 at 6:09 a.m., indicated the urine specimen collected on 2/13/16, had not been sent to the laboratory and had been thrown away. She was pale and more lethargic. No explanation was documented why the urine specimen had		testsand resulting orders. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; Onregular business days, during the morning clinical meeting, the previous day'snurses' notes and orders will be reviewed by the IDT members. Nurses' notes andnew orders from the weekends will be reviewed on the next business day. In addition, the lab/appointment calendarwill be checked to ensure that all new lab orders have been entered. Theresidents' plan of care will be promptly updated with any new pertinentinformation, by the MDS coordinator, or another designee. The IDT team willensure that all needed notifications have been completed. A new lab order tracking system has beendeveloped. Licensed nurses will be in-servicedon the new procedure for lab orders by June 3, 2016. The DON or designee will run a monthly reportand place upcoming lab orders on the lab/appointment calendar at the nurses'station. Once any identified issues havebeen corrected, the DON will review the facility policy for using the lab ordertracking system, follow through on lab orders, care plan accuracy and updatingwith the nurse(s) to make sure that they understand the process for completingphysician orders for	

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	been thrown away. A "Progress Note" for Resident #A dated 2/14/11 at 2:11 p.m., indicated she had a small amount of blood observed in her brief. She was lethargic. A "Progress Note" for Resident #A dated 2/15/16 at 10:28 p.m., indicated she had a minimal amount of blood observed in her brief. A "Physician Progress Note" for Resident #A dated 2/16/16, indicated a urine specimen collection had been attempted on Friday 2/12/16, without any return and the physician had not been notified. Her blood pressure was 90/40, respirations were 40, with probable sepsis. Her status was discussed with her son and he was deciding how to proceed; comfort care verses emergency room. A "Progress Note" for Resident #A dated 2/16/16 at 10:14 a.m., indicated the physician had been in to see her. He recommended she be sent to the emergency room and Resident #A's son had not wanted her sent. A "Progress Note" for Resident #A dated 2/16/16 at 3:25 p.m., indicated Resident #A's respirations had ceased.		obtaining and transporting laboratory specimens, notifyingthe physician when a specimen cannot be obtained or when it has not beentransported as ordered, and prompt updating of residents' care plans at thetime a change occurs. Continued noncompliance will be addressed through thefacility counseling/disciplinary process as warranted by the situation (SeeAttachment #3) howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheMDS Nurse or designee will bring results of the care plan audit and the DON ordesignee will bring the results of the lab tracking audit to the monthly QA&ACommittee meeting for review and recommendations. Any recommendations made by the committeewill be followed through by DON, MDS Nurse or designee, and the results ofthose recommendations will then be reviewed again at the next QA&ACommittee meeting. At the end of 2 months, and once the auditsshow 100% compliance, the QA&A Committee may decide to stop the writtenaudits; however, the process of review and follow up will continue on anongoing basis.	

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	A "Certificate Of Death" for Resident #A indicated she passed away on 2/16/16. Her "Certificate of Death" indicated the following: The immediate cause (final disease or condition resulting in death was septic shock. The underlying cause (disease or injury that initiated the events resulting in death) was abdominal or urinary bacterial infection. An interview with Resident #A's son on 5/2/16 at 1:40 p.m., indicated he had received different version from the facility related to the cause of his mother's bleeding. When his mother first began bleeding the CNA's had informed him the blood was coming from her urine. Other staff assumed the blood was from her vagina and he believed those staff were wrong. He believed the blood was coming from his mother's urine. He indicated the facility failed to follow the physician's order for a urinalysis on 2/12/16. He indicated his mother passed away and her Death Certificate indicated her cause of death was septic shock and secondary cause of death was bacterial urinary tract infection. An interview with the Director of Nursing (DON) on 5/2/16 at 5:40 p.m., indicated she did not know why the urine specimen collected from Resident #A on 2/13/16, had been thrown away and the			

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	staff involved in collecting and disposing the urine specimen were no longer employed at the facility. An interview with the Director of Nursing (DON) on 5/2/16 at 8:30 p.m., indicated Resident #A did not have a plan of care for bleeding in the vaginal or bladder area. A telephone interview with Resident #A's physician on 5/3/16 at 12:15 p.m., indicated he had not been notified by the facility of the two failed attempts to collect a urine specimen on 2/12/16, and had not been notified the urine specimen collected on 2/13/16, had been thrown away until Resident # A had become more ill. Resident #A had not shown any signs of infection except an increased WBC count. Resident #A's son had not wanted his mother sent to the emergency room. Resident #A had intermittent bleeding and had intermittent bleeding in the past. He believed Resident #A's bleeding was vaginal and would have required extensive work-up and testing to determine the cause of the bleeding. He believed the son had not wanted any of those interventions. Resident #A's bleeding probably had not contributed to her death. Resident #A's cause of death was probably overwhelming sepsis. He did not have Resident #A's record with			

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	him during the interview and could not confirm exact information or dates. This federal tag relates to Complaint IN00193414. 3.1-37(a)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 0329	Itis the policy of this facility that each resident's drug regimen is	06/04/2016

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	Based on record review and interview, the facility failed to ensure an excessive dose of tramadol was not given to a resident who previously had not taken this medication. This affected 1 of 3 residents reviewed for pain medication. (Resident #B) Findings include: Resident #B's record was reviewed on 5/2/16 at 1:05 p.m. Current physician's orders, dated 3/27/16, indicated Resident #B had diagnosis that included, but were not limited to, atrial fibrillation, dementia, high blood pressure, peptic ulcer, high blood fats, joint pain, and peripheral vascular disease. A quarterly Minimum Data Set assessment (MDS), dated 3/11/16, indicated Resident #B was severely impaired in cognitive skills for daily decision making and required total assist of one for all activities of daily living. A document faxed to the resident's physician on 2/19/16 indicated: "Resident experiencing quite a bit more pain lately. Tylenol [not] effective. May we have an order for Tramadol 50 mg (milligrams) 1 PO (by mouth) BID (twice a day) QD (every day)." The physician responded with this order: "Tramadol 50		free fromunnecessary drugs, including when a drug is ordered or used in an excessivedose. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #B's medication dosagewas reduced by the physician to 25mg PO BID, on February 19, 2016. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; Allresidents receiving medication have the potential to be affected by thispractice. An audit of pain medicationswas completed by the Consultant Pharmacist on May 27, 2016 to review forunnecessary drugs, (i.e. excessive dose) of pain medication. No excessive usages were identified by theConsultant Pharmacist. The physicianshave been notified of any recommendations made related to drugs that residentsare receiving, including any dosages where pertinent. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; As part of the ConsultantPharmacist's monthly visit, all medications, including	

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	mg 1 PO BID QD with food." A "Controlled Drug Use Record" that had a start date of 2/20/16 at 12:00 p.m., had documentation that the first dose of tramadol, 50 mg, was given on 2/20/16 at 12:00 p.m. "Progress Notes", dated 2/20/16 at 3:13 p.m., indicated: "CNA brought pt (patient) up to nursing station and pt was cold and non responsive, sternal rub done and pt started to arouse, pt started new med of Tramadol. Pt was helped back to bed with feet elevated." "Progress Notes", dated 2/20/16 at 4:26 p.m., indicated: "First dose of tramodol (sic) given to resident. made her very lethargic low bp (blood pressure) and plulse (sic). Dr Miller in house and lowered dose. pharmacy notified of new order." "Progress Notes", dated 2/20/16 at 7:18 p.m., indicated: "PT refused supper, but drank glass of O.J. and now is alert and talking. Dr Miller in earlier and changed Tramadol to 25 mg BID." During an interview, on 5/2/16 at 6:35 p.m., the Minimum Data Set (MDS) assessment coordinator indicated Resident #B had not taken tramadol		pain medications, willbe reviewed to identify excessive dosage. In the future, any new order receivedby the facility will be forwarded to the pharmacy as per routine procedure;however if the pharmacy finds that the dosage is excessive, a pharmacist willcontact the facility charge nurse regarding dosage parameters. The physicianwill then be notified of the issue and resulting physician response and orderswill be documented in the record. If there is still some concern over thedosage that is ordered, the DON and Administrator will notify the facility'sMedical Director for further orders or recommendations. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheDON or designee will bring results of the Pharmacy review to the QA&ACommittee meeting for review and recommendations. Any recommendations made by the committeewill be followed through by DON or designee, the results of thoserecommendations will then be reviewed again at the next QA&A Committeemeeting. This process will continue onan ongoing basis.	

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	before. During an interview, on 5/2/16 at 6:35 p.m., the MDS coordinator indicated they don't have a policy and procedure related to pain medication use. The facility's drug book, "Mosby's 2016 Nursing Drug Reference 29th Edition", was reviewed on 5/2/16 at 6:45 p.m. The drug tramadol had the following dosage and side effects listed: "Adult PO 25 mg daily, titrate by 25 mg no more than every 3 days to 100 mg/day (25 mg qid), then may increase by 50 mg no more than every 3 days to 200 mg (50 mg qid), then 50-100 mg q4-6hr, max 400 mg/day, use caution in geriatric patients...." The side effects included, but were not limited to, confusion, sedation, blood vessel and blood pressure changes, and gastro-intestinal changes. This Federal tag relates to Complaint IN00193414. 3.1-48(a)(1)			
F 0502 SS=D Bldg. 00	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and			

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	timeliness of the services. Based on interview and record review, the facility failed to ensure a urine specimen was transported to the laboratory for urinalysis and culture and sensitivity (C&S), and laboratory values were drawn as ordered, for 1 of 3 residents reviewed for laboratory values. (Resident #A and #B) Findings include: Resident #A's record was reviewed on 5/2/16 at 11:52 a.m. Resident #A's diagnoses documented on her January 2016 physician's recapitulation orders indicated but were not limited to, dementia, muscle weakness, osteoarthritis, malaise, and vitamin B deficiency. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/2715, indicated she rarely/never understood others. She was severely impaired in her cognitive skills for daily decision making. A physician's order for Resident #A dated 2/11/16 at 6:00 p.m., indicated a urine specimen would be collected for urinalysis and C&S for blood in urine/vaginal area and increased white blood cells.	F 0502	Itis the policy that the facility will provide laboratory services to ensure thatlaboratory specimens are obtained and transported as per the physician's order. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #A is no longer aresident of the facility. Resident #B'sphysician and family was notified of the missed lab. New orders were obtainedand the lab was drawn. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents had the potentialto be affected by this practice. Anaudit of all active residents' lab orders was conducted and completed by May27, 2016. The physician will be notifiedof any lab work that has not been completed as per previous orders, and followthrough will occur with any new orders, as well as notification of any affectedresidents' families/legal representatives. whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; Onregular business days, during the morning clinical meeting, the	06/04/2016

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	A "Progress Note" for Resident #A dated 2/13/16 at 6:10 a.m., indicated cloudy tan urine had been obtained using a straight catheter technique. A "Progress Note" for Resident #A dated 2/14/16 at 6:09 a.m., indicated the urine specimen collected on 2/13/16, had not been sent to the laboratory and had been thrown away. No explanation was documented why the urine specimen had been thrown away. An interview with the Director of Nursing (DON) on 5/2/16 at 5:40 p.m., indicated she did not know why the urine specimen collected from Resident #A on 2/13/16, had been thrown away and the staff involved in collecting and disposing the urine specimen were no longer employed at the facility. The DON indicated no other urine specimen had been collected from Resident #A. 2. Resident #B's record was reviewed on 5/2/16 at 1:05 p.m. Current physician's orders, dated 3/27/16, indicated Resident #B had diagnosis that included, but were not limited to, atrial fibrillation, dementia, high blood pressure, peptic ulcer, high blood fats, joint pain, and peripheral vascular disease. A quarterly Minimum Data Set		previous day'snurses' notes and orders will be reviewed by the IDT members. Nurses' notes andnew orders from the weekends will be reviewed on the next business day. In addition, the lab/appointment calendarwill be checked to ensure that all new lab orders have been entered. Theresidents' plan of care will be promptly updated with any new pertinentinformation, by the MDS coordinator, or another designee. The IDT team willensure that all needed notifications have been completed. A new lab order tracking system has beendeveloped. Licensed nurses will bein-serviced on the new procedure for lab orders by June 3, 2016. The DON or designee will run a monthly reportand place upcoming lab orders on the lab/appointment calendar at the nurses'station. Once any identified issues havebeen corrected, the DON will review the facility policy for using the lab ordertracking system, follow through on lab orders, care plan accuracy and updatingwith the nurse(s) to make sure that they understand the process for completingphysician orders for obtaining and transporting laboratory specimens, notifyingthe physician when a specimen cannot be obtained or when it has not beentransported as ordered, and prompt updating of residents' care plans at thetime a change occurs. Continued	

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	assessment (MDS), dated 3/11/16, indicated Resident #B was severely impaired in cognitive skills for daily decision making and was total assist of one for all activities of daily living. Physician's orders, dated 2/19/16, indicated an order for a CBC (complete blood count), CMP (complete metabolic panel), and a fasting lipid panel (to test for fats in the blood), every six months in April and October. The resident's record indicated the last labs for the CBC, CMP, and fasting lipid panel were done were on 10/5/15. During an interview, on 5/4/16 at 3:44 p.m., the Administrator indicated the physician had discontinued the lab orders on 2/19/16 and then the physician gave new orders on 2/19/16 for all the labs except the ferritin level. The Administrator indicated they have not been able to find that the labs had been drawn in April. During an interview, on 5/5/16 at 9:30 a.m., the Corporate Consultant indicated the resident's physician gave a verbal order to discontinue the ferritin level on 12/15/15. The MDS coordinator rewrote the order for the labs without the ferritin order, because there were 4 lab orders in		noncompliance will be addressed through thefacility counseling/disciplinary process as warranted by the situation. (SeeAttachment #3) howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheDON or designee will bring results of the lab tracking audit to the monthly QA&ACommittee meeting for review and recommendations. Any recommendations made by the committeewill be followed through by DON or designee, the results of thoserecommendations will then be reviewed again at the next QA&A Committeemeeting. At the end of 2 months, and once the audits show 100% compliance, theQA&A Committee may decide to stop the written audits; however, the processof review and follow up will continue on an ongoing basis.	

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	a row (that included the ferritin order), and they have to re-enter the orders to discontinue the one that the physician discontinued. The nurse puts the orders in the computer, then the physician signs the order when he comes in. The order was obtained on 12/15/16 and the physician signed the order on 12/17/16. During an interview, on 5/5/16 at 2:00 p.m., the DoN and Corporate Consultant indicated they had no further information on how the lab orders were not carried forward. An interview with the DON, on 5/2/16 at 8:30 p.m., indicated the facility had no policy and procedure for obtaining and sending out laboratory specimens. This Federal tag relates to Complaint IN00193414. 3.1-49(a)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted			

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	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 interview and record review, the facility failed to document a resident received her showers according to her scheduled shower days for 1 of 3 residents reviewed for shower documentation. (Resident #A) Findings include: Resident #A's record was reviewed on 5/2/16 at 11:52 a.m. Resident #A's diagnoses documented on her January 2016 physician's recapitulation orders indicated, but were not limited to, dementia, muscle weakness, osteoarthritis, and malaise. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 11/2715, indicated she rarely/never understood others. She was severely impaired in her cognitive skills for daily decision making. She required extensive assistance of 1 person for personal hygiene.	F 0514	Itis the policy of this facility to maintain accurate clinical records for eachresident, including documentation of residents' showers. whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Resident #A is no longer aresident of the facility. howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents had the potentialto be affected by this practice. Anaudit was conducted which showed that shower days had been erroneously enteredin the electronic clinical record system as PRN, rather than on a scheduledbasis. Electronic records were updatedas of May 4, 2016, to schedule showers on a routine schedule. whatmeasures will be put into	06/04/2016

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	A "Care Plan" for Resident #A updated 11/30/15, indicated she was unable to do her own care. Her goal was to have a neat and clean appearance daily. Her interventions included but were not limited to, a partial bath daily and a shower twice a week. Resident #A's shower documentation for January 2016, indicated she received a shower on the 14th, 18th, and 28th. Her shower documentation for February 2016, indicated she had not received any showers from the 1st through the 16th. The facility was unable to provide documentation Resident #A received her showers twice weekly according to her plan of care. During an interview with Resident #A's son on 5/2/16 at 11:06 a.m., he indicated he had observed his mother to be unclean "90% of the time." An interview with the Nurse Consultant on 5/4/16 at 11:30 a.m., indicated the MDS Coordinator had identified an issue with bathing documentation in late February 2016 or early March 2016. She indicated a resident's bathing documentation had originally been listed under an as needed (PRN) choice in the		place or what systemic changes will be made to ensurethat the deficient practice does not recur; An inservice with Nursing staff willbe conducted by June 3, 2016, to review the bathing/shower policy andprocedures. Licensed Nursing staff willreview electronic medical records for completion of shower documentation eachshift. The DON or designee will conduct routineaudits to ensure completion of the shower documentation. Any lack ofdocumentation related to showers or bathing will be addressed by the chargenurse and/or the DON with the nursing staff involved. A review of the facilitypolicy regarding bathing/showers for each resident will be reviewed at thattime, and continued noncompliance will be addressed through the facilitycounseling/disciplinary process as warranted by the situation. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheDON or designee will bring results of the shower audit to the monthly QA&ACommittee meeting for review and recommendations. Any recommendations made by the committeewill be followed through by DON or designee, the results of thoserecommendations will	

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	computer, so staff were not prompted to complete a resident's bathing documentation. The bathing issue had been corrected and documentation is now listed under routine as a choice in the computer, so staff are prompted to complete any bathing task they performed for a resident every shift. An interview with CNA #1 on 5/4/16 at 11:50 a.m., indicated she had bathed Resident #A in bed the last week to the last week and a half of Resident #A's life. CNA #1 indicated Resident #A accepted showers prior to becoming ill. CNA #1 was unable to provide any information regarding the lack of bathing documentation for January and February 2016. An interview with CNA #2 on 5/4/16 at 11:55 a.m., indicated Resident #A had become bed fast the last week of her life. CNA #2 indicated she had bathed Resident #A in bed during that time. CNA #2 indicated Resident #A was cooperative with taking her showers prior to becoming ill. CNA #2 was unable to provide any information regarding the lack of bathing documentation for January and February 2016. This federal tag relates to Complaint IN00193414.		then be reviewed again at the next QA&A Committeemeeting. At the end of 2 months, andonce the audits show 100% compliance, the QA&A Committee may decide to stopthe written audits; however, the process of review and follow up will continueon an ongoing basis.	

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	3.1-50(a)(1)			