

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 12/07/2011
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6521 GREENDALE DR EVANSVILLE, IN 47711
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R0000	<p>This visit was for the Investigation of Complaint IN00100273.</p> <p>Complaint IN00100273 Substantiated, State residential findings related to the allegations are cited at R90, R241, R247, R268, and R349.</p> <p>Survey dates: December 6 and 7, 2011</p> <p>Facility number: 010681 Provider number: 010681 AIM number: N/A</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: Residential: 44 Total: 44</p> <p>Census payor type: Other: 44 Total: 44</p> <p>Sample: 5</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/9/11 Cathy Emswiller RN</p>	R0000	<p>The following is the Plan of Correction for Sterling House of Evansville in regards to the Statement of Deficiencies for the complaint survey completed on 12-7-11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	
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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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R0090	<p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a</p>			
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	<p>notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to ensure laboratory services were obtained as ordered by the physician, for 1 of 3 residents reviewed for laboratory services, in a sample of 5. Resident E</p> <p>State findings include:</p> <p>The clinical record of Resident E was reviewed on 12/6/11 at 7:15 P.M. Diagnoses included, but were not limited to, Coronary Artery Disease and Atrial Fibrillation.</p> <p>A Physician's order, dated 10/10/11, indicated, "Coumadin 3 mg Tues [Tuesday], Wed [Wednesday], Fri [Friday], Sun [Sunday]...Recheck PT/INR [Prottime; lab work to determine dosage of Coumadin] 1 wk [week]."</p> <p>Documentation of a PT/INR was not observed in the clinical record until 11/16/11.</p> <p>On 12/7/11 at 9:05 A.M., during interview with the Administrator in Training [AIT] and the Director of</p>	R0090	<p>The following is the Plan of Correction for Sterling House of Evansville in regards to the Statement of Deficiencies for the complaint survey completed on 12-7-11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. <u>R 090 Administration</u> - <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i> · Resident E: Physician and Family were</p>	01/06/2012			

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	<p>Nursing [DON], the DON indicated the lab work was ordered on 10/10/11 to be done in 1 week, and "was missed." The AIT indicated the corporate nurse found the error on 11/8/11. The DON indicated the nurse who made the error did not write the lab order on the "Coumadin sheet," and so it was missed. The DON indicated that nurse no longer worked at the facility.</p> <p>This state residential tag relates to Complaint IN00100273.</p>		<p>notified regarding the missed lab.</p> <ul style="list-style-type: none"> · A new PT/INR was obtained and corresponding updates to Coumadin dose were made and documented on the Medication Administration Record. · The existing INR Tracking form has been updated to include any new orders/updates. · The nurse who failed to document the initial order changes is no longer employed at this community. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Residents who receive Coumadin have the potential to be affected by the alleged deficient practice. · At the current time, a total of four residents currently receive this medication at the community. · The Health and Wellness Director and designee have audited the clinical records of the above residents to determine that the current orders have been appropriately documented on the INR flow sheet and the Medication Record, and that, in the event there are discrepancies, the physician has been notified and appropriate follow-up has occurred. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Nursing staff has been re-educated by the Health and Wellness Director/Designee 	

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			<p>on the appropriate transcription process for the existing INR flow sheet as well as the system for tracking lab orders associated with Coumadin users. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <ul style="list-style-type: none"> · The Health and Wellness Director /Designee will audit weekly for compliance with the use of the INR tracking form for all residents who receive Coumadin. · The Health and Wellness Director /Designee will audit weekly for completion of PT/INR orders as well as physician notification of lab results. · Nursing staff will be required to perform a "double-check" each day prior to administering Coumadin, that outstanding labs have been completed as ordered, and that physician has been notified of results. · All residents receiving Coumadin will be discussed twice monthly during the Collaborative Care Meeting process (a Multi-disciplinary meeting) to review outcomes and compliance with the above procedures. This process will continue monthly in an ongoing manner, as part of existing Sterling House procedure. The community will utilize its existing Collaborative Care Meeting notes to document results of weekly PT/INR audits. By what date 		

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			<i>will these systemic changes be implemented?</i> · 1-6-12	
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R0241	<p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to ensure the medication Coumadin was administered as ordered by the physician, for 1 of 2 residents reviewed for Coumadin use, in a sample of 5. Resident E</p> <p>Findings include:</p> <p>The clinical record of Resident E was reviewed on 12/6/11 at 7:15 P.M. Diagnoses included, but were not limited to, Coronary Artery Disease and Atrial Fibrillation.</p> <p>A Physician's order, dated 9/30/11, indicated, "Coumadin [blood thinner] 3 mg on Wed [Wednesday], Fri [Friday]. Coumadin 2 mg rest of week. Recheck PT/INR [Protime; lab work to determine dosage of Coumadin] in 1 week...."</p> <p>A Physician's order, dated 10/10/11, indicated, "Coumadin 3 mg Tues [Tuesday], Wed, Fri, Sun [Sunday]. Coumadin 2 mg Mon [Monday], Thurs [Thursday], Sat [Saturday]. Recheck</p>	R0241	<p>R 241 Health Services <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i> · Resident E: Physician and Family were notified regarding the medication error. Any new physician orders / adjustment to Coumadin dosage have been added to the Medication Administration Record (MAR). · The existing INR Tracking form has been updated to include any new order changes. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Residents who receive Coumadin have the potential to be affected by the alleged deficient practice. · At the current time, a total of four residents currently receive this medication at the community. · The Health and Wellness Director and designee have completed an audit of the clinical records of the above residents to determine that the current orders have been appropriately documented on the Medication</p>	01/06/2012			

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	<p>PT/INR 1 wk."</p> <p>The resident's Medication Administration Record for October 2011 indicated an order for Coumadin dated 10/10/11, but not from 9/30/11 until 10/10/11.</p> <p>On 12/7/11 at 9:05 A.M., during interview with the Administrator in Training [AIT] and the Director of Nursing [DON], the DON reviewed the September and October MARs, and indicated the nurse must have written the September 30, 2011 order for Coumadin on the September MAR but not the October MAR. The September MAR indicated two entries of "Coumadin 3 mg Wed [and] Fri," but were crossed out, and no boxes were initialed indicating the medication was administered on those days. Another entry on the September MAR indicated, "Coumadin 2 mg rest of week," and was initialed as given on the 1st, 2nd, 3rd, 4th, 6th, 8th, and 9th.</p> <p>On 12/7/11 at 10:30 A.M., during interview with the DON, she indicated it appeared as if the Coumadin 3 mg was missed on 10/5/11 and the wrong dosage of 2 mg was administered on 10/7/11.</p> <p>This state residential tag relates to Complaint IN00100273.</p>		<p>Administration Record (MAR), and that, in the event there are discrepancies, the physician has been notified and appropriate follow-up has occurred. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> · Nursing staff has been re-educated by the Health and Wellness Director/Designee on the appropriate process for transcription of new orders onto the Medication Administration Record. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Health and Wellness Director /Designee will audit weekly for compliance with transcription of any new Coumadin orders onto the MAR · The Executive Director/AIT/ Designee will be notified of the results of MAR audits and determine further corrective actions for quality assurance, based on findings. · All residents receiving Coumadin will be discussed twice monthly during the Collaborative Care Meeting process (a Multi-disciplinary meeting) to review outcomes and compliance with the above procedures. This process will continue monthly in an ongoing manner, as part of existing Sterling House procedure. The 				

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			community will utilize its existing Collaborative Care Meeting notes to document results of weekly PT/INR audits. By what date will these systemic changes be implemented? 1-6-12	

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R0247	<p>(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified of a medication error of not receiving the correct dose of Coumadin, failed to ensure the error was documented in the clinical record, for 1 of 1 residents reviewed for physician notification and medication errors, in a sample of 5. Resident E</p> <p>Findings include:</p> <p>The clinical record of Resident E was reviewed on 12/6/11 at 7:15 P.M. Diagnoses included, but were not limited to, Coronary Artery Disease and Atrial Fibrillation.</p> <p>A Physician's order, dated 9/30/11, indicated, "Coumadin [blood thinner] 3 mg on Wed, Fri. Coumadin 2 mg rest of week. Recheck PT/INR [lab work to determine dosage of Coumadin] in 1 week...."</p> <p>A Physician's order, dated 10/10/11, indicated, "Coumadin 3 mg Tues, Wed, Fri, Sun. Coumadin 2 mg Mon, Thurs, Sat. Recheck PT/INR 1 wk."</p>	R0247	<p>R 247 Health Services What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident E: Physician and Family have been notified regarding the alleged medication error and missed lab. Any changes to the physician orders has been transcribed onto the existing INR tracking form and the Medication Administration Record (MAR) for clarification purposes. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Residents who receive Coumadin have the potential to be affected by the alleged deficient practice. · At the current time, a total of four residents currently receive this medication at the community. · The Health and Wellness Director and designee have completed an audit of the clinical records of the above residents to determine that the current orders have been appropriately documented on the Medication Administration Record (MAR), and that, in the event there are discrepancies, the</p>	01/06/2012			

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	<p>Documentation of a PT/INR was lacking in the clinical record until 11/16/11.</p> <p>The resident's Medication Administration Record for October 2011 indicated an entry for Coumadin dated 10/10/11, but not from 9/30/11 until 10/10/11.</p> <p>On 12/7/11 at 9:05 A.M., during interview with the Administrator in Training [AIT] and the Director of Nursing [DON], the DON reviewed the September and October MARs, and indicated the nurse must have written the September 30, 2011 order for Coumadin on the September MAR but not the October MAR. The September MAR indicated two entries of "Coumadin 3 mg Wed [and] Fri," but were crossed out, and no boxes were initialed indicating the medication was administered on those days. Another entry on the September MAR indicated, "Coumadin 2 mg rest of week," and was initialed as given on the 1st, 2nd, 3rd, 4th, 6th, 8th, and 9th. The DON indicated the corporate consultant found the errors on 11/8/11. The DON indicated the clinical record appeared as if the physician was notified on 11/16/11.</p> <p>Interdisciplinary Progress Notes, dated 11/16/11 at 4:30 P.M., indicated, "PT/INR results here. MD notified. N.O.</p>		<p>physician has been notified and appropriate follow-up has occurred. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Nursing staff has been re-educated by the Health and Wellness Director/Designee on the appropriate process for physician notification of medication or lab-related errors.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Health and Wellness Director /Designee will audit weekly for compliance with physician notification regarding medication or lab-related errors. · The Executive Director/AIT/ Designee will be notified of the results of the above audits and determine further corrective actions for quality assurance, based on findings. · All residents receiving Coumadin will be discussed twice monthly during the Collaborative Care Meeting process (a Multi-disciplinary meeting) to review outcomes and compliance with the above procedures. This process will continue monthly in an ongoing manner, as part of existing Sterling House procedure. The community will utilize its existing Collaborative Care Meeting notes to document results of weekly</p>				

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	<p>[new order] received [sic] for Coumadin 3 mg po [by mouth] on Sun Mon Tue, Wed et [and] Coumadin 2 mg on Thur et Sat, Recheck PT/INR on 11/30/11...."</p> <p>On 12/7/11 at 10:30 A.M., during interview with the DON, she indicated it appeared as if the Coumadin 3 mg was missed on 10/5/11 and the wrong dosage of 2 mg was administered on 10/7/11.</p> <p>This state residential tag relates to Complaint IN00100273.</p>		<p>PT/INR audits. By what date will these systemic changes be implemented? · 1-6-12</p>	
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R0268	<p>(a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements.</p> <p>Based on observation, interview and record review, the facility failed to provide planned meals which were appetizing to the residents, for 3 of 4 residents interviewed regarding food services, in a sample of 5. Residents A, B, and D</p> <p>Findings include:</p> <p>1. On 12/6/11 at 5:15 P.M., the Administrator in Training [AIT] provided a list of residents who were considered interviewable. Residents A, B, and D were listed as interviewable.</p> <p>On 12/6/11 at 5:20 P.M., the Administrator in Training provided the past month of menus. The menu indicated the meals for 12/6/11 included: Main Meal [lunchtime]: Mini Caesar Salad, Veal Italiano, Roasted Rosemary Potatoes, Almondine Style Cauliflower, Apple Pie. Light Meal [supper]: Five-Bean Soup, Pulled Pork Sandwich.</p> <p>On 12/6/11 at 5:30 P.M., staff was</p>	R0268	<p><u>R 268 – Food and Nutritional Services</u> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>Dining Services Manager (DSM)/Designee will conduct personal interviews with residents, and/or their family members, individually. Food preferences, likes and dislikes will be updated in clinical record. Food dislikes will be noted in kitchen service area for reference prior to serving of meals. Resident input will be used to re-develop “Always available menu” for choice of items preferred as an alternate to main course. DSM/Designee will change menus in accordance with company policy and nutritional requirements. Registered Dietician will review and approve all substitutions and changes, monitor menu postings and available alternate item lists during visits. DSM/Designee will conduct weekly menu chats every Monday, immediately following breakfast to ensure active participation from residents, and plan week at a glance menu. List of available alternate items will be reviewed for preference and acceptance.</p>	01/06/2012			

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	<p>observed to begin serving residents in the dining room. The meal consisted of a Grilled Cheese sandwich, Tomato soup, Cole slaw, and Fruit cocktail.</p> <p>On 12/6/11 at 5:35 P.M., during interview with the Dietary Manager [DM], she indicated the facility was in the process of changing menus. The DM indicated she sometimes has to "tweak" the menus, but tries to follow the menus as close as possible. The DM indicated she held "Food Chat" meetings once a week in which she obtains information from the residents. She indicated she always has cottage cheese, soup, peanut butter and jelly, and bologna for substitutes.</p> <p>2. On 12/6/11 at 6:30 P.M., during a confidential interview with Resident A, she indicated the "food just is not good." She indicated she did not know what was wrong, but that "it just isn't cooked well." Resident A indicated the meat was tough at times, and the vegetables are mushy at times. Resident A indicated, "They even can mess up macaroni and cheese." Resident A indicated she was aware there were weekly food meetings, and felt like the facility "tried."</p> <p>3. On 12/6/11 at 6:45 P.M., during a confidential interview with Resident B, she indicated she did not like the food.</p>		<ul style="list-style-type: none"> · Cooks will be re-educated on appropriate cooking methods according to standardized recipes. Meals will be tasted for appropriateness and palatability by culinary personnel and at least one other non-dining manager prior to each meal. Inappropriate meal items will not be served and replaced with appropriate meal items. · Dining Services will remain a topic of conversation at each resident council to gain feedback from residents related to their dining experience. <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Other residents have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · Dining Services Manager (DSM)/Designee will conduct personal interviews with residents, and/or their family members, individually. Food preferences, likes and dislikes will be updated in clinical record. · Resident input will be used to re-develop "Always available menu" for choice of items preferred as an alternate to main course. · DSM/Designee will change menus in accordance with company policy and nutritional requirements. · Registered Dietician will review and approve all substitutions and changes, monitor menu postings and available alternate item lists 				

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	<p>She indicated she could get a substitute, but that "usually wasn't any better." She indicated she "did not know what the problem was." Resident B indicated vegetables were either not cooked long enough or cooked too long, and meat was frequently too tough to eat. Resident B indicated food was her only complaint.</p> <p>4. On 12/6/11 at 7:00 P.M., during a confidential interview with Resident D, she indicated she thought "maybe the food is getting a little better." Resident D indicated for lunch that day she received a bowl of chili, one piece of bread with peanut butter, and ice cream. Resident D indicated they frequently receive soup and a sandwich, and she feels she gets enough food, but that it isn't always very good.</p> <p>5. The resident council minutes from the past 3 months were received by the Activity Director on 12/7/11 at 9:00 A.M. Under dining services, it was documented to "See weekly food chat..."</p> <p>The "Weekly Food Chats," dated 11/3/11 through 12/2/11, were provided by the Dietary Manager on 12/7/11 at 9:15 A.M., and indicated different resident preferences, such as "more fruit, ice cream." The most recent document, dated 12/2/11, indicated, "...Residents request bean soups to have more liquid (broth)...."</p>		<p>during visits. · DSM/Designee will conduct weekly menu chats every Monday, immediately following breakfast to ensure active participation from residents, and plan week at a glance menu. List of available alternate items will be reviewed for preference and acceptance. · Cooks will be re-educated on appropriate cooking methods according to standardized recipes. Meals will be tasted for appropriateness and palatability by culinary personnel and at least one other non-dining manager prior to each meal. Inappropriate meal items will not be served and replaced with appropriate meal items. · Dining Services will remain a topic of conversation at each resident council to gain feedback from residents related to their dining experience.</p> <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · DSM/Designee will conduct weekly menu chats every Monday, immediately following breakfast to ensure active participation from residents, and plan week at a glance menu. · Cooks will be re-educated on appropriate cooking methods according to standardized recipes. · An "always available menu" will be redeveloped to include resident preferences. · Food dislikes tool will be reviewed</p>				

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	<p>The documents had attendance lists, which indicated non-interviewable residents frequently were the only residents attending the meetings. The Dietary Manager indicated at that time that the facility "had been doing food chat for awhile. It used to be once a month, but the residents would forget what they wanted."</p> <p>On 12/7/11 at 9:30 A.M., the AIT indicated the facility tries to have weekly food meetings, but the interviewable residents don't come. The AIT indicated the staff had begun to interview those residents "one-on-one" to determine their food likes and dislikes. The AIT indicated the kitchen staff was not new, but had experience.</p> <p>This state residential tag relates to Complaint IN00100273.</p>		<p>prior to serving out of meals, to ensure resident satisfaction. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <ul style="list-style-type: none"> · Daily checklist will be utilized to ensure posted menu matches what is served at each meal period during morning meeting process. · Executive Director/AIT/Designee will monitor resident council minutes to ensure resident satisfaction in Dining Services. · Executive Director/AIT/Designee will monitor weekly menu chats to ensure resident preferences are reasonably honored. · DSM/Designee will continue to update resident individual food preferences, likes and dislikes as needed, and at least quarterly. · The Registered Dietician during visits will monitor for updated food preferences and dislikes. · Executive Director/AIT/Designee will review meals prior to service to ensure standards and expectations are met. · Residents food and nutritional services will be discussed twice monthly during the Collaborative Care Meeting process (a Multi-disciplinary meeting) to review outcomes and compliance with the above procedures. This process will continue monthly in an ongoing manner, as part of existing Sterling House procedure. The 				

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			community will utilize its existing Collaborative Care Meeting notes to document results. By what date will these systemic changes be implemented? 1-6-12	
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R0349	<p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure a Medication Administration Record was dated correctly, and medications were dated correctly, for 1 of 3 residents reviewed for complete and accurate clinical records, in a sample of 5. Resident E</p> <p>Findings include:</p> <p>The clinical record of Resident E was reviewed on 12/6/11 at 7:15 P.M. Diagnoses included, but were not limited to, Coronary Artery Disease and Atrial Fibrillation.</p> <p>A Physician's order, dated 9/30/11, indicated, "Coumadin [blood thinner] 3 mg on Wed [Wednesday], Fri [Friday]. Coumadin 2 mg rest of week. Recheck PT/INR [Prottime; lab work to determine dosage of Coumadin] in 1 week...."</p> <p>A Physician's order, dated 10/10/11, indicated, "Coumadin 3 mg Tues [Tuesday], Wed, Fri, Sun [Sunday]."</p>	R0349	<p><u>R 349 Clinical Records</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident E: The Medication Administration record was updated for the current month after verifying current orders were accurate, based on review of current physician orders for labs and Coumadin adjustments. · The INR flow sheet form has been updated to include all current Coumadin orders and due dates of corresponding labs. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Residents who receive Coumadin have the potential to be affected by the alleged deficient practice. · At the current time, a total of four residents currently receive this medication at the community. · The Health and Wellness Director and designee have completed an audit of the clinical records of the</p>	01/06/2012			

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	<p>Coumadin 2 mg Mon [Monday], Thurs [Thursday], Sat. [Saturday] Recheck PT/INR 1 wk [week]."</p> <p>An additional physician's order, dated 11/16/11, indicated, "Coumadin 3 mg daily Sun, Mon, Tues, Wed, Fri. Coumadin 2 mg on Thur [and] Sat only."</p> <p>The resident's Medication Administration Record [MAR], dated October 2011 indicated an entry for Coumadin dated 10/10/11, but not from 9/30/11 until 10/10/11.</p> <p>The resident's MAR, dated November 2011, had entries for Coumadin dated 10/16/11 instead of 11/16/11.</p> <p>On 12/7/11 at 9:05 A.M., during interview with the Administrator in Training [AIT] and the Director of Nursing [DON], the DON reviewed the September, October, and November MARs, and indicated the nurse must have written the September 30, 2011 order for Coumadin on the September MAR but not the October MAR. The September MAR was not dated and indicated two entries of "Coumadin 3 mg Wed [and] Fri," but were crossed out, and no boxes were initialed indicating the medication was administered on those days. The DON indicated the November MAR had</p>		<p>above residents to determine that the current orders have been appropriately documented on the Medication Administration Record (MAR), and that, in the event there are discrepancies, the physician has been notified and appropriate follow-up has occurred. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Nursing staff has been re-educated by the Health and Wellness Director/Designee on the appropriate process for transcription of physician orders onto the MAR. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Health and Wellness Director /Designee will audit daily for compliance with transcription of new orders onto the MAR. MAR audits will be conducted daily and documented on the change of shift report. · The Executive Director/AIT/ Designee will be notified of the results of the above audits and determine further corrective actions based on findings. · Audits will be discussed twice monthly during the Collaborative Care Meeting process (a Multi-disciplinary meeting) to review outcomes and compliance with the above</p>				

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	<p>the wrong dates of 10/16/11.</p> <p>This state residential tag relates to Complaint IN00100273.</p>		<p>procedures. This process will continue monthly in an ongoing manner, as part of existing Sterling House procedure. The community will utilize its existing Collaborative Care Meeting notes to document results of the audits.</p> <p>By what date will these systemic changes be implemented? · 1-6-12</p>				