

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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F000000	<p>This visit was for the investigation of Complaints IN00136857 and IN00136889.</p> <p>Complaint IN00136857: Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309, and F329.</p> <p>Complaint IN00136889: Substantiated. Federal/State deficiencies related to the allegations are cited at F226, F282, F333, and F428.</p> <p>Survey dates: October 7, 8, 9, and 10, 2013</p> <p>Facility number: 012305 Provider number: 155779 AIM number: 200987990</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Sandra Nolder, R.N.</p> <p>Census bed type: SNF--51 SNF/NF--10 Residential--52 Total--113</p>	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey (IN00136857 and IN00136889) on October 10, 2013. Please accept this plan of correction as the provider's credible allegation of compliance.	

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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	<p>Census payor type: Medicare--18 Medicaid--6 Other--89 Total--113</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on October 16, 2013.</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their Abuse Prevention policy/procedures, related to immediately notifying the Executive Director or designee of an allegation of verbal abuse, immediately suspending the staff member involved in the allegation, and providing inservicing for all staff following the allegation, in 1 of 2 examples reviewed for facility investigation of allegations of abuse.</p> <p>Findings include:</p> <p>At entrance on 10/7/13 at 10:30 A.M., the Executive Director and Director of Nursing were requested to provide the facility's Abuse Prevention Policy/Procedure, two to three examples of investigations the facility had completed for allegations of abuse, and any/all staff inservices on abuse that had been completed in the previous 12 months.</p> <p>On 10/7/13 at 11:00 A.M., the</p>	F000226	F 226 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: An investigation for the allegations of verbal abuse for Example 1 was completed by the Executive Director (E.D.) and Director of Health Services (DHS). Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). The Clinical Support Nurse will re-educate the Leadership Team on the campus guideline of Abuse and Neglect. 2). Then, the DHS or designee will re-educate the staff on the campus guideline of Abuse and Neglect. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: 1). The Clinical Support Nurse will re-educate the Leadership Team on the campus guideline of Abuse and Neglect. 2). Then, the DHS or designee will re-educate the staff on the campus guideline of Abuse and Neglect. How the corrective measures will be monitored to ensure the alleged deficient practice does not	11/05/2013	

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	<p>Executive Director provided a three page document titled "Abuse and Neglect Procedural Guidelines," and dated 11/2010. The policy/procedure included, but was not limited to, the following:</p> <p>"b. Training: i. Provide training for new employees through orientation and with ongoing training program... ii. Documentation of training of Trilogy employees will be maintained with inservice records in the campus...</p> <p>d. Identification: ii. Any person with knowledge or suspicion of suspected violations shall report immediately... iii. The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee.</p> <p>e. Protection: i Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to, the following: ...iv. Suspend suspected employee(s) pending outcome of investigation...."</p>		<p>recur: The following interviews for 5 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Abuse and Neglect Procedural Guideline The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation</p>		

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	<p>During the daily conference on 10/8/13 at 3:55 P.M., the Executive Director and Director of Nursing were again requested to provide examples of investigations of allegations of abuse, and any staff inservicing completed associated with the allegations.</p> <p>On 10/9/12 at 9:30 A.M. , the Director of Nursing provided 2 examples of facility investigations into allegations of abuse.</p> <p>One report indicated an incident of alleged verbal abuse occurred on 4/21/13 about 5:30 P.M. The "Brief Description" of the incident, which occurred on the Legacy/Alzheimer's unit, indicated "Family member reported on April 22, 2013 around 6 PM that [LPN staff member's name] was rude to [resident's name] at dinner on Sunday evening."</p> <p>In an interview on 10/7/13 at 1:35 P.M., the family member indicated she had actually reported the incident the evening it happened, Sunday, 4/21/13; that other nursing staff were present when the incident happened; and that the LPN who was involved worked the next evening.</p>			

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	<p>A statement, taken from another staff person who was present at the time of the incident, indicated the LPN had told the resident "You're ugly" in a sarcastic manner. A statement from a second family member who was present indicated the LPN had told the resident "Shut up, [resident's first name]. We don't like you. Nobody likes you. Why don't you just go to your room."</p> <p>A type-written statement, signed by the LPN involved and dated 4/24/13, indicated ".... On Monday, April 22, 2013 when i arrived to work for my shift beginning at 3 pm, i was pulled into office by my supervisor [name of supervisor] who informed me I received a complaint from [name of family member], that I verbally abused previously mentioned resident. This was not the case, my supervisor then dismissed me from the office to finish the remainder of my shift which ended at 11pm that night. On Tuesday April 23 2013, I received a call from [name of supervisor] stating I am not to come to work pending investigation with no further information." (sic)</p> <p>In an interview on 10/9/13 at 11:07 A.M., the Director of Nursing indicated the incident was not</p>						

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	<p>reported to him until the next day. He indicated the LPN involved was not suspended immediately. Both the LPN and the Supervisor were terminated. The Director of Nursing indicated a staff inservice on abuse had been done following this incident.</p> <p>During the daily conference on 10/9/13 at 3:45 P.M., the Area Director of Health Services and the Assistant Director of Nursing were given the opportunity to submit any abuse prevention inservices completed in the previous 12 months, including any inservices completed following the incident in April.</p> <p>On 10/10/13, the Director of Nursing provided documentation of Abuse Prevention training provided to 6 of 8 new employees, who were hired in March, May, June, July, and September, 2013, and who were randomly selected for review of new hire abuse training.</p> <p>At the final exit on 10/10/13 at 12:30 P.M., other Abuse Prevention inservices were not provided for review.</p> <p>This Federal tag relates to Complaint IN00136889</p>			

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	3.1-28(a) 3.1-28(c)			

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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> <p>Based on interview and record review, the facility failed to follow physician orders related to Accu-checks (a finger stick blood sugar test) and the administration of an eye medication for 2 residents in a sample of 6 residents reviewed for physician orders . (Resident # E and #G)</p> <p>Findings include:</p> <p>1. The record for Resident #G was reviewed on 10/7/13 at 3:09 P.M. Diagnoses included, but were not limited to, diabetes mellitus type 2.</p> <p>The resident was admitted to the hospital on 8/17/13 with a diagnosis of chronic obstructive pulmonary disease exacerbation. The resident was discharged from the hospital and returned to the facility on 8/20/13 with the diagnosis of pneumonia.</p> <p>The record indicated the resident had a readmission order for Accu-checks. The physician order indicated the Accu-checks were to be monitored</p>	F000282	<p>F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident #E: Review of MAR (Medication Administration Record). Accu-checks have been completed and documented as ordered for past 7 days. 2). Resident #G: The order for Travatan Z eye drop medication was clarified to read one witness to initial. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). DHS or designee will review all residents with Accu-check and eye medication orders to ensure MD orders are being followed. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Accu-Checks 2). Medication Administration - General How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or</p>	11/05/2013			

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	<p>four times daily and to call the doctor for blood sugars greater than 350 or if two consecutive blood sugars greater than 300.</p> <p>The following dates and times the Accu-checks were not found documented on the resident's record.</p> <p>8/26/13 at 11:00 A.M. 8/27/13 at 8:00 P.M. 8/28/13 at 11:00 A.M. 8/31/13 at 4:00 P.M. 8/31/13 at 8:00 P.M.</p> <p>9/1/13 at 6:00 A.M. 9/1/13 at 11:00 A.M. 9/1/13 at 4:00 P.M. 9/1/13 at 8:00 P.M. 9/4/13 at 8:00 P.M. 9/8/13 at 11:00 P.M. 9/9/13 at 11:00 P.M. 9/12/13 at 11:00 P.M. 9/14/13 at 6:00 A.M. 9/15/13 at 4:00 P.M. 9/15/13 at 8:00 P.M. 9/30/13 at 8:00 P.M.</p> <p>On 10/7/13 at 3:45 P.M., the missing Accu-check documentation was requested from the Director of Nursing (DON).</p> <p>During an interview on 10/7/13 at 3:45 P.M., the DON indicated the</p>				<p>designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review all residents with Accu-check and eye drop orders to ensure MD orders were followed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>Accu-check results are documented on the medication administration record (MAR). He indicated the Accu-checks were not documented on any other form of documentation.</p> <p>During an interview on 10/9/13 at 9:37 A.M., the DON indicated he could not provide any further documentation for the undocumented Accu-checks for August and September.</p> <p>An undated policy titled "Guidelines for Accu-checks" was provided on 10/9/13 at 11:30 A.M., by the DON and deemed to be current. The policy stated, "Purpose: To provide guidelines for performance of Accu-checks and glucometer maintenance. Procedure: 1. Accu-checks shall be completed for the resident per the physician order... 5. Results shall be recorded on the appropriate form with insulin administered per physician order...."</p> <p>2. The record for Resident #E was reviewed on 10/8/13 at 9:53 A.M. Diagnoses included, but were not limited to, senile dementia-Alzheimer's type with behavior disturbance and psychosis, depression, chronic kidney disease,</p>			

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	<p>incontinence, sleep apnea, and glaucoma.</p> <p>The physician order recap (recapitulation) sheet for October 2013, included an order for "Travatan Z [eye drop medication for glaucoma] .004%--Instill 1 drop into both eyes every bedtime. Administer in bed lying down with C-PAP on. *Have 2 witnesses sign*." The medication was scheduled to be given at bedtime. The original date of the order was March 27, 2012.</p> <p>The MAR (Medication Administration Record) sheets for April through August, 2013, listed this medication and had a box for the "Witness" to initial daily. The MARs had documentation of a "Witness" as follows:</p> <p>April, 2013--There were no initials the entire month.</p> <p>May, 2013--There were initials on 5/14/13, but no other days during the month.</p> <p>June, 2013--There were initials for 8 days during the month.</p> <p>July, 2013--There were initials for 4 days during the month.</p> <p>August, 2013--There were initials for 4 days during the month.</p>						

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	<p>The September MAR with the listing for the Travatan was not provided for review.</p> <p>In an interview on 10/9/13 at 9:20 A.M., the Director of Nursing indicated the instruction for the "Witness" must be an old instruction. He indicated any current directions would be located in the front of the MAR book. He indicated he was not aware a witness was required at this time, or had ever been.</p> <p>In an interview on 10/9/13 at 10:30 A.M., LPN #4 indicated any specific administration directions would be included with the order on the MAR sheet. She reviewed the MAR book at that time, and did not locate any other special instructions in the front. The LPN indicated that, as far as she knew, licensed nursing staff were supposed to have a witness when the eye drops were administered. She indicated she did so when she worked that shift.</p> <p>This Federal tag relates to Complaints IN00136857 and IN00136889.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=G	<p>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.</p> <p>Based on interview and record review, the facility failed to ensure respiratory assessments were completed for 1 resident who returned from the hospital for a respiratory condition; and failed to ensure that skin assessments, care and treatment of a known skin condition were provided for the same resident, which resulted in a severe fungal infection, and who was readmitted to the hospital for a urinary tract infection and a severe fungal infection of the perineal area and the buttocks. This impacted 1 of 6 residents reviewed for assessments and skin issues. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/8/13 at 9:50 A.M. Diagnoses included, but were not limited to, aspiration pneumonia, chronic urinary tract infections, chronic obstructive pulmonary disease and Alzheimer's disease.</p>	F000309	F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B has been discharged from the campus. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). All residents with a current respiratory infection will be reviewed to ensure respiratory assessments are complete. 2). All residents skin condition will be observed to ensure any areas of impairment have been identified and that assessment, care and treatments are in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Vital Signs 2). Skilled Nursing Assessment and Data Collection 3). Admission Nursing Assessment and Data Collection 4). Wound Care 5). Skin Impairment Circumstance and	11/05/2013			

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	<p>The admission physician orders included the following: 9/12/13--Duoneb nebulizer solution one vial every six hours as needed for wheezing. 9/12/13--Chopped soft diet, Nectar thick liquids. 9/12/13--Skilled charting upon admission every eight hours times three days then discontinue. 9/12/13--Weekly skin assessment every ____ (the blank was not filled in) based on resident preferred bathing schedule. Record: 0=No area skin impairment; 1= New area impairment; 2=Existing skin impairment (See wound sheets) 9/12/13--Levaquin 500 milligrams give one tablet by mouth daily times 10 days upon rising. 9/12/13--Keflex 250 milligrams give one capsule by mouth daily upon rising. Start on 9/23/13 when Levaquin treatment is complete.</p> <p>A. Acute care hospital progress notes, dated 9/9/13 through 9/12/13, indicated the resident was admitted to the hospital for pneumonia on 9/9/13 after a choking episode with loss of consciousness while eating, and which was resolved with the Heimlich maneuver. The notes indicated the resident was discharged on 9/12/13</p>		<p>Reassessment Form 6). Change of condition documentation / use of SBAR form How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). All new admits and current residents with respiratory infection will be reviewed to ensure respiratory assessments are being completed / documented. 2). All new admits skin condition will be observed by DHS or designee to ensure any areas of impairment have been identified and that assessment, care and treatment are in place and documented. 3). Observe 5 current residents per hallway to ensure any areas of skin impairment have been identified and that assessment, care and treatment are in place and documented. 4). Audit 5 residents per hallway with noted change in condition to ensure assessment has been documented. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>to the facility on antibiotics, a dysphagia diet, and thickened liquids.</p> <p>The facility document titled "Nursing Admission Assessment and Data Collection" was completed on 9/12/13 at 1:50 P.M. This document indicated there was a current infection present on admission, which was pneumonia. The respiratory portion indicated the resident's lung sounds were diminished bilaterally and she had a cough, and had a temperature of 99.1 Fahrenheit (F) when she was admitted to the facility.</p> <p>An assessment of the resident's lung sounds were not documented on the "Skilled Nursing Assessment and Data Collection" for 9/19/13.</p> <p>There were no temperatures found to monitor for infection on the following dates of 9/13/13 through 9/16/13, 9/20/13, and 9/21/13.</p> <p>There were no nurses notes with vital signs on 9/23/13 after 10:15 A.M., the day the resident was sent to the hospital for evaluation and treatment and admitted to the hospital.</p> <p>During an interview on 10/9/13 at 1:37 P.M., the DON indicated he could not find any vital signs for the</p>			

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	<p>dates of 9/13/13 through 9/16/13, 9/20/13, and 9/21/13 to indicate temperatures were monitored. He indicated he was unable to find where an assessment or vital signs were completed before the resident was discharged to the hospital.</p> <p>A policy titled "VITAL SIGNS GUIDELINES," with a revised date of 12/07, was provided on 10/10/13 at 11:58 A.M., by the DON and deemed current. The policy included the following: "PURPOSE: To document and track vital signs to monitor changes in condition of residents in relation to vital sign results. PROCEDURE: 1. Vital signs will be taken at the following times: a. Upon admission... c. Change in condition d. Following an incident or accident...h. To monitor infections..."</p> <p>B. A discharge summary from the hospital dated 9/12/13 indicated the resident's coccyx was pink with no skin breakage and a barrier cream had been used for protection of skin breakdown while the resident was admitted to the hospital.</p> <p>A facility document titled "Hospital Discharge Report," which did not have a signature from the nurse receiving the report or the date the</p>						

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	<p>report was taken from the hospital, indicated the nurse giving the report to the facility reported the resident had a skin issue, which was a red sacral area, and the treatment was barrier cream every shift and as needed.</p> <p>The facility document titled "Nursing Admission Assessment and Data Collection" was completed on 9/12/13 at 1:50 P.M. The skin assessment portion indicated the resident had bruises located in the following areas, one bruise to the right antecubital area, one bruise to the left posterior hand, and 4 bruises to the abdomen.</p> <p>A facility document titled, "CNA Bath/Shower Skin Check Sheet" completed on 9/13/13 indicated the resident was given a shower and the CNA circled the entire buttocks area on the diagram of the person on the sheet with an arrow from the buttocks area and stated, "Sore and pink, cream on bottom." This form was signed by the CNA, but there was no charge nurse signature.</p> <p>On 10/10/13 at 12:17 P.M., the Director of Nursing (DON) provided a document dated 10/10/13 titled, "CORP-CNA Skin Assessment Detail Report." The report indicated on</p>						

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	<p>9/13/13 at 11:18 A.M., the CNA had documented the resident had a new skin problem, it was on her bottom, the area was pink in color, and she did notify the nurse of the skin problem. The report indicated on 9/15/13 at 9:43 A.M., the CNA had documented the resident had a new skin problem, but did not explain the location. She indicated she did notify the nurse about the new skin problem.</p> <p>During an interview on 10/10/13 at 10:28 A.M., CNA #3 indicated on the resident's shower days, the CNA's would look for new skin issues and would document them on the shower sheets or would document no skin issues on the shower sheets. She indicated the nurses would visually inspect the resident's skin on the shower days, then they would sign their name on the shower sheets. She indicated if she found a new skin condition she would alert the nurse of the new skin issue and chart the skin condition in the kiosk (computer). She indicated the CNA's must document daily on the resident's skin to indicate if there is a new skin issue.</p> <p>A facility document titled "Skin Impairment Assessment," dated 9/22/13, indicated the resident had</p>						

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	<p>excoriation between her buttocks which was red in color and measured 5.0 x 3.0 centimeters. A pictograph on the document indicated an "X" mark on the area of the inner buttocks with a line and stated, "between buttocks." The physician was called and ordered antifungal powder for the excoriation.</p> <p>A facility document titled "Accident/Incident Report" dated 9/22/13 with time of occurrence at 11:00 A.M., indicated the resident had excoriation between buttocks that was red in color. The report indicated the measures taken to prevent this from happening again was the resident was cleaned and dried, the treatment was applied, and the staff was reminded to check resident's skin when toileting them and make nurses aware of any skin issues. The report indicated the resident was last toileted by the CNA at 10:00 A.M.</p> <p>A nurses note, dated 10/1/13 at 2:00 P.M., written as a late entry for 9/22/13, indicated the resident's skin was reddened around the labia folds, up to the pubis and up to the area around the anus.</p> <p>During an interview on 10/10/13 at 9:30 A.M., LPN #4, who wrote the late</p>						

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	<p>entry note, indicated she had assessed the resident's skin on the day she was sent to the hospital, and had applied the powder twice. She indicated her late entry should have been for 9/23/13, not 9/22/13.</p> <p>Facility documents titled "Skilled Nursing Assessment and Data Collection" were not found for the following dates of 9/13/13 through 9/16/13 and 9/20/13 through 9/23/13, this included any skin assessments.</p> <p>There were no skin assessments found on the facility document titled "Skilled Nursing Assessment and Data Collection" for 9/19/13.</p> <p>There were no nurses notes with assessments on 9/23/13 after 10:15 A.M., the day the resident was sent to the hospital for evaluation and treatment and admitted to the hospital.</p> <p>During an interview on 10/9/13 at 1:37 P.M., the DON indicated he could not find any facility documents titled "Skilled Nursing Assessments or Data Collection" for the following dates of 9/13/13 through 9/16/13 and 9/16/13 through 9/23/13 to indicate skin assessments were completed on these dates. He indicated he was</p>						

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	<p>unable to find where an assessment or vital signs were completed before the resident was discharged to the hospital.</p> <p>During an interview on 10/8/13 at 1:35 P.M., the Unit Manager of the Conner and Pioneer Units indicated she thought the resident was discharged to the hospital around supper time.</p> <p>On 10/10/13 at 8:54 A.M., the care Executive Director of Health Information Management of an acute hospital provided inpatient records for Resident #B. The admitting diagnosis on 9/23/13 was urinary tract infection.</p> <p>A hospital document titled "History" dated 9/23/13 at 5:59 P.M., indicated the resident's temperature in the emergency room was 99.3 F. The doctor had indicated her urine was infected and the resident's overall skin condition over the coccyx area was the reason for his decision to admit the resident to the hospital.</p> <p>A hospital document titled "History and Physical" dated 9/23/13 at 11:20 P.M., indicated the resident had intertrigo (skin chafing that occurs in or around skin folds. The irritation</p>				

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	<p>and trapped moisture results in secondary bacterial or fungal infections), and the doctor ordered an antifungal medication to treat the condition. He indicated she had skin breakdown in her perineal area.</p> <p>A hospital document titled "Wound Care Note" dated 9/24/13 at 3:02 P.M., indicated the initial consult was for a "sacral sore". The note indicated an extra thick antifungal would be ordered to the buttocks, medial thighs, and groin. The note indicated erythema (redness) was present related to moisture and shearing and it appeared fungal with satellite lesions. The note indicated a waffle mattress was applied to the bed and an antifungal medication was ordered.</p> <p>A undated facility policy titled "CLINICAL DOCUMENTATION SYSTEMS Skilled Nursing Assessment and Data Collection" was provided by on 10/9/13 at 11:30 A.M., by the DON and deemed current, stated: " PURPOSE: To complete and document a comprehensive assessment of the resident's current medical status and skilled nursing needs.. a. This form may be used for interim assessments for acute episodes, change in condition or</p>			
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	<p>episodic events... 4. The comprehensive head to toe assessment shall address each body system and skilled service. 5. The form shall be completed daily for each day the resident is receiving skilled services... 8. Staff not assigned to complete the assessment shall note on the back of the form any changes to the assessment and/or any pertinent information that occurs during their shift...."</p> <p>This Federal tag relates to Complaint IN00136857.</p> <p>3.1-37(a)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review the facility failed to ensure Accuchecks (a finger stick blood sugar test) were monitored for a resident with a physician order to monitor accuchecks, for 1 of 1 resident reviewed for accuchecks in a sample of 6. (Resident #G)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 10/7/13 at 3:09 P.M.</p>	F000329	F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident #G: Review of MAR (Medication Administration Record). Accu-checks have been completed / monitored / documented as ordered for past 7 days. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with Accu-check orders to ensure	11/05/2013

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	<p>Diagnoses included, but were not limited to, diabetes mellitus type 2.</p> <p>The resident was admitted to the hospital on 8/17/13 with a diagnosis of chronic obstructive pulmonary disease exacerbation. The resident was discharged from the hospital on 8/20/13 with the diagnosis of pneumonia.</p> <p>The record indicated the resident had a physician order for accuchecks when he was readmitted back to the facility on 8/20/13. The physician order indicated the Accuchecks were to be monitored four times daily, call the doctor for blood sugars greater than 350 or if two consecutive blood sugars greater than 300.</p> <p>Physician orders for October 2013 indicated an order for Levemir 12 units sub q (subcutaneous) injection at bedtime with on original date ordered of 9/10/13. The orders also indicated the resident was on Novolog 12 units sub q every morning at breakfast with an original date ordered of 8/27/13, Novolog 14 units sub q every day with lunch with an original date ordered of 8/27/13, and Novolog 14 units sub q every day with supper with an original date ordered of 8/27/13.</p>		<p>they have been completed / monitored / documented as ordered. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Accu-Checks 2). Medication Administration - General How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review all residents with Accu-check orders to ensure they have been completed / monitored / documented as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>The following dates and times the Accuchecks were not found documented on the resident's record:</p> <p>8/26/13 at 11:00 A.M. 8/27/13 at 8:00 P.M. 8/28/13 at 11:00 A.M. 8/31/13 at 4:00 P.M. 8/31/13 at 8:00 P.M.</p> <p>9/1/13 at 6:00 A.M. 9/1/13 at 11:00 A.M. 9/1/13 at 4:00 P.M. 9/1/13 at 8:00 P.M. 9/4/13 at 8:00 P.M. 9/8/13 at 11:00 P.M. 9/9/13 at 11:00 P.M. 9/12/13 at 11:00 P.M. 9/14/13 at 6:00 A.M. 9/15/13 at 4:00 P.M. 9/15/13 at 8:00 P.M. 9/30/13 at 8:00 P.M.</p> <p>On 10/7/13 at 3:45 P.M., the missing Accu-check documentation was requested from the Director of Nursing (DON) at this time.</p> <p>During an interview on 10/7/13 at 3:45 P.M., DON indicated the Accu-check results are documented on the medication administration record (MAR). He indicated the accuchecks were not documented on</p>						

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	<p>any other piece of documentation.</p> <p>During an interview on 10/9/13 at 9:37 A.M., the DON indicated he could not provide any further documentation for the undocumented accuchecks for August and September.</p> <p>A policy titled "Guidelines for Accuchecks" was provided on 10/9/13 at 11:30 A.M. by the DON. The policy stated, "Purpose: To provide guidelines for performance of accuchecks and glucometer maintenance. Procedure: 1. Accuchecks shall be completed for the resident per the physician order... 5. Results shall be recorded on the appropriate form with insulin administered per physician order...."</p> <p>This Federal tag relates to Complaint IN00136857.</p> <p>3.1-48(a)(3)</p>				

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F000333 SS=E	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure that 1 resident received all doses of a routinely ordered corticosteroid bronchodilator inhalation medication over a 4 month period, by ensuring the contents of the inhaler were not expired and/or exhausted. The facility also failed to ensure 1 resident did not receive more of a diuretic medication than ordered. This deficiency impacted 2 of 6 residents reviewed for medication usage. (Resident #E and Resident #D)</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 10/8/13 at 9:53 A.M. Diagnoses included, but were not limited to, senile dementia- -Alzheimer's type with behavior disturbance and psychosis, depression, remote history of tuberculosis, history of frequent bronchitis, and obstructive sleep apnea.</p> <p>The October, 2013 Physician order recap (recapitulation) form listed current orders which included, but</p>	F000333	<p>F 333 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident E: Inhaler is in supply and not expired and / or exhausted. It is being administered as ordered. 2). Resident D: Lasix is being administered as ordered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will complete the following: 1). Review of all inhalers to ensure the contents are not expired and / or exhausted. 2). Review all resident MARs (Medication Administration Record) to ensure medications are being administered as ordered. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: 1). DHS or designee will re-educate the Nursing Team on the following campus guidelines: Oral Inhalation Administration and Medication Administration - General 2). Clinical Support Nurse will educate the DHS (Director of Health Services) and ADHS (Assistant Director of Health Services) on the following</p>	11/05/2013			

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	<p>were not limited to, "Advair (a corticosteroid bronchodilator inhaler medication) 250/50 Diskus--give 1 puff by mouth twice a day. *Rinse mouth after use*." The medication was originally ordered on 4/10/13, and was scheduled to be administered "After rising" and "Evening."</p> <p>An entry on the facility's consultant pharmacy "Medication Regimen Review" sheet, dated 7/5/13, indicated "Exp [expired] med [medication]."</p> <p>A "Medication Error Circumstance, Assessment and Intervention" form, dated as "noted" on 9/18/13, indicated an error was discovered by the facility's Consultant Pharmacist during an audit on 9/14/13. The form indicated "Advair Diskus was expired on 8/20/13 and should have been empty on 8/20/13. New Diskus didn't arrive till 9/16/13."</p> <p>On 10/10/13 at 10:00 A.M., the Director of Nursing provided the individual consultant pharmacist review for Resident #E for 7/5 and 9/14/13.</p> <p>The consultant pharmacist review on 7/5/13 indicated "Advair inhalers</p>		<p>campus guideline: Consultant Pharmacist Report How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: 1). The following audits / observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: a). All inhaler medications to ensure the contents are not expired and / or exhausted. b). Review 5 resident MARs per hallway to ensure medications are being administered as ordered c). Medication Pass observation on 1 nurse, to include all 3 shifts.</p> <p>2). The following audits will be conducted by the Clinical Support Nurse 1 time per month times 6 months to ensure compliance: review of the monthly pharmacy review reports to ensure it has been reviewed by DHS or designee and action items have been followed up on. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>expire 30 days after the foil pouch is opened or when 60 inhalations are used, whichever comes first. This resident's Advair inhaler was opened on 5/22/13 and is now expired. Please discard current inhaler and reorder if not already reordered."</p> <p>In an interview on 10/10/13 at 10:00 A.M., the Director of Nursing indicated all consultant pharmacy review reports initially come to him. He indicated he does not review them, but passes them out to the Unit Managers. None of the Unit Managers had brought this one, related to Resident #E, to his attention. In a previous interview on 10/9/13 at 11:07 A.M., the Director of Nursing indicated the Unit Manager for the unit on which Resident #E resided had been terminated following an abuse issue in April, 2013. As of 10/9/13, the Assistant Director of Nursing was the acting interim Unit Manager. There had been a Unit Manager for about a month, several weeks ago, but she had transferred to a different area of the campus.</p> <p>The consultant pharmacist review on 9/14/13 indicated "Advair inhalers expire 30 days after the foil pouch is opened or when 60 inhalations are</p>				

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	<p>used, whichever comes first. This resident's Advair inhaler was opened on 7/20/13 and is now expired. Please discard current inhaler and reorder if not already reordered. There are NO puffs remaining. Assuming she received one puff two times daily as ordered, this ran out on 8/20/13. What has she gotten since then?"</p> <p>On 10/9/13, the Executive Director provided a four-page document titled "Prairie Lakes Health Campus Investigative Summary and Corrective Actions," dated 9/27/13. The document indicated "an investigation was initiated when the medication error was brought to leadership's attention."</p> <p>The investigative document included, but was not limited to, the following information:</p> <p>The pharmacy delivery dates of the Advair for Resident #E was April 10, May 21, July 8, and September 15, 2013. The Consultant Pharmacist tested the trigger lever on the container, and found the lever did not lock when all doses had been dispensed. The Pharmacist did note, however, that at doses 5 to 0 the number window would be red in color</p>						

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	<p>to trigger reordering the medications. The Pharmacist indicated this was noted in the medication package insert.</p> <p>"Total doses missed were calculated by month: April, 2013-September, 2013: * Medication began April 11. Medication expired or exhausted on May 11. Refill not received until May 21. Ten days, 20 doses not administered. * May/June, 2013: Doses from new container should have started on May 21. The medication would have exhausted or expired on June 21. Nine days, 18 doses missed for June; * July, 2013: Medication received on July 8 but not dated as opened until July 20 (see pharmacy consultative report). 38 doses, 19 days. A total of 56 doses missed from June 21 through July 20, 2013. *July 20/August/September, 2013: Medication would have exhausted or expired on August 20, 2013. new diskus not ordered until September 15 (pharmacy was closed as that was a Sunday, would have been received September 16-early AM 17. Unit Manager stated that she personally pulled the diskus box out of the tote and put it in the medication cart.) Total doses expired or exhausted</p>						

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	<p>(August 21-September 17): 56."</p> <p>Nursing and physician progress notes from June through September had occasional documentation the resident was not experiencing any shortness of breath.</p> <p>2. The record for Resident #D was reviewed on 10/7/13 at 3:30 P.M. Diagnoses included, but were not limited to, dementia, edema, venous insufficiency, and hypotensive heart disease.</p> <p>The September, 2013 Physician's order recap (recapitulation) sheet listed an order, dated 7/22/13, for Furosemide (Lasix--a diuretic medication) 20 mg. (milligrams) one by mouth on Monday-Wednesday-Friday.</p> <p>The July, 2013 MAR (Medication Administration Record) had this order listed, including the directions to administer the medication only on Monday, Wednesday and Friday.</p> <p>The licensed nurses administering medications had initialed in the box for each day, from 7/22 through 7/31, that the Furosemide had been given daily.</p>				

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	<p>During the daily conference on 10/8/13 at 3:55 P.M., the Director of Nursing was given the opportunity to clarify the administration of the medication on a daily basis, instead of on Monday, Wednesday and Friday.</p> <p>In an interview on 10/9/13 at 9:30 A.M., the Director of Nursing indicated that the nurses had, in fact, administered the Furosemide in error, and that it had been given daily for 10 days, instead of the 5 days it was supposed to be given.</p> <p>This Federal tag relates to Complaint IN00136889.</p> <p>3.1-25(b)(9)</p>			

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F000428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure irregularities reported by the facility's Consultant Pharmacist were acted upon, related to the periodic expiration/exhaustion of a routinely ordered corticosteroid bronchodilator inhalation medication over a 4 month period. This deficiency impacted 1 of 6 residents reviewed for medication usage. (Resident #E)</p> <p>Findings include:</p> <p>The record for Resident #E was reviewed on 10/8/13 at 9:53 A.M. Diagnoses included, but were not limited to, senile dementia-Alzheimer's type with behavior disturbance and psychosis, depression, remote history of tuberculosis, history of frequent bronchitis, and obstructive sleep apnea.</p> <p>The October, 2013 Physician order</p>	F000428	F 428 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The pharmacy review recommendations for October 2013 will be reviewed when it is received and any irregularities will be acted upon. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: 1). Clinical Support Nurse will educate the DHS (Director of Health Services) and ADHS (Assistant Director of Health Services) on the following campus guideline: Consultant Pharmacist Report How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: 1). The following audits will be conducted by the Clinical Support	11/05/2013			

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	<p>recap (recapitulation) form listed current orders which included, but were not limited to, "Advair (a corticosteroid bronchodilator inhaler medication) 250/50 Diskus--give 1 puff by mouth twice a day. *Rinse mouth after use*." The medication was originally ordered on 4/10/13, and was scheduled to be administered "After rising" and "Evening."</p> <p>An entry on the facility's consultant pharmacy "Medication Regimen Review" sheet, dated 7/5/13, indicated "Exp [expired] med [medication]."</p> <p>On 10/10/13 at 10:00 A.M., the Director of Nursing provided the individual consultant pharmacist review for Resident #E for 7/5/13.</p> <p>The consultant pharmacist review on 7/5/13 indicated "Advair inhalers expire 30 days after the foil pouch is opened or when 60 inhalations are used, whichever comes first. This resident's Advair inhaler was opened on 5/22/13 and is now expired. Please discard current inhaler and reorder if not already reordered."</p> <p>In an interview on 10/10/13 at 10:00 A.M., the Director of Nursing</p>		Nurse 1 time per month times 6 months to ensure compliance: review of the monthly pharmacy review reports to ensure it has been reviewed by DHS or designee and action items have been followed up on. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.				

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	<p>indicated all consultant pharmacy review reports initially come to him, but he does not review them. He passes them out to the Unit Managers. The Director of Nursing indicated none of the Unit Managers had brought this one, related to Resident #E, to his attention.</p> <p>In a previous interview on 10/9/13 at 11:07 A.M., the Director of Nursing indicated the Unit Manager for the unit on which Resident #E resided had been terminated following an abuse issue in April, 2013. As of 10/9/13, the Assistant Director of Nursing was the acting interim Unit Manager. There had been a Unit Manager for about a month, several weeks ago, but she had transferred to a different area of the campus. There was no licensed nurse Unit Manager on Resident E's unit from May through August, 2013.</p> <p>A "Medication Error Circumstance, Assessment and Intervention" form, dated as "noted" on 9/18/13, indicated an error was discovered by the facility's Consultant Pharmacist during an audit on 9/14/13. The form indicated "Advair Diskus was expired on 8/20/13 and should have been empty on 8/20/13. New Diskus didn't arrive till 9/16/13."</p>			

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	<p>The consultant pharmacist review on 9/14/13 indicated "Advair inhalers expire 30 days after the foil pouch is opened or when 60 inhalations are used, whichever comes first. This resident's Advair inhaler was opened on 7/20/13 and is now expired. Please discard current inhaler and reorder if not already reordered. There are NO puffs remaining. Assuming she received one puff two times daily as ordered, this ran out on 8/20/13. What has she gotten since then?"</p> <p>On 10/9/13, the Executive Director provided a four-page document titled "Prairie Lakes Health Campus Investigative Summary and Corrective Actions," dated 9/27/13. The document indicated "an investigation was initiated when the medication error was brought to leadership's attention."</p> <p>The investigative document included, but was not limited to, the following information:</p> <p>The pharmacy delivery dates of the Advair for Resident #E was April 10, May 21, July 8, and September 15, 2013. The Consultant Pharmacist tested the trigger lever on the</p>			

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	<p>container, and found the lever did not lock when all doses had been dispensed. The Pharmacist did note, however, that at doses 5 to 0 the number window would be red in color to trigger reordering the medications. The Pharmacist indicated this was noted in the medication package insert.</p> <p>"Total doses missed were calculated by month: April, 2013-September, 2013: * Medication began April 11. Medication expired or exhausted on May 11. Refill not received until May 21. Ten days, 20 doses not administered. * May/June, 2013: Doses from new container should have started on May 21. The medication would have exhausted or expired on June 21. Nine days, 18 doses missed for June; * July, 2013: Medication received on July 8 but not dated as opened until July 20 (see pharmacy consultative report). 38 doses, 19 days. A total of 56 doses missed from June 21 through July 20, 2013. * July 20/August/September, 2013: Medication would have exhausted or expired on August 20, 2013. new diskus not ordered until September 15 (pharmacy was closed as that was a Sunday, would have been received</p>						

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	<p>September 16-early AM 17. Unit Manager stated that she personally pulled the diskus box out of the tote and put it in the medication cart.) Total doses expired or exhausted (August 21-September 17): 56."</p> <p>This Federal tag relates to Complaint IN00136889.</p> <p>3.1-25(i)</p>			