

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2014
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: February 3, 4, 5, 6, and 7, 2014</p> <p>Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540</p> <p>Survey Team: Julie Wagoner, RN, TC (02/03, 02/04, 02/06, 02/07) Lora Swanson, RN (02/03, 02/04, 02/06, 02/07) Deb Kammeyer, RN Julie Ferguson, RN</p> <p>Census Bed Type: SNF/NF: 32 Total: 32</p> <p>Census Payor Type: Medicare: 02 Medicaid: 25 Other: 05 Total: 32</p> <p>These deficiencies also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality Reveiw completed on</p>	F000000	<p>This Plan of Correctionconstitutes the written allegation of compliance for the deficiencies cited.However, submission of this Plan of Correction is not an admission that adeficiency exists or that one was cited correctly. This Plan of Correction is submittedto meet requirements established by state and federal law. Hickory Creek at Peru desiresthis Plan of Correction to be considered the facility's Allegation ofCompliance. Compliance is effective on March7, 2014...</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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F000250 SS=D	<p>February 14, 2014, by Brenda Meredith, R.N.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>1. Based on interview and record review, the facility failed to ensure anxiety was addressed in the the behavioral management plan for 1 of 5 resident's reviewed for unnecessary medications. (Resident #34)</p> <p>2. Based on observation, interview and record review, the facility failed to maintain contact and receive quarterly updates regarding a specialized services-workshop at local program center for 1 of 1 resident's reviewed for Social Services. (Resident #2)</p> <p>Findings include:</p> <p>1. A. On 2/6/14 at 11:12 A.M., record review indicated Resident #34's diagnoses included but were not limited to "...dementia with delusions, dementia with behavioral disturbances, atypical psychosis,</p>	F000250	<p><b>F250</b> It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 1. What corrective action will be accomplished for residents affected? Resident#34's behavioral management plan has been updated to include anxious behavior.This behavioral management plan will list non-pharmalogical interventions to address the resident's anxiety. Resident#2's quarterly review is due February 2014. Social Service Director completed review on February 26, 2014. This review included all documentation received by the specialized service provider, which included monthly service updates from July 2013 to January 2014. 2. How will the facility identify o the residents having the potential to be affected by the same practice and what corrective action will be taken? An audit of all residents with an active psychiatric diagnosis has been completed to make sure</p>	03/07/2014
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	<p>depression, anxiety and atrial fibrillation...."</p> <p>The resident's medication regimen included the anti anxiety medication, Buspar 10 mg (milligrams) to be given three times a day, ordered on 11/2/13, and an anti psychotic medication, Zyprexa 2.5 mg to be given daily at bedtime for atypical psychosis, ordered on 11/2/13.</p> <p>A Behavior Monitoring Record, dated 5/21/13, indicated "...Behavior #1 Dementia with delusions. Interventions: A. Provide reassurance. B. Provide positive reinforcement. C. Contact my husband [name] to come. Behavior #2 Aggressive-physically. Interventions: A. Explain care procedure 1st. B. Give me some time to calm. C. Reapproach and explain what you want. Behavior #3 Elopement Risk. Interventions: A. Monitor my movement when talking about wanting to go home. B. Redirect me. There was no documentation any of the plans addressed the resident's anxiety issues.</p> <p>A Monthly Behavior Summary, dated October 2013, indicated "...Team discussed resident increased</p>		<p>that each resident has non-pharmalogical interventions included in their behavioral management plan. There have been no other residents identified as being affected. No further action needed at this time. We currently have 3 residents receiving specialized services within the facility. All 3 residents have been audited for timely reviews and quarterly reviews were scheduled as needed.</p> <p><u>3.What measures will be put into place to ensure this practice does not recur?</u> During our behavior management meeting held once monthly, the interdisciplinary team along with the SSD will review all behavior management plans as well as active psychiatric diagnosis to ensure that there are behavioral management plans in place for all active diagnosis and any other behaviors as applicable. During MDS quarterly review, the SSD will ensure that all quarterly updates regarding specialized services have been received to ensure continuity of care between Hickory Creek and the provider. If updates have not been received, the SSD will contact the specialized services provider to send the needed updates. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Findings from the initial audit of the behavior management plans</p>		

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	<p>anxious...resident at risk for physical injury d/t [due to] anxiousness, getting up, unsteady, not using call light...."</p> <p>A Monthly Behavior Summary, dated November 2013, indicated "...Recommendations: Recent order on 11/21/13 of Haldol [antipsychotic medication] one time for acute psychosis...."</p> <p>A Social Service note, dated 10/28/13, indicated "...Resident had order for Buspar 5 mg now one time dose...."</p> <p>A Social Service note, dated 10/29/13, indicated "...Resident's anxious behavior continues...Gets agitated at times with redirection...."</p> <p>A Social Service note, dated 11/1/13, indicated "...Resident's continued anxious behavior, tremors. Resident aware of changes and feels like a "mexican jumping bean"...Continue meds as ordered, psych services and behavioral management plan...."</p> <p>A Social Service note, dated 11/5/13, indicated "...Resident had med changes recently...order for Buspar for signs and symptoms of</p>		<p>will be reviewed by the Administrator and then forwarded to the QA&amp;A committee for further review at the next monthly meeting. Findings from the monthly behavioral management meeting will also be forwarded to the QA&amp;A committee monthly. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee. <b>Addendum:</b> The SSD will be required to complete an audit monthly to ensure all updates have been received by the service provider for those residents receiving specialized services. The audits will be discussed monthly at the QA&amp;A Committee for 6 months. The SSD will complete the audits on an ongoing basis indefinitely even when the QA&amp;A Committee members no longer require that audits be reported to the committee. <u>Date of compliance:</u> March7, 2014</p>				

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	<p>anxiety...."</p> <p>A nurse note, dated 10/28/13, indicated "...4:15 A.M. Resident in and out of bed numerous times, extremely restless and unable to sit still...Notified nurse practitioner of behavior...new order for a one time dose of Buspar 5 mg now...."</p> <p>A nurse note, dated 10/31/13, indicated "...5:30 A.M. Resident up and down, anxious and restless, started at 3:30 A.M. and continues...."</p> <p>A nurse note, dated 11/2/13, indicated "...1:30 A.M... Resident still anxious when up...."</p> <p>A nurse note, dated 11/2/13, indicated "...11:15 A.M. New order... Discontinue Buspar 5 mg TID [three times a day]. Start Buspar 10 mg TID...."</p> <p>A nurse note, dated 11/7/13, indicated "...12:10 A.M...No tremors noted but resident will shake her hands and arms when agitated. Resident states that she cannot lay still. Staff continuously in room r/t [related to] alarm going off...."</p> <p>A nurse note, dated 11/12/13,</p>						

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	<p>indicated "...12:20 A.M. Resident continues to be restless and anxious. Keeps getting out of bed and walking across room, when asked what she needed resident states "I don't know" and shakes her fists and stomps her feet...."</p> <p>A nurse note, dated 11/21/13, indicated "...8:30 A.M. Ask [sic] resident if she needs anything. Resident begins yelling, screaming, stomping feet and swinging arms around. Yells out 'so sick of this s---, I'm getting the h--- out of here and going home'...When told to please sit down, resident begins yelling again 'Sit down, sit down, sit down. That's all you people ever say. I'm sick of this s---'....Got order for Haldol (anti psychotic) 0.5 mg. Give 1/2 (half) tab 0.25 mg now for acute psychosis wait 45 minutes. If no change administer other 1/2 tab 0.25 mg. First 1/2 tab 0.25 mg was administered at 6:30 A.M., after 45 minutes resident was still yelling at staff, being combative. While up in main dining room for breakfast got upset when asked repeatedly to sit down for fear she was going to flip over wheelchair therefore other 1/2 tab 0.25 mg was administered...."</p> <p>A behavior log, dated October 2013,</p>			

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	<p>indicated no documentation that any behaviors had occurred for the month of October 2013.</p> <p>A behavior log, dated November 2013, indicated on 11/8/13 at 3:00 A.M., resident keeps getting up and down every 2 seconds. No documentation was noted that any interventions were attempted or if they were successful or unsuccessful.</p> <p>On 2/6/14 at 1:00 P.M., review of a care plan, initiated on 10/28/13 and revised on 11/2/13, indicated the problem: I have a new order for Buspar for a diagnosis signs and symptoms of anxiety. Interventions included but were not limited to "...Meds as ordered. Monitor for any signs and symptoms of adverse side effects...Medication monitoring/pharmacy/psych reviews. Routine psych services. Routine Behavioral/Medication Meetings...." There were no interventions included in the plan for staff to utilize other than pharmacological interventions to address the resident's anxiety.</p> <p>A Care Plan, initiated on 11/5/13 and revised on 1/23/14, indicated the problem:...I am increasingly</p>						

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	<p>anxious...Interventions included but were not limited to "... Meds as ordered. Monitor for any signs and symptoms of adverse side effects, changes in mood and behaviors...."</p> <p>There were no interventions included in the plan for staff to utilize other than pharmacological interventions to address the resident's anxiety.</p> <p>On 2/7/14 at 9:30 A.M., an interview with CNA #3 indicated Resident #34 has not had any behaviors lately. CNA #3 indicated the resident did have behaviors when she was first admitted but was unable to recall what the behaviors were. CNA #3 further indicated if the resident did have any behaviors she would document them in the behavior log book and notify the Social Service Director.</p> <p>On 2/7/14 at 1:05 P.M., an interview with the Social Service Director indicated the Behavioral Management Team would decide as a team if a behavior needed to be added to the Behavioral Management Plan. The Social Service Director further indicated she was unsure why the anxiety behavior had not been added to the Behavior Management Plan.</p>						

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	<p>On 2/7/14 at 1:20 P.M., review of the current policy titled "Behavior Management &amp; Monitoring Program" received from the Director of Nursing indicated "...It is the policy of this facility that residents who exhibit negative behavior problems will be included in the behavior management and monitoring program...the following residents will be included in the behavior monitoring system: anyone receiving an Anxiolytic...medication that is used to manage behavior, stabilize mood, or treat a psychiatric disorder...Anyone receiving an antipsychotic medication used for the following conditions/diagnoses...delusional disorder...atypical psychosis...4. A behavior management plan, which will be part of the Interdisciplinary care plan, will be developed. The behavior management plan will specify the problem (behavioral symptom), goal, and individual approaches...5. The interventions that guide the staff on how to deal with a problem behavior when it occurs will be found on the Behavior Monitoring Record. The Behavior Log form will be used to document each observed episode of the targeted behavior. It will record the</p>			

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	<p>following information: date, time, behavior, precipitating events, staff interventions, and outcome...."</p> <p>2. A. On 2-4-14 at 8:25 A.M. Resident #2 was observed sitting in a wheelchair with his coat on. The staff indicated the resident was ready to leave the facility to attend a local program center.</p> <p>The clinical record for Resident # 2 was reviewed on 2-4-14 at 4:00 P.M. The diagnoses included, but were not limited to: Cerebral palsy, seizure disorder, mental retardation, cerebral degeneration manifested in childhood, and depression.</p> <p>On 2-4-14 at 4:05 P.M., a form titled "Review Pre-admission Screening/Annual Resident Review Certification" dated 1-31-13, indicated the resident required specialized services for the developmental disability and services will be provided by a local program center.</p> <p>On 2-3-14 at 4:07 P.M., a review of resident's careplan indicated the resident enjoys going to work each AM M-F (Monday thru Friday) at the local program center. Interventions included, but were not limited to:</p>			

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	<p>resident enjoys going to work study M-F at local program center, make sure he is ready to go.</p> <p>On 2-4-13 at 4:10 P.M., a review of the Activity note, dated 11-25-13, indicated the resident went to program center 5 days a week.</p> <p>On 2-4-14 at 4:12 P.M., review of most recent program communication form, titled " Waiver Participant Status Monthly Summary," dated June 2013, indicated the resident had no reported absences the month of June and attended 3 outings and had no reportable incidences.</p> <p>During an interview, on 2-4-14 at 4:15 P.M, . the Social Service Director indicated the program center was behind on sending their updates/reports. She confirmed that the last monthly summary in the chart was dated 6/2013.</p> <p>On 2-4-14 at 4:25 P.M., a review of the program's monthly and quarterly summaries, faxed to Social Service Director on 02-4-14, indicated the last quarterly reviews were completed in August and November of 2013.</p>			

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F000282 SS=D	<p>During an interview, on 2-7-13 at 11:25 A.M., Social Service Director indicated she kept updated with resident's progress at program center thru their Summary Reports. When asked how she did that without updated summaries, she didn't have an answer.</p> <p>3.1-34(a)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 record review and interview, the facility failed to ensure the care plan was followed in regards to the assessment and effectiveness of prn (as needed) medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Findings include:  Resident #18's clinical record was</p>	F000282	F282 It is the policy of this facility that services will be provided by qualified persons in accordance with each resident's written plan of care. 1. What corrective action will be accomplished for residents affected? Resident #18 suffered no adverse reactions in regards to the assessment and effectiveness of PRN medications. Resident #18's PRN Tylenol for pain order was clarified to read "Tylenol 325mg 2 tablets PO every 4 hours as needed for pain or temperature	03/07/2014

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	<p>reviewed on 02/06/14 at 10:54 AM. Resident's diagnoses included, but were not limited to, hypertension, cerebral vascular disease, insulin dependent diabetes mellitus-poor controlled, anxiety, congestive heart failure, depression, and coronary artery disease.</p> <p>A physician's order, originally dated 05/18/11, was Siltussin SA SYP (syrup) 100/5 ML (Milliter)(cough syrup), take 10 MLS (milliliters) by mouth every 4 hours as needed cough. A physician's order, originally dated 05/18/11, was MAPAP (acetaminophen) (pain analgesic) 325 mg (milligrams) tab, take 2 tablets (650 mg) by mouth every 4 hours as needed fever/pain.</p> <p>The December 2013 MAR (Medication Administration Record) indicated the following : MAPAP 650 MG was given on 12/6 at 3:40 PM. The "PAIN MANAGEMENT FLOWSHEET" indicated pain rating of "7" in a scale of 1 to 10 with 10 as "worst possible pain." The "Staff Assessment for Pain" was nonverbal sounds and indicated the resident was holding his head in his hands. The "Alternative Tx (treatments)" indicated cough medications, Z-Pack (Antibiotic medication) and</p>		<p>greater than 101. If administered for pain assess for effectiveness 30 minutes post dose." A care plan was developed for Resident #18's cough syrup and effectiveness to be addressed one hour post dose. Resident #18's PRN Siltussin SA SYP 100/5 ML, take 10 MLS by mouth every 4 hours as needed for cough, assess one hour post dose." The nurses were in-serviced on the follow up needed after administering a PRN medication and the documentation needed to show the assessment of the resident's condition and any other action taken. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? An audit of all residents' careplans for PRNs was completed by the Director of Nursing and designee. All applicable residents with timed goals were added to the PRN orders on the Residents' MARs. 3. What measures will be put into place to ensure this practice does not recur? The Director of Nursing and/or designee will randomly audit 5 records 3 times a week for documentation of effectiveness of PRN medication. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON audit will be reviewed by the</p>		

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	<p>rest. This same record indicated no pain rating after intervention.</p> <p>Silitussin 10 MLS was given on the following dates and times: 12/5/13 at 3:30 AM, 12/5/13 at 11:30 AM, 12/5/13 at 8 PM, 12/6/13 at 3:30 PM, 12/8/13 at 8 PM and 12/19/13 at 4 PM. The December 2013 MAR record indicated no reason for PRN cough syrup and no results on the effectiveness of medication.</p> <p>During interview with DoN (Director of Nursing) on 04/07/14 at 4:00 PM, the DoN indicated when giving PRN pain medication, the resident should be assessed for reason and the effectiveness of the medication whether given for verbal or non-verbal reasons. She indicated no flowsheets were used for cough syrup.</p> <p>The resident's "INTERDISCIPLINARY CARE PLAN" was as follows:</p> <p>The problem was complaint (c/o) of "bottom" pain and muscle pain, originally dated 04/28/11, rewritten 06/10/13 and last updated 12/2013. The goal was to verbalize pain relief within thirty minutes post intervention. The interventions</p>		<p>Administrator and then forwarded to the QA&amp;A committee for further review. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee.</p> <p><b>Addendum:</b> All Tylenol orders for temperature will be clarified "Tylenol 325mg 2 tablets PO every 4 hours as needed for temperature greater than 101, not to exceed 3 gm/day. Assess for effectiveness 30 minutes to an hour post dose." Date of compliance: March 7, 2014</p>		

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	<p>included, but were not limited to, muscle rub creams as ordered, offer me repositioning, prn Tylenol (pain medication) as ordered, document pain and interventions on pain flowsheet, offer me periods of rest throughout day, and Ultram (pain analgesic) as ordered.</p> <p>The problem was occasional c/o "headache" and "leg pain," originally dated 6/28/11, rewritten 6/10/13 and was last updated 12/13. The goal was to remain free from adverse effects related to headaches, and the pain would be effectively controlled through interventions. The interventions included, but were not limited to, assessing my pain, document my pain and interventions, prn pain meds as ordered, meds (medications) as ordered for stroke prevention, and observe me for symptoms of TIA/CVA (Transient Ischemic Attack/Cerebral Vascular Accident) and report to my Doctor if observed.</p> <p>3.1-35(g)(2)</p>				

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F000329 SS=E	<p>483.25(I) 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.</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 observation, record review, and interviews, the facility failed to ensure there was an adequate indication for an increase in a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #11) In addition, the facility failed to ensure there was adequate monitoring of medication symptoms to support the use of a psychotropic medication for 3 of 5 residents reviewed for unnecessary</p>	F000329	F329It is the policy of this facility to ensure thatresident's drug regimen must be free from unnecessary drugs. 1. What correctiveaction will be accomplished for residents affected?Thefacility held a comprehensive behavior committee meeting on 2/14/2014 to reviewall residents who are receiving psychotropic medications. ForResident #11, her Seroquel was reduced to 50 mg BID on February 27, 2014.Clarification for her Seroquel was obtained and noted	03/07/2014

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	<p>medications (Resident #11, #41 and #34) and failed to monitor for the desired effects of cold medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #18)</p> <p>Findings includes:</p> <p>1. Resident #11 was observed on 02/06/14 at 9:00 A.M. lying in her bed asleep with the privacy curtain pulled around her bed.</p> <p>On 02/06/14 at 2:22 P.M., Resident #11 was observed lying in her bed, awake, mumbling to herself.</p> <p>The clinical record for Resident #11 was reviewed on 02/06/14 at 2:45 P.M. Resident #11 was admitted to the facility on 01/25/10 with diagnoses, including but not limited to, anemia, mental disorder, urinary tract infection, hypertension, hypocalcemia, pyelonephritis, delirium, anxiety, OCD (obsessive compulsive disorder), dementia with agitation, depression, vitamin D deficiency, and s/p (status post) fractured left ulna.</p> <p>On 02/06/14 at 3:10 P.M., Resident #11 was observed still lying in her bed asleep, but she was not talking</p>		<p>to be atypical psychosis. ForResident #41, his Risperidone was reduced to 0.5 mg TID on February 22, 2014. Clarification for Risperidone use was obtainedand noted to be atypical psychosis. ForResident #34, her Buspar was reduced to 10 mg BID and Zyprexa reduced to 2.5mgevery other night on February 19, 2014. ForResident #18, clarification was received for indication of PRN cough syrup. Resident#18's PRN Tylenol for pain order was clarified to read "Tylenol 325mg 2 tabletsPO every 4 hours as needed for pain or temperature greater than 101. Ifadministered for pain assess for effectiveness 30 minutes post dose." 2. How will the facility identify otherresidents having the potential to be affected by the same practice and what correctiveaction will be taken? Residentsreceiving psychoactive medications have the potential to be affected by thispractice. TheSocial Services Director is conducting a monthly Behavior Committee meetingcomprised of the interdisciplinary team members and the consultant pharmacist-the psychiatric nurse practitioner will attend as needed or requested. Allresidents on a behavior management program and all residents who are currentlytaking any type of psychoactive medication are reviewed. Recommendations forreductions are made by the</p>		

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	<p>anymore.</p> <p>Review of the current physician's orders for Resident #11 included the anitaxiety medication, Buspirone 10 mg one tablet twice a day for severe anxiety and 5 mg one and 1/2 tablets at bedtime. The orders also included the antipsychotic medication, Seroquel 25 mg three tablets at bedtime and 50 mg one tablet in the morning.</p> <p>Review of the physician's orders indicated the antipsychotic Seroquel was ordered originally on 09/20/12. The dose was Seroquel 50 mg by mouth in the morning and 50 mg 1 1/2 mg (75 mg) by mouth in the evening. On 04/05/13, a physician's order was written to decrease the evening dose to 50 mg and to continue the 50 mg morning dose. On 04/15/13, a physician's order was written to increase the evening dose of Seroquel back to 75 mg.</p> <p>Review of the April 2013 behavior log for Resident #11 indicated there was only one behavior documented for the month. The behavior, documented on 04/08/13 at 12:30 P.M., indicated the resident was complaining in the dining room about not getting drinks "like</p>		<p>team with the DON and/or Social Services Director following up accordingly and documenting that follow up in the residents' records. If clinically contraindicated letters are need, the DON and/or SocialService Director will follow up with the physician to make sure that the appropriate documentation is obtained. The interventions for behaviors on the logs and care plans are reviewed and revised as indicated by the team, with revisions to the CNA assignment sheets as needed. Follow up to all recommendations is reviewed at the next scheduled monthly Behavior Committee meeting. 3. What measures will be put into place to ensure this practice does not recur? New physician orders are reviewed during the morning IDT clinical meeting that occurs at least 5 days a week. At that time, the team will review any orders obtained for any reason, including psychoactive drug orders. If any questions or concerns are raised at that time regarding the order, the DON will follow up with the physician and clarify the issue. The behavior plan for these residents will also be reviewed at that time to make sure that the interventions are appropriate and in place. Care plans and CNA assignment sheets will be reviewed and revised at that time, as well. The DON and Social</p>		

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	<p>everybody else." In addition the resident had also displayed "irritation" and had refused to take a shower. The form indicated the facility's non-pharmalogical interventions had been successful.</p> <p>Review of the Nursing progress notes, from 04/05/13 - 04/17/13, indicated the resident had displayed the following behaviors: On 04/08/13, time not indicated, the resident had refused medications three different times. On 04/08/13 at 12:30 P.M. she was "slightly anxious" and had refused medications. On 04/08/13 at 3:10 P.M. she had brought clothing to the nurses station, slammed them down, and exclaimed they were not hers. The resident then went back to her room and displayed no further behaviors. On 04/09/13 at 10:15 A.M., the resident was tearful, confused, and was going to the doors looking for a ride. The resident was given redirection and she displayed no further behaviors. There were no further behaviors documented from 04/10/13 - 04/16/13. On 04/17/13 at 2:00 P.M. the resident was documented as being "very agitated, pacing the hallways and exit doors, and indicating she desired to leave and</p>		<p>Services Director have set up a system of tracing psychoactivedrug order changes for all residents who receive psychoactive medications. Theywill review this with the consultant pharmacist during her drug regimen reviewsand will use this as a guide during the Behavior Committee meetings to makesure that requests for drug reductions are occurring as required. 4. How will corrective action be monitored toensure the deficient practice does not recur and what QA will be put into place?The Social Services Director will report the results of the behavior committeereview, including the status of drug reductions to the monthly QA&amp;ACommittee meeting for further review and recommendations. Recommendations will be followed up by the Social Services Director who will report the results at the next Committeemeeting. This will continue on an ongoing basis.Date of compliance: March7, 2014</p>				

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	<p>was not a patient. The psychiatric nurse practitioner was called and an order to increase the Seroquel back to 75 mg in the evening and a one time order for the antianxiety medication, Vistaril was obtained. There was no indication any non-pharmalogical intervention was attempted prior to the order change for the Seroquel.</p> <p>Review of the behavior monitoring record for Resident #11 indicated she was to be monitored for: 1. "pacing halls, going to exits, trying to "go home" and asking "where's my checkbook, car, keys, or money?", 2. verbal aggression, 3. refusing care - to get up and dressed, showers, and to go to meals. Both plans for behaviors #1 and #2 indicated there were multiple interventions and both behaviors indicated "write down on paper to explain/assure me" were included. There was no documentation this intervention was attempted on 04/08/13 or 04/17/13. In addition, the interventions for the care refusal focused on showering and did not give specific interventions for medication refusals.</p> <p>Interview with the Director of Nursing, RN #10, on 02/07/14 at</p>				

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	<p>2:50 P.M., indicated the Seroquel was administered to Resident #11 to treat Dementia with Agitation and was originally initiated on 02/60/10. She indicated the Buspar, which is given for severe anxiety, was initiated originally on 01/27/10.</p> <p>Interview with CNA #11, indicated Resident #11 was usually pretty good (in regards to behavior issues) but occasionally she "gets in a rampage." CNA #11 indicated when that happened, she watched her but "backing off and giving her space" was the most successful intervention. CNA #11 indicated the more you try to approach and calm her down the more upset she would get. CNA #11 did not seem aware of specific behaviors for which she should be documenting and following interventions from the behavior plan.</p> <p>2. The clinical record for Resident #41 was reviewed on 02/04/14 at 2:00 P.M. Resident #41 was admitted to the facility, on 01/18/14, with diagnosis, including but not limited to, dementia with delusions, congestive heart failure, coronary artery disease, prostatitis, hypertension, history of urinary tract infections,, renal function</p>						

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	<p>deterioration, agitation, delusions, aggressive behaviors, depression, and increased confusion.</p> <p>The admitting physician's orders, dated 01/18/14, for Resident #41 included the antipsychotic medication, Risperidone 1 mg tid (three times a day) for dementia with delusions.</p> <p>The Behavior Monitoring Record and Logs for January and February 2014 indicated the resident was to be monitored for the behaviors of "delusions" and "yelling out hey." The behavior management plan did not indicate how Resident #41 displayed his "delusions." There were 3 behaviors documented for Resident #41 in January 2014. All three behaviors, documented by the Social Service Designee, Employee #12, indicated the resident had displayed behavior #1, delusions, but the description of the "precipitating event and location" indicated the resident was displaying behavior #2, yelling out hey." The interventions documented as successful indicated "yes" rather than the specific interventions attempted.</p> <p>Interview with CNA #13, on 02/06/14</p>				

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	<p>at 10:58 A.M, who was assigned to care for Resident #41, indicated the resident was usually cooperative with care, especially if he had rested well. She indicated if he was too tired, he would get "grouchy" and would grab and squeeze their arms. She indicated when he did this she asked him to let go and also sometimes had to pry his fingers off of her arm. When asked what specific behaviors she was expected to be monitoring for Resident #41 she indicated "standing unassisted." When asked if she ever charted things in the behavior book for residents she indicated "sometimes." When asked if she knew what behaviors forms were in the behavior book for Resident #41 she indicated she was not certain but could go look at the book. She indicated when she first started she had been given an assignment sheet with care needs but she did not carry one around anymore. She indicated she had worked at the facility for almost a month.</p> <p>Interview on 02/06/14 at 3:10 P.M. with CNA #14, indicated Resident #41 was not resistive to care and had no behaviors. She indicated it did take him a long time to get to a seated position because he was</p>			

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	<p>frightened of sitting. She indicated she was not aware of any behaviors for which Resident #41 was to be monitored.</p> <p>Although Resident #41 had been recently admitted with physician's order for antipsychotic medications and was supposed to be monitored for delusions and yelling "hey" it was determined staff were not aware of the delusional behavior and did not consistently document and monitor specific behaviors for Resident #41.</p> <p>3. The clinical record for Resident #34, conducted on 2/6/14 at 11:12 A.M., indicated the resident had diagnoses included but were not limited to "...dementia with delusions, dementia with behavioral disturbances, atypical psychosis, depression, anxiety and atrial fibrillation...."</p> <p>The resident's current medication regimen included the anti anxiety medication, Buspar 10 mg (milligrams) to be given three times a day, ordered on 11/2/13, an antidepressant medication, Remeron 7.5 mg to be given daily as an appetite stimulant, ordered on 10/28/13, and the antipsychotic medication, Zyprexa 2.5 mg to be</p>						

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	<p>given daily at bedtime for atypical psychosis, ordered on 11/2/13.</p> <p>A Behavior Monitoring Record, dated 5/21/13, indicated "...Behavior #1 Dementia with delusions. Interventions: A. Provide reassurance. B. Provide positive reinforcement. C. Contact my husband [name] to come. Behavior #2 Aggressive-physically. Interventions: A. Explain care procedure 1st. B. Give me some time to calm. C. Reapproach and explain what you want. Behavior #3 Elopement Risk. Interventions: A. Monitor my movement when talking about wanting to go home. B. Redirect me. There was no documentation regarding a behavior of anxiety on the Behavior Management Plan.</p> <p>A Monthly Behavior Summary, dated October 2013, indicated "...Team discussed resident increased anxious...resident at risk for physical injury d/t [due to] anxiousness, getting up, unsteady, not using call light...."</p> <p>A Monthly Behavior Summary, dated November 2013, indicated "...Recommendations: Recent order on 11/21/13 of Haldol [anti psychotic</p>						

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	<p>medication] one time for acute psychosis...."</p> <p>A Social Service note, dated 10/28/13, indicated "...Resident had order for Buspar 5 mg now one time dose...."</p> <p>A Social Service note, dated 10/29/13, indicated "...Resident's anxious behavior continues...Gets agitated at times with redirection...."</p> <p>A Social Service note, dated 11/1/13, indicated "...Resident's continued anxious behavior, tremors. Resident aware of changes and feels like a "mexican jumping bean"...Continue meds as ordered, psych services and behavioral management plan...."</p> <p>A Social Service note, dated 11/5/13, indicated "...Resident had med changes recently...order for Buspar for signs and symptoms of anxiety...."</p> <p>A nurse note, dated 10/28/13, indicated "...4:15 A.M. Resident in and out of bed numerous times, extremely restless and unable to sit still...Notified nurse practitioner of behavior...new order for a one time dose of Buspar 5 mg now...."</p>						

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	<p>A nurse note, dated 10/31/13, indicated "...5:30 A.M. Resident up and down, anxious and restless, started at 3:30 A.M. and continues...."</p> <p>A nurse note, dated 11/2/13, indicated "...1:30 A.M... Resident still anxious when up...."</p> <p>A nurse note, dated 11/2/13, indicated "...11:15 A.M. New order... Discontinue Buspar 5 mg TID [three times a day]. Start Buspar 10 mg TID...."</p> <p>A nurse note, dated 11/7/13, indicated "...12:10 A.M...No tremors noted but resident will shake her hands and arms when agitated. Resident states that she cannot lay still. Staff continuously in room r/t [related to] alarm going off...."</p> <p>A nurse note, dated 11/12/13, indicated "...12:20 A.M. Resident continues to be restless and anxious. Keeps getting out of bed and walking across room, when asked what she needed resident states "I don't know" and shakes her fists and stomps her feet...."</p> <p>A nurse note, dated 11/21/13,</p>			

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	<p>indicated "...8:30 A.M. Ask [sic] resident if she needs anything. Resident begins yelling, screaming, stomping feet and swinging arms around. Yells out 'so sick of this s---, I'm getting the h--- out of here and going home'...When told to please sit down, resident begins yelling again 'Sit down, sit down, sit down. That's all you people ever say. I'm sick of this s---'....Got order for Haldol (anti psychotic) 0.5 mg. Give 1/2 (half) tab 0.25 mg now for acute psychosis wait 45 minutes. If no change administer other 1/2 tab 0.25 mg. First 1/2 tab 0.25 mg was administered at 6:30 A.M., after 45 minutes resident was still yelling at staff, being combative. While up in main dining room for breakfast got upset when asked repeatedly to sit down for fear she was going to flip over wheelchair therefore other 1/2 tab 0.25 mg was administered...."</p> <p>A behavior log, dated October 2013, indicated no documentation that any behaviors had occurred for the month of October 2013.</p> <p>A behavior log, dated November 2013, indicated on 11/8/13 at 3:00 A.M., resident keeps getting up and down every 2 seconds. No documentation was noted that any</p>						

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	<p>interventions were attempted or if they were successful or unsuccessful.</p> <p>On 2/6/14 at 1:00 P.M., review of a care plan, initiated on 10/28/13 and revised on 11/2/13, indicated the problem: I have a new order for Buspar for a diagnosis signs and symptoms of anxiety. Interventions included but were not limited to "...Meds as ordered. Monitor for any signs and symptoms of adverse side effects...Medication monitoring/pharmacy/psych reviews. Routine psych services. Routine Behavioral/Medication Meetings...."</p> <p>A Care Plan, initiated on 11/5/13 and revised on 1/23/14, indicated the problem:...I am increasingly anxious...Interventions included but were not limited to "... Meds as ordered. Monitor for any signs and symptoms of adverse side effects, changes in mood and behaviors...."</p> <p>On 2/7/14 at 9:30 A.M., an interview with CNA #3 indicated, that Resident #34 has not had any behaviors lately. CNA #3 indicated that the resident did have behaviors when she was first admitted but was unable to recall what the behaviors were. CNA #3 further indicated that</p>			

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	<p>if the resident does have any behaviors she would document them in the behavior log book and notify the Social Service Director.</p> <p>On 2/7/14 at 1:05 P.M., an interview with the Social Service Director indicated that the Behavioral Management Team would decide as a team if a behavior needs to be added to the Behavioral Management Plan. The Social Service Director further indicated she was unsure why the anxiety behavior had not been added the the Behavior Management Plan.</p> <p>4. Resident #18's clinical record was reviewed on 02/06/14 at 10:54 AM. Residents's diagnoses included, but were not limited to, hypertension, cerebral vascular disease, insulin dependent diabetes mellitus-poor controlled, anxiety, congestive heart failure, depression, and coronary artery disease.</p> <p>A physician's order, originally dated 05/18/11, was Siltussin SA SYP (syrup) 100/5 ML (Milliter)(cough syrup), take 10 MLS (milliliters) by mouth every 4 hours as needed cough. A physician's order, originally dated 05/18/11, was MAPAP (acetaminophen) (pain analgesic) 325 mg (milligrams) tab,</p>			

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	<p>take 2 tablets (650 mg) by mouth every 4 hours as needed fever/pain.</p> <p>Review of the December 2013 MAR (Medication Administration Record) indicated the following : MAPAP 650 MG was on given 12/6 at 3:40 PM, prn (as needed). There was no indication of a pain rating after the intervention.</p> <p>Siltussin 10 MLS (Milliliters) was given on the following dates and times: 12/5/13 at 3:30 AM, 12/5/13 at 11:30 AM, 12/5/13 at 8 PM, 12/6/13 at 3:30 PM, 12/8/13 at 8 PM and 12/19/13 at 4 PM. The December 2013 MAR record indicated no reason for PRN cough syrup and no results on the effectiveness of medication.</p> <p>During interview with DoN (Director of Nursing) on 04/07/14 at 4:00 PM, the DoN indicated when giving PRN pain medication, the resident should be assessed for reason and the effectiveness of the medication whether given for verbal or non-verbal reasons. She indicated no flowsheets were used for cough syrup.</p> <p>The "Pain Assessment" policy was provided by the Administrator on 02/07/14 at 4:00 PM. This current</p>				

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	<p>policy indicated the following: "...GUIDELINES: ...The Pain Management Flowsheet will be used to document pain assessment, medication intervention, and evaluation of the resident's pain relief. ...Pain Management Flowsheet 1. Fill in the resident's name... 2. Assessment and Medication/Intervention: a. Record date and time in which pain was identified. Record location of pain immediately under the date &amp; (and) time, in that same column. ....3. Pain Relief Assessment: a. Record time and level of pain relief, according to the appropriate scale. b. Record any pertinent comments....."</p> <p>3.1-48(a)(6)</p>						

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure that kitchen equipment was clean and sanitary, related to dirty utensils, baking sheets and a dirty air vent. This had the potential to affect 32 of 32 resident's that receive meals from 1 of 1 kitchen. In addition, the facility failed to distribute and serve food under sanitary conditions related to handling of food and dishware. This had the potential to affect 28 of 28 resident's that receive meals in the dining room. (CNA #6)</p> <p>Findings include:</p> <p>1. On 2/3/14 at 6:20 P.M., during the initial kitchen tour with the Dietary Aide (Employee #1), the following was observed: the air vent above the milk cooler had dust hanging from the edges of the vent. A measuring scoop was observed lying in the sugar and flour containers. Three</p>	F000371	<p>F371Itis the policy of this facility to ensure that we store, prepare, distribute andserve food under sanitary conditions. 1. What corrective action will be accomplished forresidents affected?Noresidents were identified as being negatively affected by this practice. Theevent was cleaned and painted on February 6, 2014. Baking trays were ordered on February 6, 2014and were received February 13, 2014. 2.How will the facility identify other residents having the potential to beaffected by the same practice and what corrective action will be taken? Everyresident had the potential of being affected by this practice. All staffinserviced on March 4, 2014 and will bere-inserviced once a month for 90 days regarding the practice of distributingfood under sanitary conditions, including hand washing and use of alcohol basedsanitizer. All dietary staff will beinserviced on March 3, 2014 general sanitation as well as cleaning anddisinfecting utensils as well as proper storage of utensils. 3.What measures will</p>	03/07/2014	

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	<p>metal baking sheets had a brown crusty substance around all 4 edges of each sheet. Employee #1 opened a 3 drawer rubbermaid container and removed a plastic spatula, the spatula was observed to have a yellow dried substance on it. Employee #1 indicated the rubbermaid container should contain clean utensils.</p> <p>On 2/6/14 at 10:15 A.M., 3 metal baking sheets were noted to have a brown crusty substance around all 4 edges of each sheet. The Dietary Manager removed a ladle, a metal whisk and a spatula from a rubbermaid container, all 3 utensils had a dried substance on each one of them. The Dietary Manager indicated that they keep the clean utensils in this container.</p> <p>On 2/6/14 at 10:30 A.M., an interview with the Dietary Manager indicated the baking sheets were old and very hard to clean, and dietary staff covered the baking sheets with foil before they were used so that no food touches the metal. The Dietary Manager further indicated the utensils were to be rinsed off in the sink first to ensure all substances are removed before running them through the dishwasher. In addition,</p>		<p>be put into place to ensure that this practice does not recur? Department Managers will monitor meal tray distribution 2 times a day, 5 days a week for 90 days and record findings. If there are findings during a meal distribution, the Department Manager involved will intervene and counsel the necessary staff member at that time. Registered Dietician will observe one meal pass at least every two weeks to monitor compliance with distributing food under sanitary conditions. The kitchen will be audited for cleanliness 3 times a week for 90 days. This audit will include utensils, vents, baking sheets and other cookware cleanliness. 4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of the monitoring of tray distribution and kitchen cleanliness will be brought to daily stand up meeting to review. This information will be forwarded to the QA&amp;A committee and after 90 days, the decision will be made to continue the observation or discontinue if 100% compliance is obtained. Date of compliance: March 7, 2014</p>		

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	<p>the Dietary Manager indicated the air vents were to be cleaned by the maintenance department monthly, and the maintenance man was going to paint the air vent grill but just had not had a chance to do it.</p> <p>2. On 2/6/14 at 12:05 P.M., CNA #2 was observed in the dining room pouring juice into several glass drinking cups, and then touched the handle of the serving cart and the handle of the juice pitcher. CNA #2 did not wash her hands or use a hand sanitizer, and then was observed transporting 2 plastic drinking cups against her uniform. CNA #2 was then observed running her fingers around the inside of the plastic lids before placing them on top of the cups for a resident.</p> <p>On 2/6/14 at 12:15 P.M., an interview with CNA #2 indicated when she serves food she should not to touch the inside of the cups or plates, ice, drinks or food of the resident. CNA #2 further indicated she should use hand sanitizer between each tray and wash her hands after every 3rd tray is served.</p> <p>On 2/7/14 at 2:45 P.M., record review of the current policy titled "Dishwashing Procedures" received</p>			

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	<p>from the Dietary Manager indicated "...Proper sanitation of dishware and dishware equipment is essential to prevent the spread of illness from one resident to another. For dishes and storage equipment to be properly cleaned, dishes and equipment must be washed to remove visible dirt and sanitized to kill germs...5. After each meal, equipment must be washed and sanitized...."</p> <p>On 2/7/14 at 3:00 P.M., record review of the current policy titled "Handwashing/Alcohol Based Hand Rub" received from the Director of Nursing indicated "...Guidelines:...Before and after each resident contact...After touching a resident or handling his/her belongings...When to use Alcohol Based Hand Rub:...After contact with inanimate objects...."</p> <p>3. On 2-4-14 at 7:48 A.M. the Activity Director was observed holding toast with her bare hands to apply jelly to a piece of toast for Resident #6.</p> <p>4. On 2-4-14 at 7:52 A.M., CNA#23 was observed picking up Resident #41's toast with her bare hands to apply butter on it. CNA #23 was</p>			
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F000406 SS=D	<p>then observed going to another table to assist another resident with their meal and returned back to Resident #41 to assist him with eating. She did not sanitizer her hands between the residents.</p> <p>3.1-21 (i)(3)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, interview and record review, the facility failed to provide routine screening from a therapist (physical or occupational) in regards to a loose positioning device in 1 of 1 residents reviewed for Pre-admission Screening/Annual Resident Review (PASARR) in a</p>	F000406	F406It is the policy of this facility to providespecialized rehab services. 1. What correctiveaction will be accomplished for residents affected?Resident#2 has a new order for therapy evaluation and treatment for wheelchair sizingand positioning. Once that is completed,the facility will follow through as indicated to improve	03/07/2014	

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	<p>universe of 3. (Resident #2)</p> <p>Findings include:</p> <p>During an interview on 2-3-14 at 8:26 P.M., the DON indicate Resident #2 had been in facility since 1982. He had contracture's of neck and back with no Range of Motion (ROM) being provided at this time. She further indicated the resident had a harness on that attached to his wheelchair to keep him somewhat upright.</p> <p>On 2-4-14 at 9:46 A.M., Resident #2 was observed leaning to the right of his wheelchair while propelling himself with right arm on the wheel and using legs/feet. His positioning harness strap on the left side was down on upper left arm, instead of being positioned across the residents shoulders. The harness strap on the right side was tight and the left side was loose.</p> <p>During an interview on 2-4-14 at 10:00 A.M., Therapist #22 indicated she was aware of the resident's harness not fitting and lying loose on the resident's left arm. She further indicated at a recent Medicare meeting the situation was discussed and a vender had been contacted to</p>		<p>his wheelchairpositioning. Resident #2 continues to propel himself throughout the facilityindependently. 2.How will the facility identify other residents having the potential to beaffected by the same practice and what corrective action will be taken? Lead therapist reviewed or screened allresidents for appropriate positioning devices. No other residents were found to be effected by this practice. 3.What measures will be put into place to ensure that this practice does notrecur?Resident# 2 will be screened monthly and PRN by therapy indefinitely. All other residents will be screenedquarterly and PRN. All staff will beinserviced March 4, 2014 on the rehab communication form which would allow themto communicate concerns related to positioning. All screens will now be reviewed during weekly Medicare meeting by theInterdisciplinary Team. 4.How will the corrective action be monitored to ensure the deficient practicedoes not recur and what QA will be put into place?Therapistwill audit wheelchair positioning for the QA&amp;A monthly meetings for 90days. This information will be forwardedto the Administrator to be reviewed in the QA&amp;A committee and after 90days, the decision will be made to continue the observation or discontinue</p>				

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	<p>see if there was an attachment that could be added to the back of his wheelchair to aid in bringing the straps up into proper placement.</p> <p>On 2-4-14 at 10:10 A.M, a review of the therapy record for Resident #2 was completed. A form titled "Occupational Therapy (OT) Evaluation &amp; Plan of Treatment, " dated 7-15-13, indicated resident had lack of coordination and abnormal posture. Goal was to screen resident for powered vehicle operation with screening tool and to be fitted for appropriate w/c (wheelchair) or adaptations to be made to current w/c to improve position, increase safety and decrease risk of pneumonia due to poor positioning. Resident had exhibited significant R (right) lateral flexion of C-spine in the past, but had recently become more severe. C-spine was flexed 65 degrees laterally to R side. He was requiring extensive assist with ADL (activities of daily living) The Assessment Summary indicated resident had been fitted for a head support in the past to manage R lateral neck flexion and he would duck out of the head support. Resident was seated in 16' wide w/c with sling seat and harness to aid in positioning.</p>		if 100% compliance is obtained. Date of compliance: March 7, 2014		

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	<p>Bilateral supports in place. Staff reports that resident was bumping head on door frames due to decline in positioning. Risk factors: resident was at risk for pneumonia, skin tears and injury. Review of another form titled "Therapy Addendum, " dated 7-26-13, indicated Reedo (posture assessment tool) to be completed to further guide intervention for w/c positioning, resident's current w/c size appropriate but due to severity of R side lateral flexion unable to find proper support for head. Resident trial on power wheelchair and unable to use fine motor skills needed to use the device per Stephanie Physical therapist, and resident refused to allow PROM (passive range of motion) to neck due to pain when attempted. Reedco positioning score 35/100</p> <p>Review of another Rehabilitation Assessment - Quarterly, dated 8-21-13, indicated resident currently on caseload. Review of another Rehabilitation Assessment, dated 11-13-13, indicated no request for PT, OT or ST. The last Rehabilitation Assessment, dated 12-7-13, indicated a request for ST due to resident demonstrating a change in communicating needs and wants.</p>						

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	<p>The clinical record for Resident # 2 was reviewed on 2-4-14 at 4:00 P.M. The diagnoses included, but were not limited to: cerebral palsy, seizure disorder, mental retardation, cerebral degeneration manifested in childhood and depression.</p> <p>A review of the treatment records from July 2013 to present, stated "safety harness in wheelchair for positioning" FYI (for you information). Nurses were not documenting whether the harness was on or if the harness was in the correct position.</p> <p>On 2-5-14 at 10:30 A.M. a review of form titled "OBRA Annual Resident's Review Case Analysis" dated 10-11-13 indicated the following: Mobility: resident propels himself independently in his wheelchair and can move about the facility with purpose. He has impaired fine motor skills due to spasticity and contracture's in his upper extremities. Resident receives quarterly screenings for any PT/OT/ST needs. He received skilled OT services in the past year to work on bilateral upper extremity strength and improve posture, and for wheelchair positioning and</p>				

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	<p>management. His care plan goals included but were not limited to: continue to propel self in wheelchair; and continue to participate in his ADL's as he is able, he will be properly and comfortably positioned in his wheelchair with use of positioning device, ...and he will propel self in his wheelchair while leaning out to his right side daily. Recommendation included but were not limited to: may benefit from continued routine screenings for PT, OT, and ST for evaluations and treatment, may continue to benefit from evaluation and modification of his wheelchair and other adaptive equipment to maintain proper function and fit ..."</p> <p>On 2-5-14 at 2:45 P.M. resident was observed in hallway propelling self in his wheelchair with right arm and legs/feet. The positioning harness was loose on the resident's left upper arm.</p> <p>On 2-6-14 at 8:45 A.M. an observation of Resident #2 indicated harness was positioned loosely over left upper arm.</p> <p>During an interview on 2-6-14 at 1:45 P.M., the Social Service Director indicated she wasn't sure</p>			

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	<p>when his harness became loose but thought it was around a month ago and that physical therapy was trying to find a solution to the loose harness but wasn't aware of a PT or OT evaluation. She further indicated that other devices like a head rest was tried however the resident would get his head around it so that he could lean over the wheelchair and use right arm to propel and move wheel. The Social Service Director indicated resident and guardian were adamant regarding the resident being able to propel himself in the facility and any device, or harness that may prevent him from doing that will be declined/refused.</p> <p>On 2-6-14 at 3:30 P.M. a review of careplans indicated resident wore a harness while up in wheelchair. The interventions included but not limited to: apply harness while up in wheelchair, check periodically throughout day for proper placement of harness, observe for skin damage, replace harness as needed and quarterly and PRN (as needed) therapy screens. Another careplan indicated resident leaning to right when he was in wheelchair and that resident did not like the electric wheelchair during a trial.</p>						

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	<p>Interventions included but were not limited to: positioning device as ordered, follow OT w/c (wheelchair) positioning recommendations, quarterly OT assessments and prn, replace the positioning device prn and use positioning device per manufacturers recommendation. In addition a careplan indicating resident wanted to propel himself in w/c, he leans to right and wears a vest-type harness to improve his posture while in w/c. Interventions included but were not limited to: honor choice, keep w/c in good, working condition, assist resident with putting on the harness, and therapy to evaluate for w/c positioning.</p> <p>During an interview on 2-7-14 at 9:20 A.M., Therapist #22 indicated resident had received no assessment or evaluation regarding the positioning harness becoming loose and slipping down across the resident's left arm. She further indicated she hadn't done an evaluation because she was waiting to see if a device could be added to the wheelchair/harness to bring the strap up into the correct position. Therapist #22 could not give an approximate date to when the strap started sliding down the arm.</p>			
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	<p>During an interview on 2-7-14 at 9:30 CNA#23 indicated she assists Resident#2 with the positioning harness according to the instructions provided by Therapist #22. CNA #23 further indicated if straps are loose or there would be a problem with the harness she would contact Therapist #22. CNA #23 indicated that the left strap had become loose and therapist was aware. CNA #23 indicated that the straps are adjustable and can be tightened. CNA #23 was aware that the left strap was loose and slipped down over left arm, and indicated if she sees it slipping down she would readjust the strap for the resident, but lately strap just not staying up.</p> <p>3.1-23(a)(1)</p>						

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and</p>	F000431	F431It is the policy of this facility	03/07/2014	

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	<p>record review, the facility failed to store medications under proper temperature controls in the refrigerator and did not timely dispose of expired equipment in 1 of 1 medication rooms observed.</p> <p>Findings include:</p> <p>On 02/05/14 from 2:32 PM to 3:00 PM, the medication room was observed. The refrigerator's thermometer indicated 20 degrees Fahrenheit as read by the DoN. The refrigerator had 1 inch build up of ice on outside of freezer. Also, 2 boxes of "Dyna Lube" (lubrication ointment) expired on 02/2013, 12 "Easy Feed Linton Nutrition Bag" expired 08/01/2013, and 19 "Compat set" (enternal tube feeding tubes and connectors) expired 06/2013 was observed in this medication room. The DoN disposed expired items immediately. At this same time during an interview, DoN (Director of Nursing) indicated that the freezer was to be defrosted at the beginning of each month, and she also indicated there were no defrosting log sheets. Expired medications were to be destroyed or put on the counter top labeled "Do Not Use" and returned to the pharmacy by the night shift nurse. The DoN also</p>		<p>to store medications under proper temperature controls and timely dispose of expired equipment. 1. What corrective action will be accomplished for residents affected? No residents were identified as being negatively affected by this practice. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were identified as being affected by this practice. All items found to be expired were not currently being utilized by any residents for their care and were immediately disposed of. The freezer was defrosted on 2/5/2014 one evening shift. The thermometer will be permanently affixed to the 2nd shelf so that it is not located too closely to the freezer portion and will provide a more accurate temperature. The Director of Nursing will clean the supply room ensuring medications and supplies are stored properly and are not expired. The Director of Nursing will add the need to discard medications on the temperature log for the night shift nurse to sign off nightly. The Director of Nursing will audit this 5 times a week to assure compliance with medication disposal and temperature recording. 3. What measures will be put into place to ensure that this practice does not recur? Nursing staff was</p>		

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	<p>indicated any nurse may clean the medication room.</p> <p>On 02/06/14 at 9:58 AM, the refrigerator thermometer indicated 30 degrees Fahrenheit by RN #15.</p> <p>On 02/05/14 at 3:30 PM, the DoN provided the nursing policy and procedure for "Medications-Storage &amp; (and) Labeling," and indicated this document was current. This policy and procedure indicated the following: "...9. Drugs requiring storage in a "cool place" must be stored in a refrigerator designated for medications only and maintained between 35 degrees Fahrenheit and 45 degrees Fahrenheit. The medication refrigerator shall contain a functional thermometer designed for use in a refrigerator. The thermometer shall be checked on a daily basis and the temperature recorded on a log."</p> <p>The medication's room compact refrigerator user manual indicated for "Haier," this compact refrigerator, was to have the freezer defrosted when the freezer compartment became 1/8 inch thick with ice.</p> <p>3.1-25(m) 3.1-25(o)</p>		<p>inserviced on February 25, 2014 and again on March 4, 2014 regarding the refrigerator temperature recording and also notifying maintenance if the temperatures are not within the parameters of 35 to 45 degrees. The nurses were also instructed that the freezer/refrigerator is to be defrosted every Sunday night and PRN as needed for ice buildup of 1/8 inch or more. Nursing staff was also inserviced regarding the need to record the temperature on the temperature log and also the need to sign off nightly for medication disposal. The Director of Nursing and/or designee will conduct monthly cleanings of the medication room to verify that medications and supplies are stored properly and are not expired. 4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Director of Nursing and/or designee will review refrigerator temperatures 5 days a week to ensure completion, no ice build-up and proper functioning of the medication room freezer/refrigerator. The findings of her daily checks as well as her monthly cleanings of the medication room will be forwarded to the QA&amp;A committee and after 90 days, the decision will be made to continue the observation or discontinue if 100% compliance is obtained. Date of compliance:</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interviews, the facility failed to</p>	F000441	F441It is the policy of this facility to follow infectioncontrol	03/07/2014	

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	<p>ensure licensed and unlicensed nursing staff followed infection control procedures while providing care. (Employees #11, 15, 16, and 18) This potentially affected all 32 residents in the facility who received medications, food, and linens.</p> <p>Findings include:</p> <p>1. On 02/07/14 at 9:40 A.M., RN #15 had a wrapped pill on the counter at the nurses station and was observed blowing her nose. She then took the pill to the medication cart, unwrapped it and put it in a pill cup, poured a cup of water for the resident, and then took the pill into the resident without washing her hands. She also touched the resident's arm, back of her shoulder, and medication cart, her keys, and the outside of the medication drawer without washing her hands. The resident did not understand/cooperate with instructions to take the pill so she put the pill cup with pill in it back into the medication cart and checked the resident's oxygen saturation with an oximeter all without washing her hands. The resident then seemed to understand she needed to take a pill so the nurse then opened the medication cart and got the pill cup</p>		<p>procedures while providing care. 1. What corrective action will be accomplished for residents affected? No residents were identified as being negatively affected by this practice. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were identified as being affected by this practice. All staff inserviced on March 4, 2014 and will be re-inserviced once a month for 90 days regarding the policy and procedure for "hand-washing/alcohol-based hand rub" and "linen handling." Nursing staff will be inserviced on March 4, 2014 regarding the policy and procedure regarding Medication Administration as well as proper storage of thickening products. 3. What measures will be put into place to ensure that this practice does not recur? The DON or designee will observe a medication administration pass one time weekly for 90 days to ensure proper hand-washing/sanitation has been completed throughout the medication pass. The Administrator and/or DON will observe linen handling randomly at least five times a week. 4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of the observation</p>		

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	<p>back out and administered the medication to Resident #25. After she had administered the medication, the nurse did then wash her hands.</p> <p>2. On 02/06/14 at 11:55 A.M. CNA#16 was observed pushing Resident #41 down the hall in his wheelchair to the dining room. Resident #2 had returned from his day programming and CNA #16 stopped to assist him to take off his coat and she removed a wet clothing protector from the resident's neck and took it to the laundry room. She then, without washing her hands, went back and pushed Resident #41 the rest of the way to the dining room.</p> <p>3. 02/06/2014 at 2:20 P.M., CNA #11 was observed to have a large stack of clean linen- wash clothes, towels held against her scrub top while she pushed a soiled linen bin with her other arm in the hallway.</p> <p>4. An observation on 02/06/14 at 9:47 AM, Housekeeper #18 carrying clean tablecloths linens up against left side of body from left hip up to left side of neck.</p>		<p>of medication administration pass will be brought to the Administrator weekly to review. The results of the linen handling will be brought to the daily morning meeting. If there are any issues, staff will immediately be instructed on the linen handling or hand-washing procedures. This information will be forwarded to the QA&amp;A committee and after 90 days, the decision will be made to continue the observation or discontinue if 100% compliance achieved. Date of compliance: March 7, 2014</p>		

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	<p>5. An observation on 02/05/14 at 3:20 PM, in the medication cart, a bag of thickening powder for juice for medication pass, had 2 medication dosing cups inside of bag. RN #15 threw cups away in garbage.</p> <p>During an interview with the DoN (Director of Nursing) on 02/07/14 at 4:00 PM, the DoN indicated staff to wash hands after sneezing, resident to resident contact, and handling soiled items.</p> <p>On 02/07/14 at 4:00 PM, the Administrator provided the nursing policy and procedure for "Handwashing/Alcohol-Based Hand Rub," and indicated this document was current. This policy and procedure indicated the following: "PURPOSE: *Medical asepsis to control infection. *To reduce transmission of organisms from resident to resident. *To reduce transmission of organisms from nursing staff to resident. *To reduce transmission of organisms from resident to nursing staff.</p> <p>GUIDELINES:</p>			
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	<p>...After sneezing, coughing, or blowing you nose, when otherwise indicated to avoid transfer of microorganisms to other residents and environments...."</p> <p>Review of the facility policy and procedure, titled, Handwashing/Alcohol-based Hand Rub, dated 06/2004, and provided by the MDS nurse, RN #17, on 02/07/14 at 2:50 P.M., indicated the following guidelines: "...The absolute indications for and the ideal frequency of handwashing are not known. However, in the absence of a true emergency, personnel should always wash their hands (even when gloves are worn) As promptly and thoroughly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them, whether or not gloves are worn...after situation during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes,...after sneezing, coughing, or blowing your nose;; after touching your hair, face, etc;; before and after each resident contact;; after touching a resident or handling his/her belongings; before preparing food, ...."</p>						

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	<p>Review of the facility policy and procedure, titled, "linen Handling", dated 06/2004, and received on 04/07, and provided by the MDS nurse, RN #17, on 02/07/14 at 2:50 P.M., included the following procedures: "...3. Do not carry clean linen from room to room in armloads, or transport on chair or top of soiled linen hamper....9. Do not carry soiled linen close to your clothing. Hold soiled linen away from the body and do not carry large armloads...." There was no specific instructions indicating staff should not hold clean linens against their uniforms.</p> <p>3.1-18(l) 3.1-19(g)(1)</p>			