

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00147730.</p> <p>Survey dates: April 7, 8, 9, 10, 11, 14, 15, 16, and 17, 2014</p> <p>Facility number: 011149 Provider number: 155757 AIM number: 200829340</p> <p>Survey team: Patti Allen, SW-TC Marcy Smith, RN Dorothy Plummer, RN (April 7, 8, 9, 10, 15, 16, and 17, 2014) Karyn Homan, RN (April 7, 8, 9, 10, and 11, 2014)</p> <p>Census bed type: SNF: 16 SNF/NF: 115 Total: 131</p> <p>Census payor source: Medicare: 25 Medicaid: 74 Other: 32 Total: 131</p>	F000000	Rosegate Village respectfully requests desk review in lieu of an onsite visit. Rosegate Village also respectfully requests a face-to-face IDR to delete F280, to delete F312, to delete F314, and to reduce the scope of F323.	

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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F000280 SS=A	<p>These deficiencies reflect state findings cited in accordance with 410 I 16.2.</p> <p>Quality review completed on April 25, 2014; by Kimberly Perigo, RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to notify the resident's family of the date and time of the residents care plan team meeting, therefore denying them participation in</p>	F000280	Rosegate Village respectfully requests a face-to-face IDR to delete F280 because we disagree with the scope and severity.F-280-Right to participate planning care-revise CP What corrective	05/12/2014

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	<p>the care planning process.(Resident #146)</p> <p>Findings include:</p> <p>During interview on 4/14/14 at 12:45 p.m., Resident #146's daughter indicated she had not been notified of a care plan meeting since October of 2013.</p> <p>On 4/16/14 at 10:30 a.m., a review of the clinical record found that there was documentation of notification in October 2013 for care plan meeting in November 2013. The November 2013 care plan documentation indicated the family attended the meeting. Documentation of notification for the January 2014, care plan meeting was not found. The documentation on the January 2014, care plan attendance record indicated the family did not attend the January meeting.</p> <p>The Social Service Staff #1 was interviewed on 4/16 at 1:00 p.m. The staff provided documentation of an invitation mailing for the November 2013 care plan meeting, but indicated she could not provide notification of a care plan meeting for January 2014. The Social Service Staff #1 indicated the family did not attend the care plan meeting in January 2014. This was</p>		<p>action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #146 responsible party member was called and a meeting was held. Care Plan Invitation Postcard was mailed on 4-30-14 to the responsible party member to invite her to attend the resident's next care plan. Documentation that the Care Plan Invitation Postcard was mailed to the responsible party member was documented in our Electronic Medical Records System. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by this deficient practice. Facility Care Plan audit will be completed and all residents identified as not receiving a care plan invitation will be mailed a new Care Plan Invitation Postcard and documented in EMR. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Social Services will be required to document that they have mailed a Care Plan Invitation Postcard in our EMR and will also make a photo copy of the Care Plan Invitation Postcard and they will be kept on file. · Social Services will be in-serviced by the Director of</p>	

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F000282 SS=E	<p>unusual, as the family is very involved in the resident's care.</p> <p>3.1-35(c)(2)(C)</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. Based on observation, record review, and interview, the facility failed to ensure plans of care were followed for scheduled toileting to prevent falls (Resident #146), pressure ulcer treatment (Resident #136),</p>	F000282	<p>Nursing and/or designee by May 12, 2014 on the Care Plan Review Policy. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The Social Service Care Plans CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with Care Plan Invitation. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. Results of Audit tool will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. <p>F- 282-Services by Qualified Persons/Per Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	05/12/2014

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	<p>and medication monitoring (Residents #145 and #173) for 4 of 39 residents who met the criteria for review of care plans.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #136 was reviewed on 4/10/14 at 11:15 a.m. Diagnoses included, but were not limited to, fall with closed fracture upper end humerus (bone in the upper arm) and fracture of radius and ulnar (wrist), hypertension, congestive heart failure, and osteoarthritis.</p> <p>The admission assessment dated 1/31/14 indicated Resident #136 had bruises on the left arm and left eye lid. No wounds were documented. Admission physician's orders included a pressure reducing/redistributing cushion for the wheelchair and a pressure reducing/mattress for the bed.</p> <p>In the most recent 30 day Minimum Data Set (MDS) assessment dated 2/26/14, Resident #136 was assessed as needing extensive assistance of two staff members for bed mobility and transfers and was assessed as being at risk for the development of pressure ulcers. Resident #136 was assessed as having a BIMS (Brief Interview for Mental Status) of 13, indicating the resident was reasonably</p>		<p>practice? · Resident #136 no longer resides in the facility. · Resident #145 received a physician order to obtain International Normalized Ratio (INR) only and to discontinue orders for Prothrombin Time (PT). · Resident #173 will have heart rate his heart rate and blood glucose level checked and followed per physician orders. · Resident #146 had a new three day bowl and bladder assessment completed and care plan and resident profile updated to reflect new toileting schedule.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents that currently have pressure ulcers, have physician orders for PT/INRs, have blood glucose and heart rate monitoring have the potential to be affected by the alleged deficient practice.</p> <p>· ALL residents are on the scheduled toileting program have the potential to be affected by the alleged deficient practice. All residents on a toileting program, resident profile were reviewed by DNS and/or Designee to ensure residents are toileted per plan of care. · All residents who receive pressure ulcer treatment medical record was reviewed to ensure physician orders are followed. · All resident records were reviewed who received PT/INR. Accucheck, and who have</p>				

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	<p>independent in decision making. Resident #136 was assessed as having an unstageable pressure ulcer.</p> <p>A nursing progress note dated 2/17/14, at 11:30 a.m., indicated Resident #136 was assessed as having a new unstageable pressure ulcer on the coccyx (tailbone), measuring 1.0 cm (centimeters) (length) x 1.0 cm (width) x 0.1 cm (depth); tissue described as slough (dying tissue).</p> <p>A physician's order was obtained on 2/17/14, "Upgrade to Roho mattress [a type of pressure relieving mattress]." Treatment to coccyx wound, "Cleanse area w/NS, [with/normal saline] apply Santyl [a treatment used to remove dead tissue] to wound bed, calmo [calmoseptine an ointment used as a barrier] to peri wound, cover w/ dry dressing and Tegaderm. Change daily and PRN [as needed] soilage/dislodgement. Roho w/c [wheelchair] cushion."</p> <p>A Visit Report, electronically signed by a nurse practitioner (NP) specializing in wound care dated 2/21/14 at 10:11 a.m., indicated the wound to the coccyx was due to pressure. On the second page of the Visit Report, a section titled "Integumentary (Hair, Skin)..." indicated, "Wound #1 Coccyx is a Necrotic Tissue</p>		<p>physician orders to monitor heart rate prior to medications were reviewed by DNS and/or Designee to ensure physician orders were followed. · Care plans for all residents identified will be updated per plan of care and physician orders. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff in-service & auditing on medication administration guidelines, following physician orders and documentation, and accessing/following residents profile and care plans will be completed by the Director of Nursing and/or designee by May 12, 2014. · The DNS and/or Designee will conduct a daily audit by completing daily monitoring tool on every shift to ensure that residents are toileted per plan of care. · The DNS and/or Designee will complete the daily monitoring tool to ensure staffs are documenting PT/INR results per physician order and care plan. · The DNS and/or Designee will complete the daily monitoring tool to ensure staff are documenting Heart Rate prior to administering medication per physician order and care plan. · The DNS and/or Designee will complete the daily monitoring tool to ensure staff are documenting Accucheck per physician order and care plan. · The DNS and/or</p>	

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	<p>[dead tissue]...Initial wound encounter measurements 1.2 cm x 0.8 cm x 0.1 cm...Discussed plan with nurse at bedside: Yes..." On the third page of the Visit Report, "<u>Wound Orders</u>: Wound #1 Coccyx <u>Santyl</u> cleanse wound bed with NS. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel [a treatment used to maintain a moist wound environment] moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN, soiled...."</p> <p>A review of the recapitulation of physician's orders dated March 2014, failed to include the NP wound orders dated 2/21/14, and indicated Resident #136 was to receive Santyl and a dry dressing to the pressure ulcer on the coccyx. A review of the Medication Administration Record (MAR) for February 2014, indicated the treatment of Santyl and dry dressing was initialed as completed on 2/19, 2/20, 2/21, 2/24, 2/25, 2/26, and 2/28/14. The facility failed to document a treatment to the coccyx was completed as ordered on 2/17, 2/18, 2/22, 2/23, and 2/27/14. A review of the MAR for March 2014, indicated the treatment of Santyl and dry dressing was initialed as completed for 3/1/14 through 3/18/14. The facility failed to document a treatment was</p>		<p>Designee will complete pressure ulcer monitoring tool daily to ensure staff are documenting treatment completed per physician order and care plan.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · A CQI audit tool "following physician orders/ care plan/residents profile", will be utilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of Audit tool will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. · If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. 	

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	<p>completed as ordered for 3/19 and 3/20/14.</p> <p>A review of the IDT (Interdisciplinary Team) Notes and the Visit Notes from the NP specializing in wound care for visit dates 2/28/14, 3/7/14, 3/14/14, and 3/21/14, indicated the wound measurements to the coccyx were improving. The Visit Note dated 3/21/14, indicated the coccyx wound was now a Stage III, (an improvement in the tissue type in the wound), and had measurements 0.9 cm x 0.4 cm x 0.2 cm.</p> <p>A physician's order dated 3/21/14 indicated, "Clarification tx [treatment] to Coccyx: Cleanse area with N/S, pat dry, apply calmo to periwound apply Santyl to wound bed followed by hydrogel [a treatment used to provide a moist environment in necrotic wounds] moistened fluffed gauze then cover /c [with] dry dressing q [every] day & [and] PRN soilage."</p> <p>During an interview with RN #3 (registered nurse), the Rehabilitation Manager, and Nurse Consultant on 4/15/14 at 11:20 a.m., RN #3 indicated the wound team, consisting of nursing, rehabilitation, dietary, and the wound care NP make rounds each week to review current wounds. RN #3 indicated</p>			

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	<p>the wound team reviewed current treatments, supplements, equipment and any changes that were indicated during the rounding. RN #3 indicated the NP provided a copy of the Visit Report for the week to the facility when rounding was completed. RN #3 and the Nurse Consultant indicated the facility had 4 visits and rounding opportunities to reconcile the "Wound Orders" on the Visit Reports, Santyl and a wet dressing, with the physician's orders, Santyl and a dry dressing.</p> <p>2A. The clinical record of Resident #145 was reviewed on 4/10/14 at 2:38 p.m. Diagnoses included, but were not limited to, Parkinson's disease, depression, severe dysphasia (difficulty swallowing), dementia with delusions, and a history of pulmonary embolism (a blood clot in the lung).</p> <p>A recapitulation of physician's orders dated April 2014, indicated Resident #145 was to receive warfarin, a medication used to prevent blood clots, on a daily basis. The most recent order for warfarin was dated 4/8/14, and indicated Resident #145 was to receive "Coumadin (warfarin) 9 mg (milligrams) q [every] Tues-Thurs-Sat-Sun (Tuesday-Thursday-Saturday-Sunday); Coumadin 9.5 mg q Mon-Wed-Fri</p>			

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	<p>(Monday-Wednesday-Friday). A PT/INR [Prothrombin Time/International Normalized Ratio, a test used to monitor the effectiveness of warfarin], was also ordered to be checked every Tuesday. The origination date of the order to check PT/INR was 1/14/14, and indicated the test was to be completed by the facility.</p> <p>A review of "Coumadin/Warfarin INR Tracking Log" for Resident #145 for the months of January, February, March, and April 2014; indicated INR was completed as ordered. The tracking log lacked documentation of results of PT for the months of January, February, March, and April 2014.</p> <p>During an interview with the Director of Nursing (DoN) on 4/10/14 at 4:35 p.m., the DoN indicated the facility had the equipment required to complete PT/INR tests, and indicated the nursing staff had received education prior to implementing the use of the equipment.</p> <p>During an interview with RN #3 (registered nurse), DoN, and Nurse Consultant on 4/15/14, at 12:00 p.m., RN #3 indicated the facility used the "Coumadin/Warfarin INR Tracking Log" to document the results of PT/INR tests performed in the facility. RN #3 indicated the equipment utilized to</p>			

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	<p>complete the test was capable of testing PT and INR. The Nurse Consultant and RN #3 indicated the tracking logs for Resident #145 lacked documentation of PT results for the months of January, February, March, and April 2014.</p> <p>2B. The clinical record of Resident #173 was reviewed on 4/10/14 at 10:51 a.m. Diagnoses for the resident included, but were not limited to, high blood pressure, coronary artery disease, diabetes, and stroke.</p> <p>a. A physician's order, dated 2/4/14, indicated Resident #173 was to receive metoprolol (heart medication) 50 mg. (milligrams) daily. This medication was not supposed to be given to the resident if his heart rate measured less that 60 beats per minute.</p> <p>A care plan for Resident #173, dated 1/9/12 and current through 7/1/14, indicated problems of high blood pressure and coronary artery disease. Approaches included, administer medications as ordered.</p> <p>Medication administration records for February and March, 2014, for Resident #173, did not indicate his heart rate had been checked prior to giving him the metoprolol.</p>			

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	<p>During an interview with the Director of Nursing on 4/16/14 at 12:30 p.m., she indicated she was aware the resident's heart rate had not been checked as ordered in February and March.</p> <p>b. A physician's order, dated 1/30/14, indicated Resident #173 was to have accuchecks (a finger stick blood test to measure blood sugar) twice daily at 7:00 a.m. and 4:00 p.m. The resident also had orders for scheduled insulin to be given at breakfast, lunch, and bedtime and he had a sliding scale of insulin to be given depending on the results of his twice daily accuchecks.</p> <p>A care plan for Resident #173, dated 1/1/12, and current through 7/1/14, indicated a problem of the resident being at risk for adverse effects of high and low blood sugars. Approaches included monitoring blood sugars as ordered.</p> <p>Review of a Capillary Blood Glucose Monitoring Tool for March, 2014, indicated Resident #173's accucheck was not performed on the following dates: 3/10 at 7:00 a.m., 3/14 at 7:00 a.m., 3/16 at 7:00 a.m., 3/19 at 7:00 a.m., 3/20 at 7:00 a.m. and 4:00 p.m., 3/24 at 7:00 a.m., 3/27 at 7:00 a.m.</p> <p>The Director of Nursing was asked about</p>			

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	<p>the missing accuchecks in March on 4/16/14 at 12:30 p.m. No further information was provided by survey exit on 4/17/14 at 11:30 a.m.</p> <p>3. Resident #146's clinical record was reviewed on 4/16/14 at 10:30 a.m. Diagnoses included, but were not limited to, paralysis agitans, hypertension, osteoarthritis, spinal stenosis, mood disorder, periods of confusion due to dementia and Parkinson's, and history of prostate cancer. There was documentation the resident had fallen on the following dates: 11-2-13, 11-11-13, 11-14-13, 11-26-13, 12-22-13, 12-26-13, 1-15-14, 1-26-14, 3-9-14, 3-23-14, 3-24-14, 3-26-14, and IDT (Interdisciplinary Team) met to review falls.</p> <p>A review of the Resident Progress notes where IDT (Interdisciplinary Team) met to review falls was held on 1/17/14 at 10:20 a.m. Documentation of immediate intervention was to encourage the resident to use toilet every hour. The IDT team feels staff should toilet the resident every hour through the night from the hours of 10:00 p.m. to 6:00 a.m., IDT also feels at this time placing an alarming floor mat next to the bed. The documentation indicated that when</p>			

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	<p>IDT met on 3/10/14 and 3/24/14, staff should toilet resident every two hours during the day and every hour between the hours of 10:00 p.m. and 6:00 a.m..</p> <p>The 1/29/14 care plan indicated the follow problem: the Resident is at risk for falls. The risk is due to a history of past and recent falls and weakness. Diagnosis of Parkinson's disease, dementia, bowel and bladder incontinence, pain, the use of anti-depressants, and poor safety awareness makes him non compliant with asking for assistance. The approaches and goal were specific to the residents history of seizure disorder and required assistance for activities of daily living and transfers.</p> <p>"Goal: Resident will be free from injuries related to falls."</p> <p>Approach start Date: 04/10/2014 The staff to toilet resident every 2 hours from 6:00 a.m., to 10:00 p.m., wake up every 2 hours at night and offer to take resident to the bathroom.</p> <p>Family requested that Resident #146 toileting program be every hour. The toileting schedule has documentation which indicated, "resident physically needs to be gotten up between 2:00 a.m. and 3:00 a.m., to be taken to restroom."</p>			

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F000314 SS=D	<p>The toileting sheets were reviewed and documentation was not complete on the following days:</p> <p>2/6/14 12:00 a.m. - 4:00 a.m. blank (not toileted) 3/5/14 12:00 a.m. - 4:00 a.m. blank 3/17/14 1:00 a.m. - 6:00 a.m. blank 3/28/14 11:00 p.m. - 6:00 a.m. blank 3/31/14 6:00 a.m. - 11:00 p.m. blank 4/1/14 12:00 a.m. - 4:00 p.m. blank 4/5/14 12:00 a.m. - 6:00 a.m. blank 4/8/14 12:00 a.m. - 6:00 a.m. blank 4/9/14 8:00 a.m. -10:00 p.m. blank</p> <p>Social Service staff #1 was interviewed on 4/16/14 at 1:00 p.m., and indicated there was no other documentation besides the toileting sheets, that documented the resident being toileted.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>			

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	<p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician's orders were implemented to promote healing of an unstageable pressure ulcer for 1 of 3 residents reviewed for pressure ulcers in a sample of 4 who met the criteria for pressure ulcer review. (Resident #136)</p> <p>Findings include:</p> <p>The clinical record of Resident #136 was reviewed on 4/10/14, at 11:15 a.m. Diagnoses included, but were not limited to, fall with closed fracture upper end humerus (bone in the upper arm) and fracture of radius and ulnar (wrist), hypertension, congestive heart failure, and osteoarthritis.</p> <p>The admission assessment dated 1/31/14 indicated Resident #136 had bruises on the left arm and left eye lid. No wounds were documented. Admission physician's orders included a pressure reducing/redistributing cushion for the wheelchair and a pressure</p>	F000314	<p>Rosegate Village respectfully requests face-to-face IDR to delete F314 because we disagree with the scope and severity.</p> <p>F- 314 – Treatment/SVCS to Prevent/Heal Pressure Sores</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #136 no longer resides at the facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents that currently have pressure ulcers may be affected by this same deficient practice. All residents with pressure ulcers will be audited by DNS and/or designee to ensure physician's orders are being implemented and documented. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Rounds will be conducted weekly by the Assistant Director of Nursing (ADON) and/or 	05/12/2014

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	<p>reducing/mattress for the bed.</p> <p>In the most recent 30 day Minimum Data Set (MDS) assessment dated 2/26/14, indicated Resident #136 was assessed as needing extensive assistance of two staff members for bed mobility and transfers and was assessed as being at risk for the development of pressure ulcers. Resident #136 was assessed as having a BIMS (Brief Interview for Mental Status) of 13, indicating the resident was reasonably independent in decision making. Resident #136 was assessed as having an unstageable pressure ulcer.</p> <p>A nursing progress note dated 2/17/14 at 11:30 a.m., indicated Resident #136 was assessed as having a new unstageable pressure ulcer on the coccyx (tailbone), measuring 1.0 cm (centimeters) (length) x 1.0 cm (width) x 0.1 cm (depth); tissue described as slough (dying tissue).</p> <p>A physician's order was obtained on 2/17/14, "Upgrade to Roho mattress [a type of pressure relieving mattress]." Treatment to coccyx wound, "Cleanse area w/NS, [with/normal saline] apply Santyl [a treatment used to remove dead tissue] to wound bed, calmo [calmoseptine an ointment used as a barrier] to peri wound, cover w/ dry dressing and Tegaderm. Change daily</p>		<p>designee on residents that have pressure ulcers to ensure that physician orders related to wound healing are implemented and documented.</p> <ul style="list-style-type: none"> The Pressure Ulcer Monitoring Tool will be completed daily to ensure treatments and documentation are completed per physician's order. Nursing staff will be in-serviced by Director of Nursing and/or designee on May 6, 2014 on implementing physician orders related promotion of healing pressure ulcers. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The Weekly Pressure Ulcers CQI audit tool will be utilized to monitor residents with pressure ulcers to ensure physician orders related to wound healing are implemented. Resident observations with pressure ulcers will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. If threshold of 95% is not achieved, an action plan will be 		

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	<p>and PRN [as needed] soilage/dislodgement. Roho w/c [wheelchair] cushion."</p> <p>A Visit Report, electronically signed by a nurse practitioner (NP) specializing in wound care dated 2/21/14 at 10:11 a.m., indicated the wound to the coccyx was due to pressure. On the second page of the Visit Report, a section titled "Integumentary (Hair,Skin)..." indicated, "Wound #1 Coccyx is a Necrotic Tissue [dead tissue]...Initial wound encounter measurements 1.2 cm x 0.8 cm x 0.1 cm ...Discussed plan with nurse at bedside: Yes..." On the third page of the Visit Report, "<u>Wound Orders</u>: Wound #1 Coccyx <u>Santyl</u> cleanse wound bed with NS. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel, (a treatment used to create a moist wound environment in necrotic wounds) moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN, soiled...."</p> <p>A review of the recapitulation of physician's orders dated March 2014, failed to include the NP wound orders dated 2/21/14, and indicated Resident #136 was to receive Santyl and a dry dressing to the pressure ulcer on the coccyx. A review of the Medication</p>		<p>developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p>	

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	<p>Administration Record (MAR) for February 2014, indicated the treatment of Santyl and dry dressing was initialed as completed on 2/19, 2/20, 2/21, 2/24, 2/25, 2/26, and 2/28/14. The facility failed to document a treatment to the coccyx was completed as ordered on 2/17, 2/18, 2/22, 2/23, and 2/27/14. A review of the MAR for March 21014, indicated the treatment of Santyl and dry dressing was initialed as completed for 3/1/14 through 3/18/14. The facility failed to document a treatment was completed as ordered for 3/19 and 3/20/14.</p> <p>A review of the IDT (Interdisciplinary Team) Notes and the Visit Notes from the NP specializing in wound care for visit dates 2/28/14, 3/7/14, 3/14/14, and 3/21/14 indicated the wound measurements to the coccyx were improving. The Visit Note dated 3/21/14, indicated the coccyx wound was now a Stage III, (an improvement in the tissue type in the wound), and had measurements 0.9 cm x 0.4 cm x 0.2 cm.</p> <p>A physician's order dated 3/21/14 indicated, "Clarification tx [treatment] to Coccyx: Cleanse area with N/S, pat dry, apply calmo to periwound apply Santyl to wound bed followed by hydrogel moistened fluffed gauze then cover /c</p>			

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F000323 SS=D	<p>[with] dry dressing q [every] day & [and] PRN soilage."</p> <p>During an interview with RN #3 (registered nurse), the Rehabilitation Manager, and Nurse Consultant on 4/15/14 at 11:20 a.m., RN #3 indicated the wound team, consisting of nursing, rehabilitation, dietary and the wound care NP, made rounds each week to review current wounds. RN #3 indicated the wound team reviewed current treatments, supplements, equipment and any changes that were indicated during the rounding. RN #3 indicated the NP provided a copy of the Visit Report for the week to the facility when rounding was completed. RN #3 and the Nurse Consultant indicated the facility had 4 visits and rounding opportunities to reconcile the "Wound Orders" on the Visit Reports, Santyl and moist dressing, with the physician's orders, Santyl and a dry dressing.</p> <p>3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident</p>						

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	<p>receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a potentially hazardous situation was prevented with the use of oxygen in the beauty salon. This had the potential to affect 3 of 7 residents who used oxygen and went to the beauty salon. (Residents #115, #56 and #20)</p> <p>Findings include:</p> <p>During a walk through of the facility on 4/7/14 at 3:20 p.m., Resident #115 was observed sitting in a chair in the beauty salon. Her head was under a hairdryer. The hair dryer was turned on. The resident was holding the nasal cannula (a hollow plastic tubing with 2 nasal prongs on the end of it, which delivered oxygen into her nose) in her hands. The nasal cannula and tubing were connected to an oxygen supply, which was sitting in the hallway outside the door to the beauty salon. The oxygen was turned on and running through the tubing and out of the nasal prongs being held in the resident's hands. This free flowing oxygen was approximately 2 1/2 feet from the hair dryer. The beautician was asked where the nearest fire extinguisher was. She indicated, "Somewhere down the hall, I</p>	F000323	<p>Rosegate Village respectfully requests a face-to-face IDR to reduce the scope of F323 because we disagree with the scope of the deficiency.F- 323 – Accidents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #115 oxygen was immediately removed and orders obtained for resident to remove oxygen while in beauty salon. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who use the beauty shop have to potential to be affected by the alleged deficiency. Audit was completed to identify residents who receive oxygen therapy and utilize the beauty salon. After physician evaluation orders were obtained for those residents to remove oxygen while in beauty salon. The Executive Director issued a new facility policy that there could be no oxygen in the beauty salon. The Director of Nursing provided an Action Plan of oxygen use while in the beauty salon and in-serviced the beautician and the managers on the policy. Additionally, the Director of nursing and the Executive Director in serviced the beautician on the location of the</p>	05/12/2014

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	<p>think. I don't really know."</p> <p>A facility policy, dated 1/2010, received from the Director of Nursing on 4/7/14 at 3:40 p.m., titled, "Oxygen Use in the Beauty Shop." indicated, "The oxygen tank will be kept as far away from the dryer unit as the tubing will allow..."</p> <p>During an interview with the Executive Director at that time, he indicated the facility policy was based on the Indiana State Department of Health Long Term Care Newsletter dated November 30, 2009. This newsletter indicated, "Advisory: Resident use of oxygen while sitting under a hair dryer is a potentially hazardous situation....This section states that oxygen use should be at least five feet from hair dryers..." The Executive Director indicated there were 3 residents in the facility who needed continuous oxygen and went to the beauty salon.</p> <p>On 4/8/14 at 9:00 a.m., the Executive Director indicated the new facility policy was that there could be no oxygen whatsoever in the beauty salon.</p> <p>On 4/9/14 at 5:15 p.m., the Director or Nursing provided an "Action Plan...O2 [oxygen] Use while in the Beauty Salon...Inservice with Beautician and Managers as to no O2 in beauty</p>		<p>fire extinguisher and usage of extinguisher. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be provided to all staff by May 12, 2014 by the Director of Nursing and/or designee on the facility policy that there could be no oxygen in the beauty salon. · Beauty salon rounds will be conducted daily by the Executive Director and/or designee to ensure no oxygen therapy is utilized while in the beauty salon. · All residents receiving new orders for oxygen therapy will be evaluated by physician to determine if oxygen may be removed prior to being allowed in the beauty salon. If residents are unable to remove oxygen, other arrangements will be made to receive beauty salon services. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Oxygen Therapy CQI audit tool will be utilized by the Executive Director and/or designee to monitor compliance with no oxygen therapy while in beauty salon. Beauty Salon will be observed weekly daily X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of this audit will be presented to the CQI</p>				

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F000329 SS=D	<p>salon...Educate Beautician on the location of fire extinguisher and usage of extinguisher..."</p> <p>3.1-45(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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 monitoring</p>	F000329	<p>Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p> <p>F- 329-Drug regimen is free from unnecessary drugs What corrective action(s) will be</p>	05/12/2014

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	<p>for anticoagulant therapy, blood glucose levels, and heart rate monitoring was completed for 2 of 5 residents reviewed for unnecessary medications. (Resident #145 and Resident #173)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #145 was reviewed on 4/10/14, at 2:38 p.m. Diagnoses included, but were not limited to, Parkinson's disease, depression, severe dysphasia (difficulty swallowing), dementia with delusions, and a history of pulmonary embolism (a blood clot in the lung).</p> <p>A recapitulation of physician's orders dated April 2014 indicated Resident #145 was to receive warfarin, a medication used to prevent blood clots, on a daily basis. The most recent order for warfarin was dated 4/8/14, and indicated Resident #145 was to receive "Coumadin [warfarin] 9 mg [milligrams] q [every] Tues-Thurs-Sat-Sun (Tuesday-Thursday-Saturday-Sunday); Coumadin 9.5 mg q Mon-Wed-Fri (Monday-Wednesday-Friday). A PT/INR [Prothrombin Time/International Normalized Ratio, a test used to monitor the effectiveness of warfarin], was also ordered to be checked every Tuesday. The origination date of the order to check</p>		<p>accomplished for those residents found to have been affected by the deficient practice? · Resident #145 received a physician order to obtain International Normalized Ratio (INR) only and discontinued orders for Prothrombin Time (PT). · Resident #173 the Director of Nursing checked resident's heart rate and inserviced nurses working that assignment. · Resident #173 nurse administered Accucheck as ordered. Director of Nursing inserviced nurses working that assignment on obtaining Accuchecks as ordered. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who have orders for PT/INR, have Accucheck orders and Heart Rate Monitoring have the potential to be affected by the alleged deficient practice. · Charts of all residents with orders to obtain PT/INR have been audited by DNS and/or designee to ensure PT/INR are being documented per physician order. · All Residents receiving medication requiring heart rate monitoring prior to medication have been identified and a daily audit by DNS an/or Designee has been initiated to ensure nurses are obtaining heart rate per physician orders. · All Residents receiving Accuchecks have been</p>	

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	<p>PT/INR was 1/14/14, and indicated the test was to be completed by the facility.</p> <p>A review of "Coumadin/Warfarin INR Tracking Log" for Resident #145 for the months of January, February, March and April 2014 indicated INR was completed as ordered. The tracking log lacked documentation of results of PT for the months of January, February, March and April 2014.</p> <p>During an interview with the Director of Nursing (DoN) on 4/10/14 at 4:35 p.m., the DoN indicated the facility had the equipment required to complete PT/INR tests and indicated the nursing staff had received education prior to implementing the use of the equipment.</p> <p>During an interview with RN #3 (registered nurse), DoN, and Nurse Consultant on 4/15/14 at 12:00 p.m., RN #3 indicated the facility used the "Coumadin/Warfarin INR Tracking Log" to document the results of PT/INR tests performed in the facility. RN #3 indicated the equipment utilized to complete the test was capable of testing PT and INR. The Nurse Consultant and RN #3 indicated the tracking logs for Resident #145 lacked documentation of PT results for the months of January, February, March and April 2014.</p>		<p>identified and a daily audit by DNS and/or Designee has been initiated to ensure nurses performing Accuchecks per physician order. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by the Director of Nursing and/or designee by May 9, 2014 to licensed nurses on Accucheck, PT/INR and heart rate monitoring and documentation. · Noncompliance with physician orders and documentation related to Accucheck, PT/INR and heartrate orders may result in reeducation and/or disciplinary action. · The Director of Nursing Services and/or designee will complete a daily audit tool of the Accucheck, PT/INR flow sheets, and MAR for heart rate monitoring of all residents with orders to monitor Accuchecks, PT/INR and heart rate to ensure nurses are performing and documenting per physician orders. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Accucheck, PT/INR and heart rate monitoring CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with documentation of Accuchecks,</p>	

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	<p>2. The clinical record of Resident #173 was reviewed on 4/10/14 at 10:51 a.m. Diagnoses for the resident included, but were not limited to, high blood pressure, coronary artery disease, diabetes, and stroke.</p> <p>a. A physician's order, dated 2/4/14, indicated Resident #173 was to receive metoprolol (heart medication) 50 mg. (milligrams) daily. This medication was not supposed to be given to the resident if his heart rate measured less than 60 beats per minute.</p> <p>A care plan for Resident #173, dated 1/9/12 and current through 7/1/14, indicated problems of high blood pressure and coronary artery disease. Approaches included, administer medications as ordered.</p> <p>Medication administration records for February and March, 2014, for Resident #173, did not indicate his heart rate had been checked prior to giving him the metoprolol.</p> <p>During an interview with the Director of Nursing on 4/16/14 at 12:30 p.m., she indicated she was aware the resident's heart rate had not been checked as ordered in February and March.</p>		<p>PT/INR and heart rate monitoring. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p>	

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	<p>b. A physician's order, dated 1/30/14, indicated Resident #173 was to have accuchecks (a finger stick blood test to measure blood sugar) twice daily at 7:00 a.m. and 4:00 p.m. The resident also had orders for scheduled insulin to be given at breakfast, lunch and bedtime, and he had a sliding scale of insulin to be given depending on the results of his twice daily accuchecks.</p> <p>A care plan for Resident #173, dated 1/1/12, and current through 7/1/14, indicated a problem of the resident being at risk for adverse effects of high and low blood sugars. Approaches included monitoring blood sugars as ordered.</p> <p>Review of a Capillary Blood Glucose Monitoring Tool for March, 2014, indicated Resident #173's accucheck was not performed on the following dates: 3/10 at 7:00 a.m., 3/14 at 7:00 a.m., 3/16 at 7:00 a.m., 3/19 at 7:00 a.m., 3/20 at 7:00 a.m. and 4:00 p.m., 3/24 at 7:00 a.m., 3/27 at 7:00 a.m.</p> <p>A care plan for Resident #173, dated 1/1/2, and current through 7/1/14, indicated a problem of the resident being at risk for adverse effects of high and low blood sugars. Approaches included monitoring his blood sugars as ordered.</p>			

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F000431 SS=E	<p>The Director of Nursing was asked about the missing accuchecks in March on 4/16/14 at 12:30 p.m. No further information was provided by survey exit on 4/17/14 at 11:30 a.m.</p> <p>3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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,</p>			

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	<p>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, record review, and interview, the facility failed to ensure narcotic medications were reconciled according to the facility policy for 5 of 9 medication carts. (100 back hall cart, 300 hall cart, 400 front and back hall carts, and 500 hall cart)</p> <p>Findings include:</p> <p>On 4/1/14 at 4:30 p.m., the Nurse Consultant provided a policy titled, "Medication Administration Guidelines, dated 7/2011, and indicated the policy was the one currently used by the facility. The policy indicated, "A narcotic audit/count must be conducted at each change of shift to ensure against any discrepancy. The nurses involved will sign the Narcotic Check List. At the time of the audit/narcotic count the nurses are to observe for correct count and correct medication."</p> <p>A review of "Controlled Drug Audit" shift reconciliation was done on 4/16/14 at 3:30 p.m. At the top of the Controlled</p>	F000431	<p>F- 431-Drug regimen is free from unnecessary drugs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The Director of Nursing (DNS) immediately ensured the narcotic count sheets reconciled with the narcotic medications for Halls: 100 Back Hall Cart, 300 Hall Cart, 400 Front and Back Hall Carts and 500 Hall Cart. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents receiving narcotics have the potential to be affected by the same alleged deficient practice. · A facility wide audit was completed of all narcotic carts to ensure narcotic medications were reconciled according to the facility policy. There were no other discrepancies identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not</p>	05/12/2014

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	<p>Drug Audit, it indicated, "Important Control drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty. Signatures by the nurse/medication aides verify that an actual count has been made and the count is the same as that indicated on the individual control drug records..."</p> <p>1. A review of the 100 back hall cart controlled drug audit indicated: No signatures for the incoming day shift nurse on April 5, 6, and 13, 2014. No signatures for the outgoing evening shift nurse on April 5, 6 and 13, 2014. No signatures for the outgoing night shift nurse on April 5 and 6, 2014.</p> <p>2. A review of the 300 hall cart controlled drug audit indicated: No signature for the evening shift outgoing nurse April 7, 2014. No signature for the night shift incoming nurse April 14, 2014.</p> <p>3. A review of the 400 front hall cart controlled drug audit indicated: No signatures for the incoming day shift nurse April 10 and 11, 2014. No signatures for the incoming evening</p>		<p>recur? · An in-service on medication administration guidelines, including shift to shift narcotic count, will be completed by the Director of Nursing and/or designees by May 12, 2014 to licensed nurses to ensure narcotic medications are reconciled according to the facility policy titled "medication administration guidelines". · Noncompliance with following the facility narcotic medication policy may result in reeducation and/or disciplinary action. · The Director of Nursing Services and/or designee will audit the shift to shift Narcotic Count sheet on a daily basis to ensure compliance. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The medication storage review CQI Audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with the shift to shift Controlled Drug Audit. Audits will be completed weekly X 4, monthly X 2 and quarterly thereafter for at least two quarters. · If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p>		

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	<p>shift nurse April 6, 13 and 14, 2014. No signatures for the outgoing evening shift nurse April 10 and 11, 2014. No signatures for the incoming night shift nurse April 2, 3 and 7, 2014. No signatures for the outgoing night shift nurse April 1, 2, 3, 6, 7, 10, 12 and 14, 2014.</p> <p>4. A review of the 400 back hall cart controlled drug audit indicated: No signature for the incoming day shift nurse April 11, 2014. No signature for the incoming evening shift nurse April 6 and 14, 2014. No signature for the outgoing evening shift nurse April 11, 2014. No signature for the outgoing night shift nurse April 6 and 14, 2011.</p> <p>5. A review of the 500 hall cart controlled drug audit indicated: No signature for the incoming day shift nurse April 12, 2014. No signature for the outgoing day shift nurse April 8, 2014. No signature for the incoming evening shift nurse April 5, 7, 10 and 14, 2014. No signature for the outgoing evening shift nurse April 2 and 12, 2014. No signature for the incoming night shift nurse April 1, 7, and 9, 2014. No signature for the outgoing night shift nurse April 1, 4, 5, 6, 7, 9, 10, 11 and 14,</p>			

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	<p>2014.</p> <p>During an interview with the Director of Nursing on 4/16/14 at 3:50 p.m., she indicated the 100 hall nurses work 8 hour shifts and should be using the controlled drug audits with day, evening and night shift places for signatures. She indicated the 300, 400 and 500 hall nurses work 12 hour shifts and are supposed to be using audits with 2 columns for incoming and outgoing. She indicated the facility had started using the new 2 column forms several months ago for the 300, 400 and 500 halls. She indicated she didn't know why the nurses were still using the 8 hour shift audit forms.</p> <p>She indicated at that time all the empty signature spaces on the 300, 400 and 500 hall's drug audits/reconciliation did not necessarily mean the controlled substances weren't counted and/or verified with a signature, since there were only 2 nurses covering the 24 hour period, instead of 3. She indicated some of the empty signature spaces should have had signatures and some of them were illegible. She indicated all of the spaces on the 100 back hall cart should have had signatures.</p> <p>3.1-25(e)(3)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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