

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2012
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NAME OF PROVIDER OR SUPPLIER  LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00101897 and IN00102345.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00103076 and IN00103436.</p> <p>Complaint IN00102345 - Substantiated. Federal/State deficiencies related to the allegations are cited at F155.</p> <p>Complaint IN00101897 - Substantiated. Federal/State deficiencies related to the allegations are cited at F246 and F312.</p> <p>Survey dates: January 31, February 1, 2, 3, 6, 7, 2012</p> <p>Facility number: 000269 Provider number: 155400 AIM number: 100267720</p> <p>Survey Team: Ginger McNamee, RN, TC Delinda Easterly, RN Karen Lewis, RN Betty Retherford, RN</p> <p>Census bed type: SNF: 9</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</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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	<p>SNF/NF: 69 Total: 78</p> <p>Census payor type: Medicare: 12 Medicaid: 62 Other: 4 Total: 78</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/13/12 Cathy Emswiller RN</p>			
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F0155 SS=D	<p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>Based on record review and interview, the facility failed to allow 1 resident in a Stage 2 Sample of 36 (Resident #M) to exercise her right to refuse a trip to the emergency room.</p> <p>Findings include:</p> <p>Resident #M's clinical record was reviewed on 2/2/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to dementia, panic attacks, depression, and insomnia.</p> <p>The resident had a 1/18/12, annual Minimum Data Set assessment. The assessment indicated the resident's Brief Interview for Mental Status indicated the resident had severe cognition impairment. The assessment indicated the resident had clear speech, is usually able to understand and can usually make self understood.</p> <p>Review of the nurse's notes indicated on 1/10/12 at 10:30 a.m., the staff responded to Resident #M's alarm sounding and found the resident lying on the floor beside her bed. The note indicated the resident was alert and</p>	F0155	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident #M was not harmed. 2. All residents have the potential to be affected. See below for corrective measures, 3. Nursing administration, along with licensed staff nurses, were re-educated on resident's rights (see attachment A). The nurse consultant or her designee will review discharges weekly for 8 weeks then monthly for 2 months, then quarterly to ensure residents/responsible parties wishes regarding transfer are acted upon unless the discharge or transfer is necessary is due to the resident presenting a risk for harm to self or others and trasfer/discharge policy is followed (see attachment B). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accrodngly.</p>	02/29/2012			

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	<p>able to state "I rolled over in bed and fell out." Resident upon assessment had full range of motion to all extremities. Found to have gash/laceration of approximately three cm [centimeter] above the left eye and beginning to have discoloration about the orbit of the left eye. The resident stated "My head hurts." The resident also had an approximately two cm cut on her right shin. The resident's vital signs were blood pressure 108/80, pulse 78, respirations 18, temperature 97.6 degrees and her oxygen saturation rate was 97 percent on 2 liters of oxygen via nasal canula. The resident's hand grasps were weak as normal for the resident and her pupils were equal and reactive to light. The resident indicated she felt a little dizzy at the time. The note indicated the resident was transferred to the hospital emergency room for assessment of the head injury and the Power of Attorney [POA] was notified. The note indicated the POA spoke with the Director of Nursing regarding the facility protocol regarding the transfer to the hospital.</p> <p>A 1/10/12, 10:20 a.m., nursing note written by the Director of Nursing indicated she had spoke with the resident's POA about the resident</p>			
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	<p>being sent to the hospital due to hitting her head. The note indicated the POA was very upset and had wanted to come to the facility and check on the resident before making a decision to send the resident to the hospital. The note indicated the Director of Nursing had explained to the POA it was the facility's policy to send residents with head injuries to the hospital. The POA indicated it was a waste of money to send the resident to the hospital and he was denying permission to send the resident out to the hospital. The POA stated "You can assess her at the facility." The note indicated the POA was told an assessment had been completed and the facility could not diagnose something that can't be seen in the resident's head. The POA replied "I can tell you that a brain bleed will not occur [sic] that fast so you don't need to send her anywhere." The Director of Nursing told the POA "As long as she is in the facility we have to make sure she is kept safe and if she has any changes we must treat them. Explained the hospital may do a CT scan or just assess her and send her back but that is what needs to be done to assure she is okay...."</p> <p>A 1/10/12, 11:15 a.m., nurse note</p>			
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	<p>indicated the emergency room staff reported the wounds were dressed with Bacitracin [an antibiotic ointment] and the resident was being returned to the facility with no testing done.</p> <p>During a 2/2/12 at 2:30 p.m., interview with the Director of Nursing, she indicated she indicated it was the facility's policy to send residents with head wounds to the hospital. A copy of the facility's policy was requested at that time.</p> <p>On 2/2/12 at 2:50 p.m., the Director of Nursing indicated there was no facility policy related to when residents should be sent to the hospital. She indicated it was just facility practice to send residents to the emergency room and at the nurse's discretion. She indicated head wounds could not be assessed for slow brain bleeding because we can't see into the head.</p> <p>The resident's POA was interviewed on 2/2/12 at 3:35 p.m. He indicated he had spoke with the resident's nurse after the resident had fallen and was comfortable with the nurse's assessment. He indicated he told the nurse to just monitor the resident and observe for changes. He indicated the Director of Nursing gave him no choice and demanded the resident be</p>				

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	<p>sent to the hospital.</p> <p>During an interview with Resident #M on 2/3/12 at 9:35 a.m., the resident was able to recall and describe rolling out of bed on 1/10/11. She indicated she did not want to go to the hospital, but had been told it was the policy to go to the hospital. She said she agreed to go because she was afraid she would get the facility into trouble if she refused.</p> <p>This federal tag relates to IN00102345</p> <p>3.1-4(d)</p>			
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F0157 SS=G	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on clinical record review and interview, the facility failed to ensure continued contact was made with the physician related to a resident's problem with penile discharge (Resident #L), and failed to notify the physician promptly when a resident developed an open area (Resident</p>	F0157	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #L received treatment for his condition. Resident #44's physician was notified and an appropriate treatment obtained. 2. All residents have the potential to be affected. The Nurse's	02/29/2012			

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	<p><b>#44), for 2 of 9 residents reviewed for physician notification in a Stage 2 Sample of 36.</b></p> <p>Findings include:</p> <p>1.) The clinical record for Resident #L was reviewed on 2/4/12 at 2 p.m.</p> <p>Diagnoses for Resident #L included, but were not limited to, right scrotal abscess, status post surgery, diabetes mellitus, hypertension, multiple sclerosis, chronic urinary tract infection, and dementia.</p> <p>A health care plan problem, dated 5/25/11 and reviewed on 11/23/11, indicated Resident #L had an anchored foley catheter and problems with chronic urinary tract infections related to a history of urinary retention secondary to a urethral stricture. Interventions for this problem included, but were not limited to, administer "medications as ordered" and "observe urine color, amount, odor, consistency, and frequency and notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification."</p> <p>A nursing note, dated 11/21/11 at 10:00 p.m., indicated "Res [resident]</p>		Notes and 24-hour Condition report sheets were reviewed to ensure that physician notification has been made when indicated. See below for additional corrective measures. 3. The facility policy and procedure on Physician Notification with Acute Changes in Condition was reviewed and no changes were indicated (see attachment C). Licensed nursing staff were re-educated on the Physician Notification with Acute Changes in Condition policy and procedure. The DON or her designee will review Nurse's Notes, 24-hour Condition Reports and lab results daily, on scheduled work days, to ensure compliance (see attachment D). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>noted to have moderate amt [amount] of penile discharge this shift-brownish, creamy. No c/o [complaints of] pain in penile/scrotal area..... Will cont [continue] to monitor for discharge." The clinical record lacked any information related to the physician having been made aware of the resident's penile discharge.</p> <p>Nursing notes, dated 11/22/11 at 2:20 a.m. and 2 p.m. indicated no penile drainage was noted at those times.</p> <p>A nursing note, dated 11/22/11 at 10:00 p.m., indicated "Res having large amt of creamy brownish discharge from penis. No c/o pain. +malodorous. Increase amt when res turned. Res to see MD [medical doctor] at next available time for eval [evaluation]...."</p> <p>A nursing note, dated 11/23/11 at 2 p.m., indicated the physician had looked at the resident related to his penile discharge and no orders were received at that time. The note did not indicate whether the resident had a penile discharge at the time of the physicians visit. The clinical record lacked any physician progress note made at the time of the 11/23/11 visit.</p>				

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	<p>A nursing note, dated 11/23/11 at 10 p.m., indicated a slight amount of brownish creamy colored penile discharge had been noted on that shift.</p> <p>A nursing note, dated 11/24/11 at 10 p.m., indicated a small amount of brownish creamy penile discharge had been noted.</p> <p>A nursing note, dated 11/25/11 at 2 p.m., indicated "Mod amount discharge from penis and light brown in color...."</p> <p>A nursing note, dated 11/25/11 at 8:05 p.m., indicated "When resident turned and repositioned, moderate amount of light brown thin foul smelling drainage comes from penis...."</p> <p>A nursing note, dated 11/26/11 at 1:55 p.m., indicated "res has had a small amt of drainage from penis...."</p> <p>A nursing note, dated 11/26/11 at 10 p.m., indicated "...small amt of creamy brownish discharge noted from penis...."</p> <p>A nursing note, dated 11/27/11 at 5 a.m., indicated "Res noted to have small amt of brownish/yellow penile</p>			

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	<p>discharge this shift..."</p> <p>A nursing note, dated 11/27/11 at 1:30 p.m., indicated "Res continues to have small amt of drainage from penis."</p> <p>A nursing note, dated 11/27/11 at 10 p.m., indicated "Res has sm [small] amt of creamy discharge from penis.... Res c/o pain all over-requested pain pill...."</p> <p>A nursing note, dated 11/28/11 at 2:25 p.m., indicated "Res had small amt of discharge...."</p> <p>The clinical record lacked any physician notification of the resident's continued problems with penile discharge and/or the development of a foul smell associated with the drainage from the time of the physician's visit on 11/23/11 and the visit by the Nurse Practitioner noted below late in the evening on 11/28/11.</p> <p>A nursing note, dated 11/28/11 at 11:20 p.m., indicated "Nurse Practitioner here and receive new order." A progress note written at the time of this visit indicated the resident had a brown mucus penile discharge and the assessment was "Candidiasis." A physician's order,</p>				

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	<p>dated 11/28/11, indicated Resident #L was to receive Diflucan (an antifungal medication) 150 mg tab 1 daily for 3 days.</p> <p>During an interview with the Director of Nursing (DoN) on 2/7/12 at 10:40 a.m., additional information was requested related to the delay in making the physician aware of the continued drainage and foul odor of the drainage noted above</p> <p>During an interview on 2/7/12 at 2:25 p.m., the DoN indicated she had no information to provide related to the lack of physician notification of the continued penile drainage and development of a foul odor associated with the drainage as noted above.</p> <p>2.) The clinical record for Resident #44 was reviewed on 2/2/12 at 10:50 a.m.</p> <p>Resident # 44's current diagnoses included, but were not limited to, Parkinson's disease, hypertension, anemia, and dementia with Alzheimer's,</p> <p>A quarterly Minimum Data Set Assessment, dated 10/27/11, indicated the resident was totally dependent upon the staff for all</p>						

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	<p>activities of daily living.</p> <p>A Braden Scale (a tool used to predict the risk of developing pressure sores), dated 10/26/11, indicated Resident #44 was at a high risk for developing a pressure sore.</p> <p>The resident had a healthcare plan initiated 5/6/11 and updated 1/31/12 which indicated the resident had a problem listed as, is at risk for development of pressure ulcers due to decreased mobility, Alzheimer's dementia, Parkinson's disease, bowel and bladder incontinence, delicate skin and history of pressure areas. Interventions for this problem included, but were not limited to, staff to observe skin when providing care, notify the charge nurses of any skin problems for further assessment and possible physician and responsible party notification, apply preventive topical medication as ordered and notify Hospice of any skin issues.</p> <p>The resident had a physician's order for 1:1:1 (nystatin/zinc/bacitracin) a preventive topical skin ointment to be applied to the coccyx every shift and as needed. The original order date was 1/14/11. The treatment sheets for October, November, December 2011 indicated the 1:1:1 ointment was</p>						

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	<p>applied every shift until 12/12/11.</p> <p>A nursing note, dated 12/9/11 (Friday), indicated the following, resident has a 3 centimeter by 3 centimeter bright red open area on top of right buttock - was informed by the hospice aide, skin sheet initiated.</p> <p>The skin sheet for Resident #44, dated 12/9/11, indicated the resident had a Stage 2 open area to the right buttock.</p> <p>The nurses notes lacked any indication the physician was notified of the open area until 12/12/11. (Monday) A physician's order, dated 12/12/11, indicated, discontinue 1:1:1 ointment to coccyx every shift, begin "Dr D's" (a medicated ointment) to open area every shift and as needed until area healed.</p> <p>The December 2011 treatment sheet for Resident #44 indicated the "Dr. D's" treatment to the open area was started on 12/12/11.</p> <p>The weekly skin sheet indicated the open area was assessed on 12/16/11 and the area had remained unchanged in size.</p> <p>During an interview with the Director</p>						

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	<p>of Nursing on 2/3/12 at 4:00 p.m. additional information was requested related to the delay in treatment of Resident #44's open area, which was observed on 12/9/11 and treatment was initiated on 12/12/11.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 1:30 p.m. she indicated she had no additional information to provide related to the resident having a pressure area observed on 12/9/11 and no change in treatment was given until 12/12/11. She indicated the physician should be notified when an open area was first observed and treatment started as soon as possible. This resulted in a 3 day period of the resident having an open area and receiving no medical treatment to the area.</p> <p>3.) Review of the current facility policy, dated 1/06, titled "ACUTE CHANGE IN CONDITION/EMERGENCY PHYSICIAN SERVICES PROCEDURE," provided by the Director of Nursing on 2/7/12 at 8:25 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To ensure an acute change in a resident's condition will be addressed in a timely manner as it pertains to needed transfer to an</p>				

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	<p>acute care setting.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Contact the attending physician/on-call physician when the resident's condition requires immediate attention or acute care follow-up.</li> <li>2. If the attending or on-call physician is not available or does not return the phone call, contact the facility's medical director...."</li> </ol> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			
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F0246 SS=D	<p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident preferences were honored for 2 of 20 residents reviewed for accommodation of individual needs and preferences in a Stage 2 Sample of 36. (Resident #K and #E)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #K was reviewed on 2/4/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #K included, but were not limited to, dysphagia, iron deficiency anemia, and cerebrovascular accident (CVA) (stroke) with left hemiplegia.</p> <p>A quarterly minimum data set assessment, (MDS) dated 11/5/11 indicated the resident required extensive assistance of the staff for bed mobility, toileting, and transfers. The MDS indicated the resident understood others and could be easily understood.</p>	F0246	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident #K's care plan has been reviewed and revised to reflect her preference regarding the time she would like to rise in the morning and the nurse aide assignments sheets were revised accordingly. Resident #E is receiving a shower or completed bed bath, as resident desires, twice weekly unless the resident refuses, at which time social services will be notified of the refusal. 2. All residents have the potential to be affected. Resident preference interviews for all residents have been reviewed by IDT members and necessary revisions made to the plan of care, as indicated. See below for additional corrective measures. 3. Resident's Rights and the Shower Procedure was reviewed and no changes were indicated (see attachment A and E). Nursing staff were re-educated on the that procedure. The DON or her designee will monitor showers/baths twice weekly for 4 weeks, then weekly for 2 months, then monthly to ensure showers are provided per policy (see attachment F). 4. The findings of the audits will be reviewed during</p>	02/29/2012			

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	<p>A social service "Resident Preference Interview", dated 5/6/10, included, but was not limited to, the following:</p> <p>"What time do you prefer to get up in the morning? (Please provide a timeframe.)" The interview form indicated the response was "8:00 a.m."</p> <p>During an interview on 2/1/12 at 1:20 p.m., Resident #K indicated she had been gotten up at 4 a.m. that morning. She indicated the staff usually got her up between 5 and 5:30 a.m. She indicated she would like to sleep later. would like to sleep later. She indicated the staff just come into her room and tell her it is time to get up.</p> <p>During an interview with CNA #10 on 2/1/12 at 1:55 p.m., she indicated she was the CNA providing care to Resident #K on this shift. She indicated Resident #K has been gotten up by the night shift and was up in the geri-chair when she came in at 6 a.m. She indicated Resident #85 was on the list for the night shift staff to get up and that shift ended at 6:00 a.m.</p> <p>During an interview with the Director of Nursing (DoN) on 2/2/12 at 5:10</p>		the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>p.m., additional information was requested related to Resident #K being gotten up on the night shift and not in accordance with her preferences to sleep later.</p> <p>During an interview on 2/3/12 at 8:35 a.m., the DoN indicated she had talked to both the CNA and nurse on the night shift. She indicated the resident had been gotten up around 5:45 a.m. on 2/2/12. She indicated they were sure of this since they usually "save her for last" since she requires two people to get her up. She indicated she was changing assignments and would make sure the resident was not gotten up that early if she desired to sleep later.</p> <p>2.) The clinical record for Resident #E was reviewed on 2/2/12 at 10:15 a.m.</p> <p>Resident #E's current diagnoses included, but were not limited to, chronic back pain, mild mental retardation, and asthma.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 1/3/12, indicated the resident was able to understand and easily understood by others. The resident was able to properly answer the screening questions for the interview process. The MDS</p>			
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	<p>indicated the resident required assistance from the staff with all activities of daily living. The MDS indicated the resident had no behavior documented of resisting care.</p> <p>A health care plan, dated June 30, 2011 indicated the resident required 1-2 staff members to assist with all activities of daily living.</p> <p>During an interview with Resident #E on 2/2/12 at 8:30 a.m., he resident indicated he only received a shower 1 time a week. He indicated he would like to have a shower more often. The resident indicated he would like to have a shower at least twice weekly.</p> <p>Review of the shower records for Resident #E for the months of October, November and December 2011 indicated the resident had indicated,</p> <p>October, no shower was documented as having been given on October 9, 10, 11, 12, 13, 14, and 15.</p> <p>November, only 1 shower was documented as having been given the week of November 20 through November 26.</p>			
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	<p>December, only 1 shower was documented as having been given the week of December 4 through 10. Only 1 shower was documented as having been given the week of December 18 through 24.</p> <p>The above shower records for Resident #E had no days document when the resident had refused a shower.</p> <p>During an interview with CNA #6 on 2/7/12 at 8:30 a.m. she indicated when the CNAs give a resident a shower they document the shower was given on the shower sheets.</p> <p>During an interview with CNA #7 on 2/7/12 at 8:40 a.m. she indicated residents are to get showers 2 times weekly. She indicated the residents have specific shower days. She further indicated the CNAs document on the shower sheets when the showers are completed.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 10:00 a.m. she indicated the shower records for Resident #E indicated the resident did not have 2 showers a week. She further indicated the resident should have had at least 2 showers a week.</p>			
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	<p><b>3. Review of the current undated facility policy titled, "Shower Procedure", provided by the Director of Nursing on 2/7/12 at 2:13 p.m. indicated,</b></p> <p><b>"Policy: Resident will receive a shower (or preferred method of bathing) two times a week unless condition warrants otherwise or resident refuses...."</b></p> <p><b>Noted: Should a resident refuse a scheduled shower, document the refusal and offer the shower at another time or on another day."</b></p> <p><b>This federal tag relates to IN00101897.</b></p> <p>3.1-3(v)(1)</p>			
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F0250 SS=D	<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. Based on record review and interview, the facility failed to notify Social Services of an increase in behaviors for 1 of 3 residents reviewed for behaviors in a sample of 36. (Resident #94)</p> <p>Findings include:</p> <p>Resident #94's clinical record was reviewed on 2/6/12 at 12:59 p.m. The resident's diagnoses included, but were not limited to, ischemic right brain stroke, insomnia, and left hemiplegia secondary to CVA [cerebral vascular accident] [stroke.]</p> <p>The resident had a 12/20/11, quarterly Minimum Data Set assessment. The assessment indicated the resident had severe cognitive impairment. No behaviors were noted on the assessment.</p> <p>Review of the nurse notes indicated the following:</p> <p>1/20/12 at 10:30 p.m., the resident was noted to be in two other residents' rooms this shift within a four hour time frame. The resident</p>	F0250	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident #94 no longer resides at the facility. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Mood and Behavior Program policy and procedures were reviewed and no changes indicated (see attachment G). Facility staff were re-educated on this procedure. The Social Services Director or designee will review Mood/Behavior Memos daily, on scheduled work days to ensure trends, changes or new onset moods/behaviors are identified, tracked, assessed, intervened and care planned accordingly (see attachment H). The facility Administrator or his designee will interview 10 staff members from various departments weekly for 4 weeks, then monthly for 2 months, then quarterly thereafter to ensure all observed behaviors are being communicated to social services (see attachment I). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/29/2012	

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	<p>was redirected several times and on 15 minute checks.</p> <p>1/22/12 at 12:45 p.m., late entry, Resident #94 had wandered to Rosewood hall via wheelchair and entered another resident's room and tried to remove the other resident's oxygen nasal canula from the resident's nose.</p> <p>1/22/12 at 9:50 p.m., Resident #94 was found in a female resident's room. The Resident #N grabbed at the female resident's earlobe when the staff tried to remove him from the room. The unit manager, Administrator and Director of Nursing were all notified.</p> <p>1/23/12 at 10:35 a.m., received a new order to send Resident #94 to the emergency room for a psychiatric evaluation. The family was made aware by Social Services.</p> <p>The resident had a care plan conference on 12/22/11, with the resident's family present. Areas reviewed during the conference included, but were not limited to, resident wanders in the facility in his wheelchair. The conference note indicated the goals were reviewed and remained appropriate at this time.</p>						

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	<p>The resident had a care plan problem of wandering behavior significantly intruding on the privacy or activities of others. This was initiated 1/10/12 and reviewed/updated again on 1/21/12. An intervention for the problem was to keep under direct staff supervision on day shift, then 15 minute checks with licensed staff checking hourly as well.</p> <p>The Behavior Monthly Flow Records and Mood and Behavior Communication Memos for Resident #94 were provided by the Social Service Designee on 2/2/12 at 3:50 p.m. She indicated, at that time, the staff are to complete the Mood and Behavior Communication Memo when the residents have a behavior and she would place the behavior on the Behavior Monthly Flow Records. She indicated at that time she had not been made aware of the increase in behaviors on 1/20, 21, and 22/12. She indicated the behaviors occurred on the weekend and the staff had not contacted her. She indicated she lived close to the facility and would have come in if she had been made aware.</p> <p>Review of the Behavior Monthly Flow Records and Mood and Behavior Communication Memos indicated</p>			
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	<p>there was one episode of wandering behavior in October, 2011, two episodes of socially inappropriate behavior in November, 2011, and there were no behavior communications completed nor nothing documented on the behavior logs for December, 2011 or January, 2012.</p> <p>During an interview with the Administrator on 2/7/12 at 9:20 a.m., he indicated the resident's behaviors had increased and he had discussed with the family the need to transfer the resident to another facility due to ensuring the safety of Resident #94 and the safety of other residents on 1/21/12. He indicated he had not contacted Social Services related to the resident's increased behaviors until on 1/23/12.</p> <p>On 2/7/12 at 1:15 p.m., the Director of Clinical Operations indicated she had reviewed Resident #94s clinical record and the facility was not following the "Mood Behavior Program Procedures." She indicated the staff excepted the behavior of wandering as being a normal behavior and did not document the wandering as being a behavior.</p> <p>The "Mood and Behavior Program</p>						

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	<p>Procedures" policy was provided by the Social Service Designee on 2/6/11 at 3:52 p.m. The policy indicated the Mood and Behavior Communication Memo forms would be at each nurses' station in a location that is accessible to all staff and completed by all staff members upon witnessing a mood and/or behavior. The policy indicated New and Worsening Mood and Behavior Problem assessment will be initiated by social services or nursing and completed by the Interdisciplinary team, upon a new or worsening behavior via the 24 hour report and/or the Mood and Behavior Communication Memo.</p> <p>3.1-34(a)</p>			
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F0253 SS=E	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview the facility failed to ensure resident rooms were properly maintained and in good repair for 9 of 33 resident rooms observed (room numbers 102, 107, 108, 111, 112, 120, 213, 218, and 304).</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance Director and the Administrator on 2/3/12 at 2:00 p.m. the following concerns were identified,</p> <p>a. The wooden sliding closet doors in room 102 had 2 sections of wood missing approximately 2 inches in area along the bottom section of the doors.</p> <p>b. The metal door frame to the bathroom in room 218 was gouged and paint was missing. The bathroom in room had a strong urine odor. The vinyl tiles from around the stool had a gap between the stool and the tile. The gap was approximately 1 inch around the stool and bare wood was exposed.</p>	F0253	<p>The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. The following corrections were made: a. Room 102- closet doors were repaired. b. Room 218 bathroom- metal door frame was sanded and re-painted and the floor was replaced with seamless flooring. c. Room 120 bathroom- caulking around sink has been replaced. Metal doorframe has been sanded and re-painted. d. Room 112 bathroom walls were patched and re-painted. e. Room 108 bathroom door has been sanded and repainted and the bathroom was re-painted. f. Room 111 bathroom door has been sanded and re-finished. g. Room 107 bathroom door has been sanded and re-finished. h. Room 213 bathroom doorframe has been sanded and re-painted. i. Room 304 bathroom door has been sanded and re-finished and bathroom walls have been re-painted. 2. All residents have the potential to be affected. See below for corrective actions. 3. The Administrator or his designee will complete a facility walk-through weekly for 2 months, then monthly thereafter to ensure any needed repairs are noted and scheduled/completed (see attachment J). 4. The</p>	02/29/2012	

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	<p>c. The bathroom sink in room 120 had sections of caulk missing from around the sink. The sink had a small gap from the wall to the sink where the caulk should have been. The sink did appear to be securely attached to the wall. The metal bathroom door frame was gouged and paint was missing.</p> <p>d. The wall in the bathroom in room 112 had several areas where the walls had been patched with plaster. The plaster had not been painted.</p> <p>e. The wooden bathroom door in room 108 was marred and scratched and the finish was missing from the door. The bathroom wall had several black scuff marks on the wall.</p> <p>f. The wooden bathroom door in room 111 had areas where the wood was marred and scratched and the finish was missing.</p> <p>g. The bathroom wooden door in room 107 was marred and scratched and the finish was missing from the door.</p> <p>h. The bathroom door frame in room 213 was gouged and paint was missing.</p> <p>i. The wooden bathroom door in room</p>		findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.		

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	<p>304 was marred and scratched and the finish was missing from the door. The bathroom wall had several black scuff marks on the wall.</p> <p>During an interview with the Maintenance Director at the time of the environmental tour he indicated the above concerns needed to be repaired.</p> <p>3.1-19(f)</p>			
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F0279 SS=E	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive health care plan was developed related to the use of antiplatelet medication, skin condition change, and discharge planning for 3 of 12 residents reviewed for comprehensive health care plan development in a Stage 2 Sample of 36. (Resident #'s 76, Q, and 107.)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #Q was reviewed on 2/2/12 at 2:44 p.m.</p>	F0279	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident #Q and #107's plans of care were revised to include a care plans for risk for bleeding and bruising related to anticoagulant use. Resident #76 no longer resides at the facility. 2. All residents have the potential to be affected. Comprehensive care plans for all residents have been reviewed and/or revised to ensure all active problems/potential problems are addressed. 3. The Care Plan Development and Review policy and procedure was reviewed and no changes were indicated (see attachment K). Licensed nursing staff were re-educated on this</p>	02/29/2012	

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	<p>Diagnoses for Resident #Q included, but were not limited to, hypertension, back pain, osteoporosis, and atrial fibrillation.</p> <p>The clinical record indicated Resident #Q received aspirin ec (an enteric coated antiplatelet medication) 325 milligrams (mg) once a day related to her diagnosis of atrial fibrillation. The original order date of the aspirin was 9/20/11.</p> <p>The clinical record lacked any comprehensive health care plan (HCP) having been developed related to Resident #Q's diagnosis of atrial fibrillation requiring the need for an antiplatelet medication.</p> <p>During an interview with the Director of Nursing (DoN) on 2/7/12 at 10:22 a.m., additional information was requested related to the lack of any comprehensive HCP having been developed related to the resident's use of an antiplatelet medication.</p> <p>The facility failed to provide any comprehensive HCP related to the resident's use of an antiplatelet medication before 2/7/12.</p> <p>2.) The clinical record for Resident #107 was reviewed on 2/3/12 at 8:40 a.m.</p>		<p>policy. The Discharge Planning policy and procedure was reviewed and no changes were indicated (see attachment L). The Social Services Director was re-educated on that policy. The DON or her designee will review 24-hour Condition Reports, Nurse's Notes, lab results and new Physician Orders daily, on scheduled work days, and ensure that any necessary information is added to the respective plans of care (see attachment D). The Social Services Consultant will review discharge plans of care every two weeks on any new admissions in that time period to ensure the plan is complete and accurate for two month,s then monthly for two months, then quarterly thereafter (see attachment M). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>				

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	<p>Resident #107's current diagnoses listed on the clinical record were chronic obstructive pulmonary disease,, squameous cell lung cancer, hypertension, gastroesophageal reflux disease, dysphasia, debility, anemia, chronic anxiety, and osteoporosis.</p> <p>The resident had a current physician's order for Aspirin (a medication used for pain relief, reducing fever, and a blood thinning medication) drug 81 milligrams enteric coated give 1 tablet daily. The original order date for the medication was 9/29/11.</p> <p>The clinical record lacked any health care plan related to the use of the Aspirin medication and any monitoring needed to note possible side effects related to the medication.</p> <p>During an interview with the Director of Nursing on 2/3/12 at 3:00 p.m. additional information was requested related to the lack of a healthcare plan related to the use of the Aspirin medication.</p> <p>During an interview with the Director of Nursing on 2/6/12 at 3:00 p.m. she indicated the facility did not have a healthcare plan related to the Aspirin medication. She further indicated Resident #107 should have had a</p>				

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	<p>healthcare plan in place related to the Aspirin medication to monitor for possible side effects.</p> <p>3.) Resident #76's clinical record was reviewed on 2/2/12 at 10:16 a.m. The resident's diagnoses included, but were not limited to, progressive dementia.</p> <p>The resident's discharge plan upon admission was to receive therapy and return home with his wife. The resident was admitted to the facility on 12/13/11 and was discharged to another facility on 1/31/12 at the wife's request.</p> <p>The resident's care plan lacked any references to related to discharge planning.</p> <p>During an interview with the Social Service Consultant on 2/2/12 at 2:10 p.m., he indicated no care plan related to discharge planning had been developed. He indicated it had been discussed during a health care meeting but was never written.</p> <p>4.) Review of the current facility policy, dated 9/10, titled "CARE PLAN DEVELOPMENT AND REVIEW PROCEDURE," provided by the RN Consultant on 2/7/12 at 2:13 p.m., included, but was not limited to, the</p>						

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	<p>following:</p> <p>"PURPOSE: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs.</p> <p>POLICY:</p> <p>1. An interdisciplinary team, in coordination with the resident and his/her family will develop a comprehensive care plan for each resident....</p> <p>...3. The resident's comprehensive care plan is developed within seven (7) days of the completions of the resident assessment or within twenty-one (21) days after the resident's admission.</p> <p>4. Care plans are revised as changes in the resident's condition dictate. Changes in the resident's care or condition must be addressed on the care plan )i.e. physician's orders, diet changes, therapy changes, behavior changes, ADL changes, skin problems, etc.)...."</p> <p>3.1-35(a)</p>			
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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on record review and interview, the facility failed to ensure the Qualified Medication Aides (QMAs) cared for residents within their scope of practice for 2 of 2 QMAs reviewed for performing neurologic assessments (QMA #8 and QMA#9) for 3 of 4 residents reviewed for neurological assessments in a Stage 2 Sample of 36. (Residents #B, #C, and #Q)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed 2/6/12 at 10:07 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and anxiety.</p> <p>Review of a neurological assessment flowsheet, dated 1/29/12 through 2/1/12, indicated QMA #9 performed the assessments of level of consciousness, pupil response, hand grasp, motor function, pain response, and additional observations on the following dates and times:</p> <p>January 29, at 2:30 a.m., 2:45 a.m., 3:00 a.m., 3:15 a.m., 3:45 a.m., 4:15</p>	F0281	<p>The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Nursing Department Charting policy and procedure was reviewed and no changes were indicated (see attachment N). Licensed nursing staff and QMA's were re-educated on this policy and the QMA Scope of Practice (see attachment O). The DON or her designee will monitor Nurse's Notes and active NeuroCheck sheets daily, on scheduled work days, to ensure QMA's on staff are practicing within their Scope of Practice (see attachment D). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/27/2012			

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	<p>a.m., 4:45 a.m., and 5:15 a.m.</p> <p>January 30, at 1:15 a.m.</p> <p>During an interview on 2/7/12 at 10:28 a.m., with the Director of Nursing (DoN), she indicated only the nursing staff are to perform neurological assessments. She further indicated QMAs were not allowed to perform any type of assessment.</p> <p>2.) The clinical record for Resident #C was reviewed on 2/2/12 at 9:30 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and mild mental retardation.</p> <p>Review of neurological assessment flowsheet dated 1/14/12 through 1/17/12, indicated QMA #9 performed the assessments of level of consciousness, pupil response, hand grasp, motor function, pain response, and additional observations on the following dates and times:</p> <p>January 15, at 2:25 a.m., and 6:25 a.m.</p> <p>January 16, at 3:00 a.m.</p>						

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	<p>During an interview on 2/7/12 at 10:28 a.m., with the Director of Nursing (DoN), she indicated only the nursing staff are to perform neurological assessments. She further indicated QMAs were not allowed to perform any type of assessment.</p> <p>3.) The clinical record for Resident #Q was reviewed on 2/2/12 at 2:44 p.m.</p> <p>Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and diabetes mellitus.</p> <p>Review of neurological assessment flowsheet dated 1/29/12 through 2/1/12, indicated QMA #8 performed the assessments of level of consciousness, pupil response, hand grasp, motor function, pain response, and additional observations on the following dates and times:</p> <p>January 7, at 8:15 a.m., and 12:15 p.m.</p> <p>January 8, at 1:50 p.m.</p> <p>During an interview on 2/7/12 at 10:28 a.m., with the Director of</p>				

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	<p>Nursing (DoN), she indicated only the nursing staff are to perform neurological assessments. She further indicated QMAs were not allowed to perform any type of assessment.</p> <p>4.) Review of the current facility policy, dated 1/08, titled "NURSING DEPARTMENT CHARTING POLICY AND PROCEDURE," provided by the RN Consultant on 2/7/12 at 2:13 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To accurately document in an organized manner all pertinent information related to the resident in the nurses' notes and other designated sections of the clinical record....</p> <p>...QMA DOCUMENTATION GUIDELINES</p> <p>QMAs may observe and document the following: Vital signs Mental Status (oriented, forgetful, confused, etc.) Respiratory status (Resp. rate, presence of cough and observable shortness of breath) Gastrointestinal Status (diarrhea,</p>				

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	<p>frequency of stools, complaints by resident, use of laxatives or stool softeners) Urinary Status (changes in continence or incontinence, presence of a catheter, any complaints, toileting schedule)</p> <p>QMAs should not assess or document on cardiac status, bowel sounds or breath sounds. The licensed nurse must complete these assessments as necessary...."</p> <p>3.1-35(g)(1)</p>			
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F0282 SS=G	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure medication was given as ordered by the physician (Resident #L), failed to ensure sliding scale insulin was given in accordance with physician's orders (Resident #58), and failed to ensure treatment for a pressure area was obtained in accordance with the resident's plan of care (Resident #44), for 3 of 36 residents reviewed for following the plan of care in a Stage 2 Sample of 36.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #L was reviewed on 2/4/12 at 2 p.m.</p> <p>Diagnoses for Resident #L included, but were not limited to, right scrotal abscess, status post surgery, diabetes mellitus, hypertension, multiple sclerosis, chronic urinary tract infection, and dementia.</p> <p>A nursing note, dated 11/27/11 at 5 a.m., indicated "Res noted to have small amt of brownish/yellow penile discharge this shift..."</p>	F0282	<p>The facility will ensure this requirement through the following corrective measures: 1. Residents L, #58 and #44 physician orders were reviewed and compared to MAR to ensure accuracy, along with plans of care. 2. All residents have the potential to be affected. Recapitulation orders, recent telephone orders, MARs, TARs and plans of care were reviewed for all residents to ensure treatments and medications are administered as ordered and treatments obtained and administered as indicated. See below for additional corrective measures. 3. Licensed nursing staff were re-educated on the Physician's Orders policy, Physician notification policy and the Care Planning Development and Review policy (attachments P, C, and K). The DON or her designee will review Nurse's Notes, 24-hour Condition Reports and lab results daily, on scheduled work days, to ensure compliance (see attachment D). Additionally, she or her designee will review physician orders and MAR/TAR's daily to ensure accurate transcription and administration as ordered (see attachment D) daily, on scheduled work days, for four weeks, then weekly for two</p>	02/29/2012			

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	<p>A nursing note, dated 11/27/11 at 1:30 p.m., indicated "Res continues to have small amt of drainage from penis."</p> <p>A nursing note, dated 11/27/11 at 10 p.m., indicated "Res has sm [small] amt of creamy discharge from penis.... Res c/o pain all over-requested pain pill...."</p> <p>A nursing note, dated 11/28/11 at 2:25 p.m., indicated "Res had small amt of discharge...."</p> <p>A nursing note, dated 11/28/11 at 11:20 p.m., indicated "Nurse Practitioner here and receive new order." A progress note written at the time of this visit indicated the resident had a brown mucus penile discharge and the assessment was "Candidiasis." A physician's order, dated 11/28/11, indicated Resident #L was to receive Diflucan (an antifungal medication) 150 mg tab 1 daily for 3 days.</p> <p>This order was transcribed to the November 2011 medication administration record (MAR). The MAR lacked any documentation that the medication was given. The dates the medication was to be given were blank without any initials. The nursing</p>		<p>months, then monthly. 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	

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	<p>notes for November 29, 30, and December 1, 2011 lacked any documentation related to the medication having been given.</p> <p>During an interview with the Director of Nursing (DoN) on 2/7/12 at 10:40 a.m., additional information was requested related to the lack of documentation of the Diflucan medication having been given as ordered by the physician.</p> <p>During an interview on 2/7/12 at 2:25 p.m., the DoN indicated she did not know why the nursing staff had not given the Diflucan medication as ordered by the physician on 11/28/11.</p> <p>2.) Clinical record review for Resident #58 was reviewed on 2/2/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #58 included, but was not limited to, diabetes mellitus, congestive heart failure, and arthritis.</p> <p>Resident #58 had a health care plan problem, dated 10/20/11 and last reviewed on 1/19/12, which indicated she was at risk for experiencing hypoglycemia and/or hyperglycemia related to her diagnoses of diabetes</p>			
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	<p>mellitus. One of the interventions for this problem was "monitor blood sugar as ordered and more frequently as indicated, notify physician per call parameters."</p> <p>The November 2011, December 2011, January 2012, and current physician's orders on the February 2012 recapitulation of orders included, but were not limited to, the following diabetic related orders:</p> <p>Accuchecks tid (three times daily) and at bedtime. Call MD if blood sugar below 50 or above 500.</p> <p>Humalog sliding scale coverage at bedtime: 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=10 units, 451-500=12 units</p> <p>These accucheck and sliding scale insulin coverage orders were present on the medication administration records (MAR) worded as above. Documentation of the sliding scale readings and insulin given was not recorded on the MARs. A notation on the MAR indicated "See flow sheets."</p> <p>The "Blood glucose monitoring records" for those months indicated accuchecks were being done three</p>			
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	<p>times daily before meals. No accuchecks were being completed at bedtime. The monitoring records indicated sliding scale insulin was being given based on the before meal accucheck readings which was not in accordance with the sliding scale insulin order noted above on the physician's recapitulation of orders.</p> <p>Sliding scale insulin coverage ranging between 2 and 6 units was given before meals on over 75 occasions during those months based on the accucheck readings. The physician's orders lacked any order for sliding scale insulin coverage before meals.</p> <p>During an interview with the RN consultant on 2/6/12 at 1:30 p.m., additional information was requested related to the physician's order for accuchecks tid before meals and at bedtime, the sliding scale insulin orders indicating coverage was to be given at bedtime only, the accuchecks only having been done tid before meals on the flow sheets, and sliding scale insulin being given before meals which was not indicated in the physician's order.</p> <p>During an interview with the DON on 2/6/12 at 1:40 p.m., she provided a telephone order, dated 10/11/11,</p>						

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	<p>which indicated coverage at bedtime was to be discontinued, but sliding scale insulin was to be given as noted above tid before meals based on the accucheck results. She provided a telephone order, dated 10/17/11, which indicated the bedtime accucheck was to be discontinued (since no coverage was to be given). She indicated she did not know why these orders were not correct on the physician's recapitulation of orders and did not know why nursing and/or pharmacy staff had not noted the errors.</p> <p>She indicated the physician had been contacted related to the discrepancies noted above. She provided a physician's order, dated 2/6/12, which indicated the accuchecks were to be done tid before meals and Humalog sliding scale insulin noted above was to be given based upon the accucheck readings.</p> <p>3. The clinical record for Resident #44 was reviewed on 2/2/12 at 10:50 a.m.</p> <p>Resident # 44's current diagnoses included, but were not limited to, Parkinson's disease, hypertension, anemia, and dementia with</p>				

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	<p>Alzheimer's,</p> <p>A quarterly Minimum Data Set Assessment, dated 10/27/11, indicated the resident was totally dependent upon the staff for all activities of daily living.</p> <p>A Braden Scale (a tool used to predict the risk of developing pressure sores), dated 10/26/11, indicated Resident #44 was at a high risk for developing a pressure sore.</p> <p>The resident had a healthcare plan initiated 5/6/11 and updated 1/31/12 which indicated the resident had a problem listed as, is at risk for development of pressure ulcers due to decreased mobility, Alzheimer's dementia, Parkinson's disease, bowel and bladder incontinence, delicate skin and history of pressure areas. Interventions for this problem included, but were not limited to, staff to observe skin when providing care, notify the charge nurses of any skin problems for further assessment and possible physician and responsible party notification, apply preventive topical medication as ordered and notify Hospice of any skin issues.</p> <p>The resident had a physician's order for 1:1:1 (nystatin/zinc/bacitracin) a</p>				

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	<p>preventive topical skin ointment to be applied to the coccyx every shift and as needed. The original order date was 1/14/11. The treatment sheets for October, November, December 2011 indicated the 1:1:1 ointment was applied every shift until 12/12/11.</p> <p>A nursing note, dated 12/9/11 (Friday), indicated the following, resident has a 3 centimeter by 3 centimeter bright red open area on top of right buttock - was informed by the hospice aide, skin sheet initiated.</p> <p>The skin sheet for Resident #44, dated 12/9/11, indicated the resident had a Stage 2 open area to the right buttock.</p> <p>The nurses notes lacked any indication the physician was notified of the open area until 12/12/11. (Monday) A physician's order, dated 12/12/11, indicated, discontinue 1:1:1 ointment to coccyx every shift, begin "Dr D's" (a medicated ointment) to open area every shift and as needed until area healed.</p> <p>The December 2011 treatment sheet for Resident #44 indicated the "Dr. D's" treatment to the open area was started on 12/12/11.</p>			
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	<p>The weekly skin sheet indicated the open area was assessed on 12/16/11 and the area had remained unchanged in size.</p> <p>During an interview with the Director of Nursing on 2/3/12 at 4:00 p.m. additional information was requested related to the delay in treatment of Resident #44's open area, which was observed on 12/9/11 and treatment was initiated on 12/12/11.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 1:30 p.m. she indicated she had no additional information to provide related to the resident having a pressure area observed on 12/9/11 and no change in treatment was given until 12/12/11. She indicated the physician should be notified when an open area was first observed and treatment started as soon as possible. This resulted in a 3 day period of the resident having an open area and receiving no medical treatment to the area.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=G	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure continued contact was made with the physician and medication was given as ordered by the physician to prevent a decline in the residents condition resulting in the need for antibiotic therapy and hospitalization for 1 of 6 residents (Resident #L) reviewed for monitoring of a change in condition and failed to ensure sliding scale insulin was correctly given as ordered by the physician for 1 of 5 residents (Resident #B) reviewed for insulin administration in a Stage 2 Sample of 36.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #L was reviewed on 2/4/12 at 2 p.m.</p> <p>Diagnoses for Resident #L included, but were not limited to, right scrotal abscess, status post surgery, diabetes mellitus, hypertension, multiple sclerosis, chronic urinary tract infection, and dementia.</p>	F0309	<p>The facility will ensure this requirement through the following corrective measures: 1. Residents L and B's physician orders were reviewed and compared to MAR to ensure accuracy. Blood glucose monitoring was also reviewed to ensure accurate administration. The MD and responsible party were notified of any errors noted. 2. All residents have the potential to be affected. Recapitulation orders, recent telephone orders, MARs, TARs and Blood Glucose Monitoring records and Nurse's Notes were reviewed for all residents to ensure treatments and medications are administered as ordered and treatments obtained and administered as indicated. See below for additional corrective measures. 3. Licensed nursing staff were re-educated on the Physician's Orders policy, and Physician notification policy (see attachments P and C). The DON or her designee will review Nurse's Notes, 24-hour Condition Reports and lab results daily, on scheduled work days, to ensure compliance (see attachment D). Additionally, she or her designee will review physician orders and</p>	02/29/2012	

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	<p>A health care plan problem, dated 5/25/11 and reviewed on 11/23/11, indicated Resident #L The clinical record indicated the resident had an anchored foley catheter and problems with chronic urinary tract infections related to a history of urinary retention secondary to a urethral stricture. Interventions for this problem included, but were not limited to, administer "medications as ordered" and "observe urine color, amount, odor, consistency, and frequency and notify the charge nurse of noted problems for further evaluation and possible physician and responsible party notification."</p> <p>A nursing note, dated 11/21/11 at 10:00 p.m., indicated "Res [resident] noted to have moderate amt [amount] of penile discharge this shift-brownish, creamy. No c/o [complaints of] pain in penile/scrotal area..... Will cont [continue] to monitor for discharge." The clinical record lacked any information related to the physician having been made aware of the resident's penile discharge.</p> <p>Nursing notes, dated 11/22/11 at 2:20 a.m. and 2 p.m. indicated no penile drainage was noted at those times.</p>		MAR/TAR's and Blood Glucose Records daily to ensure accurate transcription and administration as ordered (see also attachment D) daily, on scheduled work days, for four weeks, then weekly for two months, then monthly. 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.		

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	<p>A nursing note, dated 11/22/11 at 10:00 p.m., indicated "Res having large amt of creamy brownish discharge from penis. No c/o pain. +malodorous. Increase amt when res turned. Res to see MD [medical doctor] at next available time for eval [evaluation]...."</p> <p>A nursing note, dated 11/23/11 at 2 p.m., indicated the physician had looked at the resident related to his penile discharge and no orders were received at that time. The note did not indicate whether the resident had a penile discharge at the time of the physicians visit. The clinical record lacked any physician progress note made at the time of the 11/23/11 visit.</p> <p>A nursing note, dated 11/23/11 at 10 p.m., indicated a slight amount of brownish creamy colored penile discharge had been noted on that shift.</p> <p>A nursing note, dated 11/24/11 at 10 p.m., indicated a small amount of brownish creamy penile discharge had been noted.</p> <p>A nursing note, dated 11/25/11 at 2 p.m., indicated "Mod amount discharge from penis and light brown in color...."</p>			
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	<p>A nursing note, dated 11/25/11 at 8:05 p.m., indicated "When resident turned and repositioned, moderate amount of light brown thin foul smelling drainage comes from penis...."</p> <p>A nursing note, dated 11/26/11 at 1:55 p.m., indicated "res has had a small amt of drainage from penis...."</p> <p>A nursing note, dated 11/26/11 at 10 p.m., indicated "...small amt of creamy brownish discharge noted from penis...."</p> <p>A nursing note, dated 11/27/11 at 5 a.m., indicated "Res noted to have small amt of brownish/yellow penile discharge this shift..."</p> <p>A nursing note, dated 11/27/11 at 1:30 p.m., indicated "Res continues to have small amt of drainage from penis."</p> <p>A nursing note, dated 11/27/11 at 10 p.m., indicated "Res has sm [small] amt of creamy discharge from penis.... Res c/o pain all over-requested pain pill...."</p> <p>A nursing note, dated 11/28/11 at 2:25 p.m., indicated "Res had small</p>			

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	<p>amt of discharge...."</p> <p>The clinical record lacked any physician notification of the resident's continued problems with penile discharge and/or the development of a foul smell associated with the drainage from the time of the physician's visit on 11/23/11 and the visit by the Nurse Practitioner noted below late in the evening on 11/28/11.</p> <p>A nursing note, dated 11/28/11 at 11:20 p.m., indicated "Nurse Practitioner here and receive new order." A progress note written at the time of this visit indicated the resident had a brown mucus penile discharge and the assessment was "Candidiasis." A physician's order, dated 11/28/11, indicated Resident #L was to receive Diflucan (an antifungal medication) 150 mg tab 1 daily for 3 days.</p> <p>This order was transcribed to the November 2011 medication administration record (MAR). The MAR lacked any documentation that the medication was given. The dates the medication was to be given were blank without any initials. The nursing notes for November 29, 30, and December 1, 2011 lacked any documentation related to the</p>			
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	<p>medication having been given.</p> <p>A nursing note, dated 11/29/11 at 1:15 p.m., indicated "Noted res has mod amt drainage from penis. Scrotum swollen.... Call placed to [name of nurse practitioner]. Message left..."</p> <p>A nursing note, dated 11/29/11 at 5 p.m., indicated "...scrotum swollen. MD made aware...." A physician's order dated, 11/29/11 at 8 p.m., indicated the resident's Lasix was to be increased and the staff were to monitor vital signs every shift for 72 hours.</p> <p>The nursing notes indicated that Resident #L was seen by the physician on 11/30/11 at 12:45 p.m. Oral antibiotic therapy and intramuscular antibiotic therapy was ordered. The resident was to be sent to a urologist in 2-3 days if the swelling did not subside.</p> <p>The resident continued to have problems with scrotal swelling and swelling of the right testicle was noted on 12/1/11. A scrotal ultrasound was ordered and completed on 12/2/11 with abnormal results. After consult with the family, the resident was sent to the emergency room for evaluation</p>			
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	<p>on 12/2/11 and then admitted to the hospital for treatment of a scrotal abscess.</p> <p>During an interview with the Director of Nursing (DoN) on 2/7/12 at 10:40 a.m., additional information was requested related to the delay in making the physician aware of the continued drainage and foul odor of the drainage noted above and the lack of documentation of the Diflucan medication having been given as ordered by the physician.</p> <p>During an interview on 2/7/12 at 2:25 p.m., the DoN indicated she had no information to provide related to physician notification of the continued penile drainage and development of a foul odor to the drainage noted above. She indicated she did not know why the nursing staff had not given the Diflucan medication as ordered by the physician on 11/28/11.</p> <p>2.) The clinical record for Resident #B was reviewed on 2/3/11 at 1:16 p.m.</p> <p>Resident #B's current diagnoses included, but were not limited to, diabetes mellitus, hypertension and dementia.</p>			
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	<p>Resident #B had physician's orders for the following,</p> <p>A. Lantus (insulin) inject 5 units subcutaneous every morning. The original date of this order was 1/19/12.</p> <p>B. Humalog (insulin) inject 14 units subcutaneous daily at noon with meal and 10 units with evening meal. The original date of this order was 12/15/11.</p> <p>C. Monitor blood glucose levels before meals and at bedtime: 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 7/20/10.</p> <p>D. Administer Humalog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>200 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 8 units 401 - 450 = 10 units 451 - 500 = 12 units less than 50 call physician or greater than 500 call physician</p> <p>A health care plan, dated 4/1/11</p>				

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	<p>indicated Resident #B had a problem listed as, the resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia and hyperglycemia. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered.</p> <p>Review of the November and December 2011, and January 2012 Medication Administration Record (MAR) for Resident #B indicated documentation of incorrect amounts of sliding scale insulin coverage given on the following dates and times,</p> <p>November 13, 6:30 a.m. blood sugar result was 279, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>November 17, 9:00 p.m. blood sugar result was 238, 4 units of insulin was documented as having been given, the resident should have received 2 units.</p> <p>December 6, 4:30 p.m. blood sugar result was 218, no insulin was documented as having been given, the resident should have received 2 units.</p>			
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	<p>January 22, 4:30 p.m. blood sugar result was 480, 10 units of insulin was documented as having been given, the resident should have received 12 units.</p> <p>January 30, 4:30 p.m. blood sugar result was 353, 6 units of insulin was documented as having been given, the resident should have received 8 units.</p> <p>During an interview with the Director of Nursing (DoN) on 2/7/12 at 10:22 a.m. additional information was requested related to the incorrect amounts of sliding scale insulin coverage having been documented as give on the dates and times noted above.</p> <p>The facility failed to provide any additional information as of exit on 2/7/12.</p> <p>3.) Review of the current facility policy, titled "INJECTIONS, INSULIN," provided by the Director of Nursing on 2/7/12 at 8:25 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Insulin is injected to aid oxidation and utilization of the blood</p>						

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	<p>sugar by the tissues, and to control blood sugar levels in residents with Diabetes Mellitus.</p> <p>POLICY: Insulin is administered by licensed personnel as ordered by the physician....</p> <p>...1. Check the physician's order...</p> <p>...7. Hold insulin syringe with correct calibration in view and withdraw ordered dosage of insulin...."</p> <p>3.1-37(a)</p>			
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F0312 SS=D	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review the facility failed to ensure residents received showers twice weekly as indicated in the facility policy for 2 of 5 residents reviewed for showers in a Stage 2 Sample of 36 (Resident #E and Resident #F).</p> <p><b>Findings include:</b></p> <p>1.) The clinical record for Resident #F was reviewed on 2/2/12 at 9:30 a.m.</p> <p>Resident #F's current diagnoses included, but were not limited to, Type 2 diabetes mellitus, Alzheimer's disease, and seizure disorder.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 12/15/11, indicated Resident #F required extensive assistance from the staff with dressing and personal hygiene .The MDS indicated the resident had no documented behaviors of resisting care.</p> <p>A healthcare plan, initiated 6/17/11 and updated 12/21/11 indicated the resident had a problem listed as, requires assistance from staff with</p>	F0312	The facility will ensure this requirement is met through the following corrective measures: 1. Residents E and F were affected but not harmed. Shower schedules have been sicussed with resident's and they are in agreement with schedule. 2. All residents have the potential to be affected. See below for corrective measures. 3. Nursing staff were re-educated on the Shower procedure (see attachment E). The DON or her designee will review shower.bath documentation twice weekly for 2 months, then weekly for one month, then monthly to ensure compliance with the provision of baths/showers and that any refusals are documented and care planned as such (see attachment F). 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.	02/29/2012			

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	<p>performing activities of daily living due to impaired cognition, Alzheimer's dementia, bowel and bladder incontinence, and impaired communication skills. An approach for this problem included, showers/baths per schedule and more frequently as needed or requested.</p> <p>The shower records for November and December 2011 for Resident #F indicated,</p> <p>November, the week of November 20 through 26 the resident had only 1 shower documented as having been given.</p> <p>November, the week of November 27 through December 1 only 1 shower was documented as having been given.</p> <p>December, the week of December 4 through 10 no shower had been documented as given.</p> <p>December, the week of December 18 through 24 the resident had only 1 shower documented as having been given.</p> <p>The above shower records had no documentation on any date the</p>			
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	<p>resident had refused a shower.</p> <p>During an interview with CNA #6 on 2/7/12 at 8:30 a.m. she indicated when the CNAs give a resident a shower they document the shower was given on the shower sheets.</p> <p>During an interview with CNA #7 on 2/7/12 at 8:40 a.m. she indicated residents are to get showers 2 times weekly. She indicated the residents have specific shower days. She further indicated the CNAs document on the shower sheets when the showers are completed.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 10:00 a.m. she indicated the shower records for Resident #F indicated the resident did not have 2 showers a week. She further indicated the resident should have had at least 2 showers a week.</p> <p><b>2.</b> The clinical record for Resident #E was reviewed on 2/2/12 at 10:15 a.m.</p> <p>Resident #E's current diagnoses included, but were not limited to, chronic back pain, mild mental retardation, and asthma.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 1/3/12, indicated the resident was able to understand and easily understood by others. The resident was able to properly answer the screening questions for the interview process. The MDS indicated the resident required assistance from the staff with all activities of daily living. The MDS indicated the resident had no behavior documented of resisting care.</p>				

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	<p>A health care plan, dated June 30, 2011 indicated the resident required 1-2 staff members to assist with all activities of daily living.</p> <p>During an interview with Resident #E on 2/2/12 at 8:30 a.m., he resident indicated he only received a shower 1 time a week. He indicated he would like to have a shower more often. The resident indicated he would like to have a shower at least twice weekly.</p> <p>Review of the shower records for Resident #E for the months of October, November and December 2011 indicated the resident had indicated,</p> <p>October, no shower was documented as having been given on October 9, 10, 11, 12, 13, 14, and 15.</p> <p>November, only 1 shower was documented as having been given the week of November 20 through November 26.</p> <p>December, only 1 shower was documented as having been given the week of December 4 through 10. Only 1 shower was documented as having been given the week of December 18 through 24.</p> <p>The above shower records for Resident #E had no days document when the resident had refused a shower.</p> <p>During an interview with CNA #6 on 2/7/12 at 8:30 a.m. she indicated when the CNAs give a resident a shower they document the shower was given on the shower sheets.</p> <p>During an interview with CNA #7 on 2/7/12 at</p>			
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	<p>8:40 a.m. she indicated residents are to get showers 2 times weekly. She indicated the residents have specific shower days. She further indicated the CNAs document on the shower sheets when the showers are completed.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 10:00 a.m. she indicated the shower records for Resident #E indicated the resident did not have 2 showers a week. She further indicated the resident should have had at least 2 showers a week.</p> <p><b>3. Review of the current undated facility policy titled, "Shower Procedure", provided by the Director of Nursing on 2/7/12 at 2:13 p.m. indicated,</b></p> <p><b>"Policy: Resident will receive a shower (or preferred method of bathing) two times a week unless condition warrants otherwise or resident refuses...."</b></p> <p><b>Noted: Should a resident refuse a scheduled shower, document the refusal and offer the shower at another time or on another day."</b></p> <p>This federal tag relates to IN00101897.</p> <p>3.1-38(a)2)(A)</p>			
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F0314 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without 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, record review and interview the facility failed to ensure a resident received prompt treatment for a pressure ulcer and failed to provide repositioning services for a resident at risk for developing a pressure ulcer for 2 of 6 residents reviewed for pressure ulcers in a Stage 2 Sample of 36. (Resident #44 and Resident #K)</p> <p><b>Findings include:</b></p> <p>1.)The clinical record for Resident #44 was reviewed on 2/2/12 at 10:50 a.m.</p> <p>Resident # 44's current diagnoses included, but were not limited to, Parkinson's disease, hypertension, anemia, and dementia with Alzheimer's,</p> <p>A quarterly Minimum Data Set Assessment, dated 10/27/11, indicated the resident was totally dependent upon the staff for all</p>	F0314	The facility will ensure this requirement is met through the following corrective measures:1. Residents #44 and M's care plans were reviewed to ensure accuracy. Resident #44's wound is being treated with an appropriate treatment. Resident M has been interviewed to ensure she is in agreement with her get up time and her plan of care has been reviewed. She was laid down and care provided when the issue was brought to the DON's attention immediately.2. All residents with wounds and those residents identified to be at risk for pressure ulcer development using the Braden Scale have the potential to be affected. Care plans and treatment orders were reviewed to ensure interventions remain appropriate.3. Nursing staff were re-educated on the Skin Management Program, including interventions to reduce the risk of pressure ulcer development, and the Care Plan policy and the Physician Notification policy (see attachments Q and K). The DON or her designee will monitor	02/29/2012			

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	<p>activities of daily living.</p> <p>A Braden Scale (a tool used to predict the risk of developing pressure sores), dated 10/26/11, indicated Resident #44 was at a high risk for developing a pressure sore.</p> <p>The resident had a healthcare plan initiated 5/6/11 and updated 1/31/12 which indicated the resident had a problem listed as, is at risk for development of pressure ulcers due to decreased mobility, Alzheimer's dementia, Parkinson's disease, bowel and bladder incontinence, delicate skin and history of pressure areas. Interventions for this problem included, but were not limited to, staff to observe skin when providing care, notify the charge nurses of any skin problems for further assessment and possible physician and responsible party notification, apply preventive topical medication as ordered and notify Hospice of any skin issues.</p> <p>The resident had a physician's order for 1:1:1 (nystatin/zinc/bacitracin) a preventive topical skin ointment to be applied to the coccyx every shift and as needed. The original order date was 1/14/11. The treatment sheets for October, November, December 2011 indicated the 1:1:1 ointment was</p>		<p>wound aaseessment and documentation, along with corresponding plans of care, weekly for 2 months, then monthly for one month, then quarterly thereafter (see attachment R). The DON or her designee will review Nurse's Notes, 24-hour Condition Reports and lab results daily, on scheduled work days, to ensure compliance (see attachment D). The DON or her designee will also monitor residents at risk for pressure ulcer development twice daily, on scheduled working days, for one month, then daily for one month, then weekly to ensure care planned interventions are implemented (see attachment S). Observations will be completed on all three shifts.4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>				

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	<p>applied every shift until 12/12/11.</p> <p>A nursing note, dated 12/9/11 (Friday), indicated the following, resident has a 3 centimeter by 3 centimeter bright red open area on top of right buttock - was informed by the hospice aide, skin sheet initiated.</p> <p>The skin sheet for Resident #44, dated 12/9/11, indicated the resident had a Stage 2 open area to the right buttock.</p> <p>The nurses notes lacked any indication the physician was notified of the open area until 12/12/11. (Monday) A physician's order, dated 12/12/11, indicated, discontinue 1:1:1 ointment to coccyx every shift, begin "Dr D's" (a medicated ointment) to open area every shift and as needed until area healed.</p> <p>The December 2011 treatment sheet for Resident #44 indicated the "Dr. D's" treatment to the open area was started on 12/12/11.</p> <p>The weekly skin sheet indicated the open area was assessed on 12/16/11 and the area had remained unchanged in size.</p> <p>During an interview with the Director</p>						

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	<p>of Nursing on 2/3/12 at 4:00 p.m. additional information was requested related to the delay in treatment of Resident #44's open area, which was observed on 12/9/11 and treatment was initiated on 12/12/11.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 1:30 p.m. she indicated she had no additional information to provide related to the resident having a pressure area observed on 12/9/11 and no change in treatment was given until 12/12/11. She indicated the physician should be notified when an open area was first observed and treatment started as soon as possible. This resulted in a 3 day period of the resident having an open area and receiving no medical treatment to the area.</p> <p>2.) The clinical record for Resident #K was reviewed on 2/4/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #K included, but were not limited to, dysphagia, iron deficiency anemia, and cerebrovascular accident (CVA) with left hemiplegia.</p> <p>A quarterly minimum data set assessment, (MDS) dated 11/5/11</p>				

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	<p>indicated the resident required extensive assistance of the staff for bed mobility, toileting, and transfers and was always incontinent of urine and bowel. The MDS indicated the resident understood others and could be easily understood.</p> <p>A Braden Scale for pressure sore risk, dated 2/3/12, indicated Resident #K had a score of 13. A score of 13 indicated the resident was at moderate risk for the development of pressure sores.</p> <p>A health care plan problem, dated 9/2/11, indicated Resident #K was at risk for the development of pressure ulcers due to multiple health issues including, but not limited to, CVA with left sided hemiplegia, weakness, bowel and bladder incontinence, and limited range of motion in both upper and lower extremities. One of the interventions for this problem was for staff to "encourage and assist resident with turning and repositioning at least every two hours."</p> <p>A health care plan problem, dated 11/22/11, indicated Resident #K required assistance with changing position and body alignment due to her CVA with left hemiplegia. One of the interventions for this problem was</p>			
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	<p>for the staff to "provide the amount of assistance needed to change position approximately every two hours."</p> <p>During observation on 2/1/12 at 11:30 a.m. and 12:25 p.m., Resident #K was up in her geri-chair in the lounge and dining room areas. At 1:15 p.m., the resident was up in her geri-chair in her room and indicated the staff would be arriving shortly to put her to bed. The staff arrived in the room at that time.</p> <p>During an interview on 2/1/12 at 1:20 p.m., the resident was now lying in bed. She indicated she had just been put to bed by the nursing staff and had been up since 4 a.m. She indicated she had not been put back to bed to rest or change her brief since getting up at 4 a.m.</p> <p>During an interview with CNA #10 on 2/1/12 at 1:55 p.m., she indicated she was the CNA providing care to Resident #K on this shift. She indicated Resident #K has been gotten up by the night shift and was up in the geri-chair when she came in at 6 a.m. She indicated she had not put Resident #K back to bed prior to 1:15 p.m.</p> <p>During observations on 2/2/12 at</p>			
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	<p>10:08 a.m., 10:45 a.m., and 11:20 a.m., Resident #K was observed up in her reclining geri chair in the dining room/activity area. The resident was noted in bed at 1:25 p.m.</p> <p>During an interview on 2/2/12 at 4:45 p.m., Resident #K was resting in bed in her room. She indicated she had been gotten up around 4:00 a.m. and had not been put back to bed until after lunch (after 1:00 p.m.).</p> <p>During an interview with the Director of Nursing (DoN) on 2/2/12 at 5:10 p.m., additional information was requested related to Resident #K being gotten up on the night shift and not returning to bed until after lunch.</p> <p>During an interview on 2/3/12 at 8:35 a.m., the DoN indicated she had talked to both the CNA and nurse on the night shift. She indicated the resident had been gotten up around 5:45 a.m. on 2/2/12. She indicated they were sure of this since they usually "save her for last" since she requires two people to get her up. She indicated she was changing assignments and would make sure the resident was put back to bed between breakfast and lunch for toileting and relief of pressure.</p>			
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	<p>This indicated a time period of at least 7 hours without toileting and repositioning services being provided to resident #85 during the daytime hours on 2/1/12 and 2/2/12.</p> <p>3.) Review of the current undated facility policy, titled "Skin Management Program", provided by the Director of Nursing on 2/7/12 at 8:25 a.m. indicated the following,</p> <p>"Purpose: It is our policy to assess for and reduce risk factors that may contribute to the development of pressure ulcers and other skin alterations unless the individual's condition demonstrates that the development is clinically unavoidable.</p> <p>Procedure:</p> <p>Assessment:</p> <p>1. A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter.</p> <p>2. Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any note of red areas, skin tears,</p>			
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	<p>bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment.</p> <p>3. The Braden Scale will be completed upon admission, weekly for 4 weeks post-admission/readmission, quarterly and with significant changes in condition (as defined in the RAI manual) to determine the individual's risk factors.</p> <p>Care Plan Implementation:</p> <p>4. The plan of care will be developed or reviewed following each completion of the Braden Scale by the care plan team. Changes in interventions will be communicated via the 24 hour condition reports and nurse aide assignment sheets.</p> <p>5. Interventions will be implemented according to the individual residents risk factors that will best reduce the risk of development of pressure ulcers and/or promote the most effective healing of existing areas.</p> <p>6. Prevention and treatment interventions will include but are not limited to, the following major categories: nutritional support;</p>			
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	product availability, assistance with mobility and hygiene; physical or occupational therapy; restorative nursing and physician consultation..."  3.1-40(a)(1) 3.1-40(a)(2)			
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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of urine received incontinent care in accordance with her plan of care for 1 of 4 residents reviewed for incontinent care in a Stage 2 Sample of 36. (Resident #K)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #K was reviewed on 2/4/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #K included, but were not limited to, dysphagia, iron deficiency anemia, and cerebrovascular accident (CVA) with left hemiplegia.</p> <p>A quarterly minimum data set assessment, (MDS) dated 11/5/11 indicated the resident required extensive assistance of the staff for bed mobility, toileting, and transfers</p>	F0315	The facility will ensure this requirement is met through the following corrective measures:1. Resident K was not harmed and was provided care as soon as facility administration was notified of the concern.2. All residents exhibiting incontinence have the potential to be affected and have been identified via bowel/bladder assessments. Those residents plans of care were reviewed to ensure appropriate interventions were in place and addignment sheets were revised accordingly. See below for additional corrective measures.3. Nursing staff were re-educated on the Bowel/Blaqdder Rehab policy (see attachment T). The DON or her designee will monbitor twice daily, on scheduled work days, for one month, then daily for one month, then weekly to ensure care planned interventions are implemented (see attachment S). Observations will be completed on all three shifts.4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and	02/29/2012	

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	<p>and was always incontinent of urine and bowel.</p> <p>A "Urinary and Bowel Continence Evaluation" report, dated 11/20/11, indicated Resident #K had functional incontinence related to her inability to toilet due to cognitive and/or physical functioning. The form indicated the resident dribbled urine constantly and was at risk for skin-related complications due to incontinence and moisture.</p> <p>A health care plan problem, dated 9/2/11, indicated Resident #K was incontinent of bladder due to multiple health issues. Two of the interventions for this problem were "approach resident at least every two hours and ask for check for evidence of incontinence" and "provide peri care each shift and with each incontinent episode."</p> <p>During observation on 2/1/12 at 11:30 a.m. and 12:25 p.m., Resident #K was up in her geri-chair in the lounge and dining room areas. At 1:15 p.m., the resident was up in her geri-chair in her room and indicated the staff would be arriving shortly to put her to bed. The staff arrived in the room at that time.</p>		the plan of action adjusted accordingly.				

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	<p>During an interview on 2/1/12 at 1:20 p.m., the resident was now lying in bed. She indicated she had just been put to bed by the nursing staff and had been up since 4 a.m. She indicated she had not been put back to bed to rest or change her brief since getting up at 4 a.m.</p> <p>During an interview with CNA #10 on 2/1/12 at 1:55 p.m., she indicated she was the CNA providing care to Resident #K on this shift. She indicated Resident #K has been gotten up by the night shift and was up in the geri-chair when she came in at 6 a.m. She indicated she had not put Resident #K back to bed prior to 1:15 p.m.</p> <p>During observations on 2/2/12 at 10:08 a.m., 10:45 a.m., and 11:20 a.m., Resident #K was observed up in her reclining geri chair in the dining room/activity area. The resident was noted in bed at 1:25 p.m.</p> <p>During an interview on 2/2/12 at 4:45 p.m., Resident #K was resting in bed in her room. She indicated she had been gotten up around 4:00 a.m. and had not been put back to bed until after lunch (after 1:00 p.m.).</p> <p>During an interview with the Director</p>			
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	<p>of Nursing (DoN) on 2/2/12 at 5:10 p.m., additional information was requested related to Resident #K being gotten up on the night shift and not returning to bed until after lunch.</p> <p>During an interview on 2/3/12 at 8:35 a.m., the DoN indicated she had talked to both the CNA and nurse on the night shift. She indicated the resident had been gotten up around 5:45 a.m. on 2/2/12. She indicated they were sure of this since they usually "save her for last" since she requires two people to get her up. She indicated she was changing assignments and would make sure the resident was put back to bed between breakfast and lunch for toileting and relief of pressure.</p> <p>This indicated a time period of at least 7 hours without toileting services being provided to resident #K during the daytime hours on 2/1/12 and 2/2/12.</p> <p>2.) Review of the current facility policy, dated 3/05, titled "BLADDER &amp; BOWEL REHABILITATION PROGRAM," provided by the Director of Nursing on 2/7/12 at 8:25 a.m., included, but was not limited to, the following:</p>			
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	<p>"PURPOSE: To promote continence through means of bladder and/or bowel retraining or individualized habit programs based on the resident's cognitive ability. To keep the resident clean and dry and to enhance continence by providing routine or scheduled intervals of toileting assistance. (Per AHCPH guidelines)</p> <p>BLADDER REHAB PROCEDURE: 1. Complete the Bladder assessment form at admission, annually and with significant changes, to determine if they are a candidate for a formal retraining program or a habit training program.... ...3. After completion of the assessment and the elimination patterns determine if resident is a candidate for a formal bladder "retraining" program or a bladder "habit" training program.</p> <p>BLADDER HABIT TRAINING PROGRAM- (routine assisted or prompted toileting) 1. Determine if there is a pattern from the 3 day voiding assessment.... ...3. If there is no determinable pattern, develop a plan to toilet the resident at regular intervals and prevent incontinence related complications.</p>						

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	<p>4. Update the care plan and C.N.A. assignment sheet to include the plan...."</p> <p>3.1-41(a)(2)</p>			
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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation and interview the facility failed to ensure resident bathrooms were free from possible accident hazards for 2 of 10 resident bathrooms observed on the 200 hall. (Room numbers 212 and 218)</p> <p>Findings include:</p> <p>During the environmental tour with the Facility Administrator and the Maintenance Supervisor on 2/3/12 at 2:00 p.m. the following concerns were identified,</p> <p>Metal wall mounted heating units in the bathrooms of room numbers 212 and 218 had a section of metal on the end of the heating units which were loose from the unit. A section of the metal had pulled away from the heating units. The section of metal was sharp to the touch. The dial knobs used to adjust the heating units were missing. A 1 inch section of metal extended outward from the heating units where the dial knobs should have been.</p> <p>During an interview with the Maintenance Supervisor at the time of</p>	F0323	<p>The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Baseboard heaters in bathrooms 212 and 218 were repaired and dials were re-placed. Sharp edges were sanded down. 2. Residents with baseboard heaters in bathrooms have the potential to be affected. All baseboard heaters were checked to ensure dials were intact, no sharp edges and no loose parts. 3. The administrator or his designee will complete a facility walk-through weekly for 2 months then monthly thereafter to ensure all needed repairs are scheduled/completed (see attachment J). 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	02/29/2012			

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	<p>the above observation, he indicated he was unaware of the condition of the heating units. He indicated he would fix the heaters as soon as possible. He further indicated the bathroom heating units could possibly cause injury to a resident if their skin came into contact with the exposed metal while in the bathroom.</p> <p>3.1-45(a)(1)</p>			
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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure a resident had a diagnosis to support the use of a medication for 1 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 36. (Resident #107)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #107 was reviewed on 2/3/12 at 8:40 a.m.</p> <p>Resident #107's current diagnoses listed on the clinical record were,</p>	F0329	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #107 was not harmed and a diagnosis obtained for the use of ASA daily. 2. All residents have the potential to be affected. Recapitulation orders were reviewed to ensure a diagnosis was present for all medications ordered. 3. Licensed staff were re-educated on the Physician's Orders policy to ensure a diagnosis was obtained and listed for new medication orders (see attachment P). The DON or her designee will review new physician's orders daily, on scheduled work days, to ensure	02/29/2012	

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	<p>chronic obstructive pulmonary disease,, squameous cell lung cancer, hypertension, gastroesophageal reflux disease, dysphasia, debility, anemia, chronic anxiety, and osteoporosis.</p> <p>The resident had a current physician's order for Aspirin (a medication used for pain relief, reducing fever, and a blood thinning medication) drug 81 milligrams enteric coated give 1 tablet daily. The original order date for the medication was 9/29/11.</p> <p>The clinical record lacked any diagnosis related to why the resident was receiving the Aspirin medication on a routine basis.</p> <p>During an interview with the Director of Nursing on 2/3/12 at 3:00 p.m. additional information was requested related to a diagnosis to support the use of the medication.</p> <p>During an interview with the Director of Nursing on 2/6/12 at 3:00 p.m. she indicated the facility did not have a diagnosis on the clinical record related to the use of the routine Aspirin medication. She further indicated the facility would call the physician and verify the indication for use of the medication.</p>		continued compliance (see attachment D). 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.	

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	3.1-48(a)(4)			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/07/2012	
NAME OF PROVIDER OR SUPPLIER  LIBERTY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
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F0428 SS=D	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the need for diagnoses and/or medication order discrepancies were identified and reported to the attending physician for 2 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 36. (Resident #58 and #107)</p> <p>Findings include:</p> <p>1.) Clinical record review for Resident #58 was reviewed on 2/2/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #58 included, but was not limited to, diabetes mellitus, congestive heart failure, and arthritis.</p> <p>The November 2011, December 2011, January 2012, and current physician's orders on the February 2012 recapitulation of orders included, but were not limited to, the following diabetic related orders:</p>	F0428	<p>The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Resident #58's orders and MAR's were reviewed, along with Blood Glucose Monitoring records, to ensure accuracy and orders obtained accordingly. A diagnosis was obtained to support the use of ASA daily for resident #107. The attending physician was notified. 2. All residents have the potential to be affected. All recapitulation orders, MARs and Blood Glucose Monitoring records were reviewed to ensure accuracy with transcription and diagnosis present to support the use of the medications. 3. Licensed staff were re-educated on the Physician's Orders procedure to ensure a diagnosis is obtained with any new medication order (see attachment P) and the Medication Administration Policy (see attachment U). In an effort to ensure the consultant pharmacist is aware of facility expectations in regard to identification of irregularities (to include, but not limited to, presence of documented</p>	02/29/2012			

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	<p>Accuchecks tid (three times daily) and at bedtime. Call MD if blood sugar below 50 or above 500.</p> <p>Humalog sliding scale coverage at bedtime: 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=10 units, 451-500=12 units</p> <p>These accucheck and sliding scale insulin coverage orders were present on the medication administration records (MAR) as worded as above. Documentation of the sliding scale readings and insulin given was not recorded on the MARs. A notation on the MAR indicated "See flow sheets."</p> <p>The "Blood glucose monitoring records" for those months indicated accuchecks were being done three times daily before meals. No accuchecks were being completed at bedtime. The monitoring records indicated sliding scale insulin was being given based on the before meal accucheck readings which was not in accordance with the sliding scale insulin order noted above on the physician's recapitulation of orders.</p> <p>Sliding scale insulin coverage ranging between 2 and 6 units was given before meals on over 75 occasions</p>		<p>diagnosis and/or medication order discrepancies), a summary of F329 with excerpts from the interpretive guidance was provided to the consultant pharmacist supervisor on 2/21/12 in an effort to re-educate all consultant pharmacists within the contracted pharmacy. Additionally, a conference call was held on 2/28/12 with the supervisory staff of the contracted pharmacy in an effort to review expectations in regard to the reporting of irregularities to the physician and the Director of Nursing. Following the aforementioned training, at the time of the monthly recert/order review, should a discrepancy/irregularity be noted by administrative nursing staff which was not denoted on the consultant pharmacist recommendations/comments made during the monthly review, the same will be addressed with the consultant pharmacist. Should concern be noted with adequacy of the monthly regimen review, the same will be addressed with the consultant pharmacist supervisor to ensure compliance with ensuring the need for the medication (i.e., diagnosis) and/or to ensure the medication order discrepancies are identified and reported to the attending physician. The DON or her designee will review new physician's orders daily, on scheduled work days, to ensure</p>		

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	<p>during those months based on the accucheck readings. The physician's orders lacked any order for sliding scale insulin coverage before meals.</p> <p>During an interview with the RN consultant on 2/6/12 at 1:30 p.m., additional information was requested related to the physician's order for accuchecks tid before meals and at bedtime, the sliding scale insulin orders indicating coverage was to be given at bedtime only, the accuchecks only having been done tid before meals on the flow sheets, and sliding scale insulin being given before meals which was not indicated in the physician's order.</p> <p>During an interview with the DON on 2/6/12 at 3:05 p.m., she provided a telephone order, dated 10/11/11, which indicated coverage at bedtime was to be discontinued, but sliding scale insulin was to be given as noted above tid before meals based on the accucheck results. She provided a telephone order, dated 10/17/11, which indicated the bedtime accucheck was to be discontinued (since no coverage was to be given). She indicated she did not know why these orders were not correct on the physician's recapitulation of orders and did not know why nursing and/or</p>		<p>continued compliance (see attachment D) with diagnosis present for medication orders and proper transcription onto MAR. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>		

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	<p>pharmacy staff had not noted the errors. Additional information was requested related to pharmacy visits and recommendations made for Resident #58.</p> <p>During an interview with the DoN on 2/6/12 at 3:20 p.m., she provided copies of pharmacy visit logs for Resident #58. The logs indicated the pharmacist had reviewed Resident #58's drug regimen in October 2011 between the 1st and 20th of the month, in November 2011 between the 1st and 27th of the month, in December 2011 between the 1st and 21st of the month, and in January 2012 between the 1st and 24th of the month. She indicated no recommendations had been made related to the discrepancies between the accucheck and insulin orders noted above.</p> <p>2. The clinical record for Resident #107 was reviewed on 2/3/12 at 8:40 a.m.</p> <p>Resident #107's current diagnoses listed on the clinical record were, chronic obstructive pulmonary disease,, squameous cell lung cancer, hypertension, gastroesophageal reflux disease, dysphasia, debility, anemia, chronic anxiety, and osteoporosis.</p>			

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	<p>The resident had a current physician's order for Aspirin (a medication used for pain relief, reducing fever, and a blood thinning medication) drug 81 milligrams enteric coated give 1 tablet daily. The original order date for the medication was 9/29/11.</p> <p>The clinical record lacked any diagnosis related to why the resident was receiving the Aspirin medication on a routine basis.</p> <p>During an interview with the Director of Nursing on 2/3/12 at 3:00 p.m. additional information was requested related to a diagnosis to support the use of the medication.</p> <p>During an interview with the Director of Nursing on 2/6/12 at 3:00 p.m. she indicated the facility did not have a diagnosis on the clinical record related to the use of the routine Aspirin medication. She further indicated the facility would call the physician and verify the indication for use of the medication.</p> <p>The clinical record indicated the facility's Pharmacy Consultant had reviewed Resident #107's record on 12/16/11 and 1/18/12. The Pharmacy Consultant's report lacked any</p>				

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	<p>indication of a diagnosis to support the use of the routine Aspirin medication.</p> <p><b>3. Review of the current undated facility policy, titled "Drug Regimen Review", provided by the Director of Nursing on 2/7/12 at 8:25 a.m. indicated the following,</b></p> <p><b>"Policy:</b></p> <p><b>The consultant pharmacist will review the drug regimen of all skilled and intermediate care residents at least monthly and report any observed irregularities in drug use and other drug therapy recommendations to the Director of Nursing, Attending Physician, Administrator, and if applicable, the Medical Director. Drug regimen reviews will include all medications currently ordered for each resident, regardless of pharmacy supplier...</b></p> <p><b>Procedures:</b></p> <p><b>2. The consultant pharmacist will review the medication orders, progress notes, laboratory reports, and MARs [medication administration record] for each resident to evaluate the safety and efficiency of drug therapy, to detect the existence of actual or potentially harmful conditions, and the accuracy of medication administration...</b></p> <p><b>The consultant pharmacist will also assess the accuracy of transcribed orders, check for duplication of medications, look for documentation of medical reason for</b></p>						

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	<p><b>drug use and for appropriate physical, behavioral, and laboratory monitoring of therapy..."</b></p> <p><b>3.1-25(i)</b></p>			
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F0431 SS=A	<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 and interview, the facility failed to ensure discontinued controlled substance narcotics were maintained in a secure, double locked area for one of one storage area for discontinued drugs.</p>	F0431	The facility will ensure this requirement is met through the following corrective measures: 1. Medications were secured appropriately when brought to administrator's attention. 2. All residents have the potential to be affected. See below for	02/29/2012			

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	<p>Findings include:</p> <p>1.) During observation on 2/7/12 at 1:10 p.m., the door to the Director of Nursing's (DoN) office was open. The lights were on in the office with no staff in the office. The connecting door to the Administrator's office was open. The doorway to the hall from the Administrator's office was open also. There was no staff present in either offices.</p> <p>During an observation on 2/7/12 at 1:20 p.m., narcotic storage was checked with the DoN. The discontinued narcotics waiting to be disposed of were in the top drawer of a locked filing cabinet. The drawer contained 3 cards of Lortab 5/500 milligrams (an narcotic pain medication) and 2 cards of Lorazepam 1 milligram (an anti-anxiety medication). The filing cabinet had only 1 lock present.</p> <p>During an interview on 2/7/12 at 1:20 p.m., with the DoN, she indicated the above medications were discontinued and were in the filing cabinet to be destroyed. She indicated her office is always locked when no staff present. During the interview the DoN was informed of the above observation</p>		<p>corrective measures. 3. Licensed nurses were re-educated on storage of controlled substances. The administrator or his designee will monitor three times weekly for two months, then weekly for two months, then monthly to ensure continued compliance (see attachment V). 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>				

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	<p>related to the door being open . She indicated the facility would obtain another lock box for narcotics. She indicated the controlled medications would be kept in the locked file cabinet to ensure a two lock system for narcotics.</p> <p>2.) Review of the current facility policy, dated 8/10, titled "MEDICATION ADMINISTRATION POLICY AND PROCEDURE," provided by the RN Consultant on 2/7/12 at 2:13 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations.</p> <p>PROCEDURE:...</p> <p>...37. All Schedule II narcotics are kept under double locks, per facility policy..."</p> <p>3.1-25(n)</p>			

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure orders for accuchecks and insulin were complete and accurately documented for 1 of 4 residents reviewed for complete and accurate accucheck and insulin orders in a Stage 2 Sample of 36. (Resident #58)</p> <p>Findings include:</p> <p>1.) Clinical record review for Resident #58 was reviewed on 2/2/12 at 2:00 p.m.</p> <p>Diagnoses for Resident #58 included, but was not limited to, diabetes mellitus, congestive heart failure, and arthritis.</p> <p>The November 2011, December 2011, January 2012, and current physician's orders on the February 2012 recapitulation of orders</p>	F0514	<p>The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Resident #58's orders and MAR's were reviewed, along with Blood Glucose Monitoring records, to ensure accuracy and orders obtained accordingly. 2. All residents have the potential to be affected. All recapitulation orders, MARs and Blood Glucose Monitoring records were reviewed to ensure accuracy with transcription. 3. Licensed staff were re-educated on the Physician's Orders procedure to ensure a diagnosis is obtained with any new medication order (see attachment P) and the Medication Administration Policy (see attachment U). The DON or her designee will review new physician's orders daily, on scheduled work days, to ensure continued compliance (see attachment D) with diagnosis present for medication orders and proper transcription onto MAR and Blood Glucose Monitoring</p>	02/29/2012	

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	<p>included, but were not limited to, the following diabetic related orders:</p> <p>Accuchecks tid (three times daily) and at bedtime. Call MD if blood sugar below 50 or above 500.</p> <p>Humalog sliding scale coverage at bedtime: 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=10 units, 451-500=12 units</p> <p>These accucheck and sliding scale insulin coverage orders were present on the medication administration records (MAR) worded as above. Documentation of the sliding scale readings and insulin given was not recorded on the MARs. A notation on the MAR indicated "See flow sheets."</p> <p>The "Blood glucose monitoring records" for those months indicated accuchecks were being done three times daily before meals. No accuchecks were being completed at bedtime. The monitoring records indicated sliding scale insulin was being given based on the before meal accucheck readings which was not in accordance with the sliding scale insulin order noted above on the physician's recapitulation of orders.</p>		Records daily, on scheduled work days, for 4 weeks, then weekly for two months, then monthly thereafter (see also attachment D). 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>Sliding scale insulin coverage ranging between 2 and 6 units was given before meals on over 75 occasions during those months based on the accucheck readings. The physician's orders lacked any order for sliding scale insulin coverage before meals.</p> <p>During an interview with the RN consultant on 2/6/12 at 1:30 p.m., additional information was requested related to the physician's order for accuchecks tid before meals and at bedtime, the sliding scale insulin orders indicating coverage was to be given at bedtime only, the accuchecks only having been done tid before meals on the flow sheets, and sliding scale insulin being given before meals which was not indicated in the physician's order.</p> <p>During an interview with the DoN on 2/6/12 at 1:40 p.m., she provided a telephone order, dated 10/11/11, which indicated coverage at bedtime was to be discontinued, but sliding scale insulin was to be given as noted above tid before meals based on the accucheck results. She provided a telephone order, dated 10/17/11, which indicated the bedtime accucheck was to be discontinued (since no coverage was to be given). She indicated she did not know why</p>			
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	<p>these orders were not correct on the physician's recapitulation of orders and did not know why nursing and/or pharmacy staff had not noted the errors.</p> <p>2.) Review of the current facility policy, dated 5/00, titled "CLINICAL RECORDS," provided by the Director of Nursing on 2/7/12 at 8:25 a.m., included, but was not limited to, the following:</p> <p>"POLICY: This facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. The facility will safeguard clinical records against loss, destruction, or unauthorized use. The facility will keep confidential all information contained in the residents' records, regardless of the form or storage method of records, except when release is required...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			