

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00134747 and IN00134907.</p> <p>Survey dates: August 19, 20, 21, 22, and 23, 2013</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Survey Team: Ginger McNamee RN, TC Betty Retherford RN Karen Lewis RN Jason Mench RN Tina Smith-Staats RN</p> <p>Census bed type: SNF/NF: 127 Total: 127</p> <p>Census payor type: Medicare: 16 Medicaid: 104 Other: 7 Total: 127</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000		

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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	IAC 16.2. Quality review completed by Debora Barth, RN.			

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F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure residents were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 3 of 3 residents who had received Notification of Medicare Non-Coverage Letters. (Residents #'s 71, 154, and 139)</p> <p>Findings include:</p> <p>The Notices of Medicare Non-Coverage Letters were reviewed for Resident #'s 71, 154, and 139 on 8/21/13 at 2:30 p.m.</p> <ol style="list-style-type: none"> Resident #71 was given an undated Notice of Medicare Non-Coverage Letter. The letter was signed but not dated, indicating a discharge on 5/11/13. No Demand Bill was requested. Resident #154 was given an undated Notice of Medicare Non-Coverage Letter. The letter was signed on 7/13/13 for discharge on 7/13/13. No Demand Bill was requested. Resident #139 was given an undated Notice of Medicare 	F000156	<p>F156Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1. Business Office and Case Management staff have been re-educated on the Notices of Medicare Non-Coverage letters.2. All Notices of Medicare Non-Coverage will be dated and will include the facilities daily rate that could be incurred after the end of Medicare coverage 3. The Business Office Manager will audit all Notices of Medicare Non-Coverage weekly for 12 weeks and monthly ongoing 4. .The Business Office Manager will report the findings of the audits to the QAPI committee monthly for 6 months and quarterly thereafter to assure continued compliance</p>	09/22/2013			

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	<p>Non-Coverage Letter. The letter was signed but not dated, indicating a discharge on 6/6/13. No Demand Bill was requested.</p> <p>4. The three letters noted previously lacked any information related to the facility's daily rate that could be incurred after the Medicare coverage ended.</p> <p>The Administrator was interviewed on 8/22/13 at 8:03 a.m. The Administrator indicated he was aware the letters should have been dated and the daily rate information should have been provided for Resident's #71, #154 and #139.</p> <p>3.1-4(f)(3)</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 record review and interview, the facility failed to ensure the physician was notified of laboratory (lab) results for 1 of 5 residents reviewed for unnecessary</p>	F000157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	09/22/2013

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	<p>medications. (Resident #158)</p> <p>Findings include:</p> <p>The clinical record for Resident #158 was reviewed on 8/21/13 at 10:03 a.m.</p> <p>Diagnoses for Resident #158 included, but were not limited to, left hemiparesis, hypertension, and depression.</p> <p>Lab results completed on 8/7/13 were filed in the resident's clinical record. The record lacked any documentation of the physician having been notified of the basic metabolic panel (glucose, blood urea nitrogen, estimated Glomerular Filtration Rate if non-African American, estimated Glomerular Filtration Rate if African American, blood urea nitrogen/creatinine ratio, sodium, potassium, chloride, carbon dioxide, calcium), vitamin B12, folic acid, and hemoglobin A1c lab results.</p> <p>During an interview with the Director of Nursing on 8/22/13 at 9:14 a.m., additional information was requested related to the lack of physician notification of the lab results for Resident #158.</p>		<p>statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. RN who failed to follow up with physician after faxing lab results to physician's office, received re-education on the facilities laboratory notification protocol. Resident # 158's physician was notified of the lab results and no new orders were given. 2. All residents have the potential to be affected. Thus, this plan of correction applies to all residents. Administrative nurses/designees completed a facility wide audit to ensure all residents had appropriate physician notification of lab results. 3. Nursing staff have been re-educated by SDC and DON relative to provision of necessary care and services, including but not limited to, existing policy and procedure related to monitoring the notification of physician. 4. A performance improvement tool "Lab Monitoring with Physician notification" will be utilized by Unit Managers daily on scheduled days to work to assure continued compliance. The D.O.N. or designee will review the findings weekly and shall report to the QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>				

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	<p>During an interview with the Administrator on 8/23/13 at 8:40 a.m., he indicated he had spoken with the physician and the physician had not received the lab results from 8/7/13 for Resident #158.</p> <p>3.1-5(a)(2)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure bowel assessments were completed and interventions initiated in accordance with the resident's plan of care to help prevent constipation for 2 of 22 residents reviewed for following the care plan (Resident #'s 118 and 150) and failed to ensure daily weights were obtained in accordance with physician's orders for 1 of 1 resident reviewed for daily weights. (Resident #C)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #118 was reviewed on 8/21/13 at 7:19 a.m.</p> <p>Diagnoses for Resident #118 included, but were not limited to, colon cancer, anxiety, and depression.</p> <p>A health care plan problem, dated 9/22/10, indicated Resident #118 had a potential for alteration in bowel habit</p>	F000282	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. BM records for Resident 118 & 150 have been reviewed and no treatment for constipation was necessary for either resident. Resident C is no longer a resident at the facility. DNS/designee completed individual performance improvement counseling and re-education with nurses responsible. 2. All residents have the potential to be affected. Thus, this plan of correction applies to all residents. Administrative nurses/designees completed a facility wide audit to ensure all residents had correct BM and weight documentation. During re-admit/new admit, chart audits will be completed by the Unit Manager to assure all new orders including daily weights are transcribed correctly and followed up by the R.D. All concerns were addressed with appropriate follow</p>	09/22/2013			

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	<p>related to colon cancer and diverticulitis. One of the goals for this problem indicated the resident would have a soft formed bowel movement at least every 3 days. Interventions for this problem included monitor bowel movement records, administer medications as ordered, and keep the physician informed.</p> <p>Current physician's orders, signed 7/15/13, for Resident #118 included, but were not limited to, the following orders:</p> <p>a.) Colace (a laxative) 100 milligrams (mg) 1 capsule by mouth twice a day. The original date of this order was 9/15/10.</p> <p>b.) Miralax (a laxative) 17 grams tablet give 17 grams by mouth every day with 8 ounces of water or juice. The original date of this order was 9/15/10.</p> <p>c.) Milk of Magnesia (a laxative) 30 milliliters (ml) by mouth every day as needed for constipation. The original date of this order was 4/9/10.</p> <p>d.) Colace (a laxative) 100 mg 1 capsule by mouth twice a day as needed for constipation. The original date of this order was 6/5/10.</p>		<p>up. 3. Nursing staff have been re-Educated by the SDC and DON relative to provision of necessary care and services, including but not limited to existing policy and procedure related to BM and weights with monitoring and documentation.</p> <p>4. A performance improvement tool, "BM monitoring" was implemented to be utilized by Nursing Administration or designee to monitor for correct BM monitoring and BM protocol compliance. The BM monitoring shall be conducted daily on scheduled days to work and will be ongoing to ensure compliance. A Performance Improvement tool "Daily Weight Auditing Tool 2013" was implemented and will be utilized by the R.D. and will be completed daily on scheduled days of work. The DNS or designee will review findings weekly and shall report to QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>				

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	<p>e.) Enema 133 milliliters rectally every day as needed for constipation. The original date of this order was 6/17/10.</p> <p>The 2013 June and July treatment records included the following:</p> <p>If no bowel movement in 9 shifts give prune juice or apple juice. If no results in 12 shifts give milk of magnesia or dulcolax 10 mg per order, do a bowel assessment, and call the physician for further orders (document in nurses notes).</p> <p>The 2013 June and July treatment records indicated the resident did not have a bowel movement for the following time periods:</p> <p>June 27, 28, 29, and 30, 2013 - 10 shifts without a recorded bowel movement. July 10, 11, 12, 13, and 14, 2013 - 14 shifts without a recorded bowel movement. July 25, 26, 27, 28, and 29, 2013 - 14 shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on June 29</p>			

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	<p>or June 30, after 9 shifts without a recorded bowel movement.</p> <p>The nursing notes, treatment record, and medication administration record lacked any information related to the as needed medication having been given, a bowel assessment having been completed, or the physician having been notified on July 14 after 12 shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on July 27 or July 28, after 9 shifts without a recorded bowel movement.</p> <p>During an interview with LPN #6 on 8/22/13 at 7:29 a.m., additional information was requested related to the lack of bowel monitoring and interventions having been completed for the time periods noted above.</p> <p>During an interview with LPN #6 on 8/22/13 at 12:48 p.m., she indicated she had no additional information to provide related to the lack of bowel monitoring and interventions having been completed for the time periods noted above.</p> <p>2.) The clinical record for Resident</p>			

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	<p>#150 was reviewed on 8/20/13 at 3:38 p.m.</p> <p>Diagnoses for Resident #150 included, but were not limited to, hypertension, dementia, and constipation.</p> <p>Current physician's orders, signed 7/10/13, for Resident #150 included, but were not limited to, the following orders:</p> <p>a.) Milk of magnesia (a laxative) 30 milliliters by mouth every day as needed for constipation. The original date of this order was 5/23/13.</p> <p>The 2013 July treatment record included the following:</p> <p>If no bowel movement in 9 shifts give prune juice or apple juice. If no results in 12 shifts give milk of magnesia or dulcolax 10 mg per order, do a bowel assessment, and call the physician for further orders (document in nurses notes).</p> <p>The 2013 July treatment record indicated the resident did not have a bowel movement for the following time period:</p> <p>July 19, 20, 21, 22, and 23, 2013 - 11</p>						

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	<p>shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on July 22 or July 23, after 11 shifts without a recorded bowel movement.</p> <p>During an interview with LPN #6 on 8/22/13 at 3:49 p.m., additional information was requested related to the lack of bowel monitoring and interventions having been completed for the time period noted above.</p> <p>During an interview with LPN #6 on 8/22/13 at 4:04 p.m., she indicated she had no additional information to provide related to the lack of bowel monitoring and interventions having been completed for the time period noted above.</p> <p>3.) A physician order, dated 8/7/13, indicated Resident #C was to be weighed daily. The order required the physician to be called for a two pound weight gain in one day and/or a four pound weight gain in one week.</p> <p>The August, 2013, Treatment Record (TAR) had documented weights for 8/6/13, 8/7/13 and 8/8/13. The clinical record lacked any other daily</p>				

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	<p>weights for Resident #C.</p> <p>During and interview on 8/21/13 at 2:30 p.m., with the RN Nurse Consultant dental information was requested related to the lack of daily weights for Resident #C.</p> <p>During an interview with the Director of Nursing, on 8/21/13 at 3:15 p.m., she indicated the nurse had failed to transcribe the order to the treatment sheet as ordered by the physician and he had only been weighed for three days.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with skin impairments were assessed for the possible need for treatment for 2 of 3 residents reviewed for skin assessment of the 3 who met the criteria for non pressure related skin conditions. (Residents #C and #D) Findings include:</p> <p>1.) During an observation on 8/19/13 at 10:13 a.m., a large abraded area (approximately 5 inches by 8 inches and irregular in shape) was noted on the resident's outer lower left leg. The skin was red without drainage. The lower extremities presented with notable edema. The resident was wearing shorts and the area was easily visible. The skin was tight and shinny in appearance. The resident denied pain or discomfort.</p> <p>During an observation on 8/20/13 at 2:00 p.m. the area on the resident's leg remained as noted above. The</p>	F000309	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident C was seen by physician for skin condition and edema of lower left extremity. No new orders were given at time of visit. Skin assessment documentation was implemented. Resident D was seen by Nurse Practioner with new treatment orders given along with skin assessment and documentation by nursing staff. DNS/designee completed individual performance improvement counseling and re-education with the nurse(s) responsible. 2. All residents have the potential to be affected. Thus this plan of correction applies to all residents. Administrative nursing/designee completed a facility wide skin sweep to ensure all residents had</p>	09/22/2013	

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	<p>resident was wearing shorts and the area was easily visible.</p> <p>The clinical record for Resident #C was reviewed on 8/21/13 at 8:00 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, recurrent deep vein thrombosis, diabetes, chronic obstructive pulmonary disease, prostate cancer, iron deficiency anemia, arthritis, increased weakness, hyperlipidemia, hypertension, edema, morbid obesity, diabetic neuropathy, and long-anticoagulation therapy.</p> <p>The admission nursing assessment, dated 8/6/13, and subsequent nursing notes through 8/20/13, lacked any information related to the area on the resident's left outer leg.</p> <p>LPN #1 was interviewed on 8/21/13 at 11:00 a.m. LPN #1 indicated she was not aware of the area on the left lower leg of the resident. LPN #1 asked LPN #5 (also working on the unit) if she was aware Resident #C had an area of impaired skin on his outer left leg. LPN #5 indicated she was not aware of this area.</p> <p>2.) During an observation on 8/19/13 at 9:54 a.m., Resident #D was seen up in his geri-chair and a scaly,</p>		<p>appropriate skin assessment, treatment and documentation to any skin issues/concerns. 3. Nursing staff have been re-educated by the SDC and DON relative to provisions of necessary care and services, including but not limited to existing policy and procedure related to monitoring the wound care management program.</p> <p>4. A performance improvement tool "Nursing Rounds QA" was implemented to be utilized by the Unit Managers on scheduled days and be ongoing to ensure compliance. The DON or designee will review the findings weekly and shall report to the P.I. committee monthly for 6 months to track and trend outcomes for compliance.</p>		

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	<p>scabbed area was noted on Resident #D's forehead the approximate size of a quarter. A follow up observation of Resident #D on 8/20/13 at 3:00 p.m., revealed the scaly scabbed area was still present.</p> <p>During a Resident observation on 8/21/13 at 8:00 a.m., the resident was seen lying in bed and a scaly, scabbed area the approximate size of a quarter was noted on Resident #D's forehead. No dressing was present.</p> <p>LPN #5 was interviewed on 8/21/13 at 8:05 a.m. LPN #5 indicated Resident #D had the scaly area on his forehead since she had started working on the unit in the last month. She indicated other nursing staff had informed her the scaly area on the resident's forehead had been present on admission.</p> <p>The clinical record for Resident #D was reviewed on 8/21/13 at 8:20 a.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, Methicillin-resistant staphylococcus aureus, gastrostomy tube placement, tracheostomy, Parkinson's disease, dementia with Lewy bodies, and acute and chronic respiratory failure.</p>			

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	<p>Physician orders, nursing notes, physician progress notes and the physician history and physical lacked any information regarding the scaly, scabbed area on the resident's forehead.</p> <p>LPN #5 was interviewed on 8/21/13 at 3:30 p.m. LPN #5 indicated the Nurse Practitioner was in the building and was going to look at the skin area on Resident #D's forehead. She indicated the Nurse Practitioner was unaware of the condition and could not find any reference to that skin problem by the physician.</p> <p>3.1-37(a)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <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 with multiple pressure areas received repositioning services in accordance with his plan of care for 1 of 3 residents reviewed of the 4 who met the criteria for pressure ulcer review. (Resident #B)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 8/19/13 at 10:45 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, history of peritonitis with surgery, cerebrovascular accident, encephalopathy, hypertension and diabetes mellitus type 2. The clinical record indicated the resident had recently had a health decline and was</p>	F000314	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident B is no longer a resident at the facility. DON/designee completed individual performance improvement counseling and re-education done by SDC and DON with the nursing staff responsible. 2. All residents with routine turn schedules have the potential to be affected; thus this plan of correction applied to only those residents. Administrative nursing/designee has completed an initial audit to assure that all residents with routine turn schedules are in compliance. 3. Nursing staff have been re-educated by SDC</p>	09/22/2013			

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	<p>now receiving hospice services. He was unable to take food orally and received gastrostomy tube feedings at 40 milliliters an hour.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 7/18/13, indicated Resident #B had severe cognitive impairment and required extensive assistance from the staff for all turning and repositioning services. The assessment indicated the resident had two pressure areas on admission.</p> <p>A health care plan, dated 7/22/13 and last updated on 8/19/13, indicated the resident had a problem with impaired skin integrity related to an abdominal surgical wound, a stage 4 pressure area on the coccyx area, a stage 2 pressure area on both buttocks, and an unstageable area on the right hip. Interventions for the problem included, but were not limited to, "reposition per policy".</p> <p>A pressure ulcer risk assessment, dated 8/14/13, indicated the resident had a score of 9. This indicated the resident was at "very high risk" for pressure ulcers.</p> <p>A physician's order, dated 8/14/13, indicated the resident was to be</p>		<p>and DON relative to provision of necessary care and services, including but not limited to existing policy and procedure related to monitoring the turn schedule compliance and wound prevention or worsening. 4. Performance improvement tool "Turn Schedule Tool" was implemented to be utilized by the Unit Manager/Designee on scheduled days and be ongoing to ensure compliance. Performance Improvement tool "Compliance Resident Turn Tool" to be used by staff nurse every shift and turned into the Unit Manager daily. The DON/designee will review the findings weekly and shall report to the QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>				

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	<p>turned "side to side every hour".</p> <p>A nursing note entry, dated 8/19/13 at 6:15 p.m., indicated a new discolored area had been noted on the resident's left hip area. The area was listed as an "unstageable deep tissue injury." The area measured 19.0 centimeters (cm) by 14.0 cm with distinct edges and a clearly visible outline.</p> <p>During observations on the following dates and times, Resident #B was observed for repositioning services.</p> <p>8/21/13 at 8:50 a.m. - Resident #B was observed lying on his back in bed with the head of the bed elevated approximately 45 degrees. The resident's body was tilted slightly to the right. A small pillow was noted to be in place under the left side of the resident's back.</p> <p>8/21/13 at 9:45 a.m. - The resident's body remained in the same position as noted previously. He has moved his head slightly.</p> <p>8/21/13 at 9:57 a.m. - The resident remained in the same position as noted previously.</p> <p>8/21/13 at 10:25 a.m. - The resident remained in the same position as</p>				

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	<p>noted previously with the exception of some head movement.</p> <p>8/21/13 at 11:12 a.m.- The resident remained in the same position as noted at 8:50 a.m.</p> <p>8/21/13 at 11:35 a.m.- The resident's body remained in the same position as noted. The small pillow continued to be in place under the left side of the resident's back. He continued to be tilted to his right. He was noted to have some movement of his head on the pillow.</p> <p>8/21/13 at 11:40 a.m. - LPN #1 and CNA #2 were summoned to the room, removed the pillow from beneath the left side of the resident's back, and used a turn sheet to reposition the resident onto his left side. There were a few grooves noted in the skin on the resident's right hip/buttock/thigh area, but no reddened or new open areas were noted.</p> <p>CNA #2 was interviewed on 8/21/13 at 11:40 a.m. CNA #2 indicated he had turned the resident twice since he came in at 6 a.m. He indicated he had turned the resident around 7 a.m. and around 8 a.m. He indicated CNA #4 and CNA #3 (who was on orientation) had been assisting the</p>			

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	<p>resident since that time.</p> <p>CNA #3 came to the door of the resident's room on 8/21/13 at 11:41 a.m. and CNA #2 asked CNA #3 if she and CNA #4 had repositioned the resident. CNA #3 indicated they had been in the room and attempted to readjust the resident, but they had needed more pillows.</p> <p>The DoN and LPN #1 were interviewed on 8/22/13 at 1:00 p.m. Additional information was requested related to the lack of repositioning services for Resident #B. The DoN indicated she had helped CNA #2 reposition the resident earlier that morning and felt certain that the other CNAs had been repositioning him and she would have them talk with me.</p> <p>CNA #4 was interviewed on 8/22/13 at 1:23 p.m. He indicated he and CNA #3 had repositioned and turned the resident toward the wall on his left side around 10 a.m. He said the resident's newest wound was on the resident's right side and they were trying to keep him off of the wound.</p> <p>The newest wound was on the resident's left side and this was the side the resident would have been on if he was turned toward the wall. The</p>			

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	<p>resident was not positioned on his left side facing the wall during any of the observations noted previously on 8/21/13 from 8:50 a.m. through 11:40 a.m.</p> <p>CNA #3 was interviewed on 8/22/13 at 1:30 p.m. She indicated she and CNA #4 had turned the resident around 9:20 a.m. and he was facing the door which would be his right side. She indicated they turned him again around 10:30 a.m. (more on his back). She indicated they used pillows under him to help relieve pressure, but he was very heavy and it was hard to keep him in position. She indicated they never turned him toward the wall because that was his bad side (the left side with the newest pressure area).</p> <p>The resident was not turned from side to side in accordance with physician's orders during any of the observations on 8/21/13 from 8:50 a.m. through 11:40 a.m.</p> <p>Review of the current facility policy, dated 2011, provided by the Administrator on 8/23/13 at 10:48 a.m., titled "Skin Care and Wound Management Program" included, but was not limited to, the following:</p>			

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	<p>"Facility Practice Guidelines:</p> <p>"The facility attempts to prevent resident/patient skin impairment and to promote the fast healing of an existing wound....</p> <p>"Components of the skin care and wound management program include, but are not limited to, the following:</p> <p>Systematic identification of resident/patients at risk for the developing of pressure ulcers</p> <p>Implementation of preventative measures timely to minimize the potential for developing pressure ulcers and skin integrity issues</p> <p>...Application of treatment protocols based on clinical best practice standards for promotion of wound healing."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure interventions identified in the resident's plan of care were in place to help prevent unassisted ambulation and potential falls for 1 of 2 residents reviewed who met the criteria for falls. (Resident #158)</p> <p>Findings include: The clinical record for Resident #158 was reviewed on 8/21/13 at 10:03 a.m.</p> <p>Diagnoses for Resident #158 included, but were not limited to, left hemiparesis, hypertension, and depression.</p> <p>A quarterly Minimum Data Set assessment, dated 7/19/12, indicated the resident was moderately cognitively impaired, and required extensive assistance with 2 members of the staff for transfers, bed mobility, and toileting.</p> <p>A health care plan problem, dated</p>	F000323	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident # 158 was assessed and appropriate follow up was completed with no concerns found related to the fall. C.N.A. involved received re-education by SDC and disciplinary action by the D.O.N. 2. All residents have the potential to be affected. Thus the plan of correction applies to all residents. Administrative nursing/designee completed a facility wide audit to ensure all residents with falls had appropriate assessments for treatment/interventions and documentation for any related to falls. 3. Nursing staff have been re-educated by SDC and DON relative to provision of necessary care and services including but not limited to existing policy and procedure related the falls management</p>	09/22/2013			

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	<p>7/13/12, indicated Resident #158 required total assistance with all activities of daily living due to multiple health issues including left sided hemiparesis, a decrease in mobility and functional ability, and splints. Approaches for this problem included, but were not limited to, transfer resident per 2 staff.</p> <p>Review of the post fall investigation report for the 7/26/13 fall indicated the resident was lowered to the ground while being transferred by one staff instead of two staff as indicated in the resident's health care plan.</p> <p>During an interview with LPN #1, on 8/22/13 at 8:25 a.m., she indicated she did not know why only one staff transferred resident instead of two staff on 7/26/13.</p> <p>During an interview with the Director of Nursing on 8/22/13 at 9:14 a.m., she indicated the resident was to be transferred with two staff.</p> <p>3.1-45(a)(2)</p>		<p>program. 4. A performance improvement tool, Audit Form "Transfer-C.N.A." was implemented to be utilized by the Unit Managers on scheduled days and be ongoing to ensure compliance. A tracking form will be utilized by Unit Managers to assure all post fall actions are complete. The D.O.N. or designee will review the findings weekly and shall report to the QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to attempt a gradual dose reduction for an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #74)</p> <p>Findings include:</p> <p>Resident #74 was observed on 8/19/13 at 2:53 p.m., sitting in her room quietly.</p>	F000329	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. All resident's receiving psychotropic medications have been reviewed to ensure that all residents have had attempts made at gradual dose reductions and that the	09/22/2013			

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	<p>Resident #74's clinical record was reviewed on 8/22/13 at 9:14 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, mental disorder, psychosis, depression, dementia, and expressive aphasia.</p> <p>The resident's current physician's orders were signed by the Nurse Practitioner on 8/9/13. The resident had an order for Seroquel [an atypical antipsychotic] 25 milligrams [mg] by mouth every night at bedtime for psychosis. The orders indicated the Seroquel order had originated on 10/30/10.</p> <p>A 7/22/13, Social Service Note indicated a quarterly review had been completed and a staff interview was completed due to the resident being unable to respond to questions appropriately. The note indicated the resident had no signs or symptoms of delirium. The note indicated the resident was sleeping too much nearly everyday. The note indicated the resident had no signs and symptoms of psychosis or negative behaviors documented in the progress notes.</p> <p>Review of the Behavior Monitor Logs for June, July, and August of 2013,</p>		<p>attempt is appropriately documented. 2. The physician has reviewed the residents medications and updated a progress note regarding the gradual dose reduction 3. A quarterly audit tool will be completed by the Social Services Director ensure that gradual dose reduction attempts are completed for each resident on psychotropic medications. 4. The Social Services Director will report the findings of the audits to the QAPI committee monthly for 6 months and quarterly thereafter.</p>				

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	<p>lacked any indication of the resident having any behaviors during those months.</p> <p>Review of the "Psychoactive & Sedative/Hypnotic Utilization By Resident," dated 8/5/13, indicated Seroquel antipsychotic order 25 mg daily for psychosis. The comments indicated the following: 4/6/11, per the Nurse Practitioner there was no GDR [gradual dose reduction] with justification. 10/4/11 per MD no GDR with justification. 10/9/12 per Nurse Practitioner no GDR with justification (no patient information.)</p> <p>During an interview on 8/22/13 at 1:39 p.m., the Social Service Director indicated she could not find a justification for not attempting a dose reduction for the Seroquel for Resident #74.</p> <p>3.1-48(b)(2)</p>						

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 include hospice nursing documentation in the clinical record for 1 of 1 residents receiving hospice services. (Resident # 46.)</p> <p>Findings include:</p> <p>The clinical record for Resident #46 was reviewed on 8/20/13 at 3:05 p.m.</p> <p>Diagnoses for Resident #46 included, but were not limited to, lung cancer, hypertension, and debility.</p> <p>The clinical record for Resident #46 did not contain documentation for individual hospice nursing visits.</p> <p>During an interview with LPN #1 on</p>	F000514	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The facility has only one resident receiving hospice services, no other residents are affected. 2. Hospice providers will be required to maintain hospice nursing documentation in the clinical record. 3. The unit manager of any resident receiving hospice services will audit the resident's clinical record weekly to ensure that hospice nursing documentation is included. 4. The unit manager will report the findings of the audits to</p>	09/22/2013			

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	8/22/13 at 10:48 a.m., she indicated she could not find the hospice nurse visit documentation in the resident's clinical record. 3.1-50(a)(1)		the QAPI committee monthly for 6 months and quarterly thereafter to assure continued compliance.		

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify and put in place action plans to address the following concerns: to ensure 3 of 3 residents who met the criteria for Medicare non-Coverage Letters were notified of costs at the end of Medicare payments; to notify the Physician of lab results for 1 of 5 residents; to follow bowel protocol for 1 of 5 residents; to follow care plans for 2 of 34 residents concerning the</p>	F000520	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law 1. Corrective actions as described in the Plan of Correction were taken for all residents relative to concerns of: Medicare	09/22/2013	

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	<p>bowel movement protocol; to provide complete charting on 1 of 34 hospice residents, who were reviewed for complete and accurate charting; to ensure Physician orders were signed for 1 of 5 residents reviewed for unnecessary medications. (Residents #'s 46, 71, 118, 139, 150, 154, 158)</p> <p>Findings include:</p> <p>1.) The undated Notices of Medicare Non-Coverage Letters were reviewed for Resident #'s 71, 154, and 139 on 8/21/13 at 2:30 p.m.</p> <p>The three letters lacked any information related to the facility's daily rate that could be incurred after the Medicare coverage ended.</p> <p>The Administrator was interviewed on 8/22/13 at 8:03 a.m. The Administrator indicated he was aware the letters should have been dated and the daily rate information should have been provided for Resident's #71, #154 and #139.</p> <p>2.) The clinical record for Resident #158 was reviewed on 8/21/13 at 10:03 a.m. Diagnoses for Resident #158 included, but were not limited to, left hemiparesis, hypertension, and</p>		<p>non-Coverage Letters , Notification of the Physician of lab results bowel protocols, following care plans concerning the bowel movement protocol; complete charting on hospice residents, Physician orders being signed appropriately. process . 2. All residents have the potential to be affected. 3. All staff have been in-serviced on the role of QAPI committee 4. The QAPI committee will review monthly action plans and audits related to but not limited to Medicare non-Coverage Letters , Notification of the Physician of lab results bowel protocols, following care plans concerning the bowel movement protocol; complete charting on hospice residents, Physician orders being signed appropriately .</p>				

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	<p>depression.</p> <p>Lab results completed on 8/7/13, were filed in the resident's clinical record. The record lacked any documentation of the physician having been notified of the lab results.</p> <p>During an interview with the Director of Nursing on 8/22/13 at 9:14 a.m., additional information was requested related to the lack of physician notification of lab results for Resident #158.</p> <p>During an interview with the Administrator on 8/23/13 at 8:40 a.m., he indicated he had spoke with the physician and the physician had not received the lab results from 8/7/13 for Resident #158.</p> <p>3.) The clinical record for Resident #118 was reviewed on 8/21/13 at 7:19 a.m.</p> <p>Diagnoses for Resident #118 included, but were not limited to, colon cancer, anxiety, and depression.</p> <p>A health care plan problem, dated 9/22/10, indicated Resident #118 had a potential for alteration in bowel habit</p>						

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	<p>related to colon cancer and diverticulitis. One of the goals for this problem indicated the resident would have a soft formed bowel movement at least every 3 days. Interventions for this problem included monitor bowel movement records, administer medications as ordered, and keep the physician informed.</p> <p>Current physician's orders, signed 7/15/13, for Resident #118 included, but were not limited to, five orders for laxatives, an enema as needed, and stool softeners.</p> <p>The 2013 June and July treatment records included the following:</p> <p>"If no bowel movement in 9 shifts give prune juice or apple juice. If no results in 12 shifts give milk of magnesia or dulcolax 10 mg per order, do a bowel assessment, and call the physician for further orders (document in nurses notes)."</p> <p>The 2013 June and July treatment records indicated the resident did not have a bowel movement for the following time periods:</p> <p>June 27, 28, 29, and 30, 2013 - 10 shifts without a recorded bowel movement.</p>			

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	<p>July 10, 11, 12, 13, and 14, 2013 - 14 shifts without a recorded bowel movement.</p> <p>July 25, 26, 27, 28, and 29, 2013 - 14 shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on June 29 or June 30, after 9 shifts without a recorded bowel movement.</p> <p>The nursing notes, treatment record, and medication administration record lacked any information related to the as needed medication having been given, a bowel assessment having been completed, or the physician having been notified on July 14 after 12 shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on July 27 or July 28, after 9 shifts without a recorded bowel movement.</p> <p>During an interview with LPN #6 on 8/22/13 at 7:29 a.m., additional information was requested related to the lack of bowel monitoring and interventions having been completed for the time periods.</p>			

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	<p>During an interview with LPN #6 on 8/22/13 at 12:48 p.m., she indicated she had no additional information to provide related to the lack of bowel monitoring and interventions having been completed for the time periods.</p> <p>4.) The clinical record for Resident #150 was reviewed on 8/20/13 at 3:38 p.m.</p> <p>Diagnoses for Resident #150 included, but were not limited to, hypertension, dementia, and constipation.</p> <p>Current physician's orders, signed 7/10/13, for Resident #150 included, but were not limited to, an order for as needed Milk of magnesia (a laxative) 30 milliliters by mouth every day for constipation. The original date of this order was 5/23/13.</p> <p>The 2013 July treatment record included the following:</p> <p>"If no bowel movement in 9 shifts give prune juice or apple juice. If no results in 12 shifts give milk of magnesia or dulcolax 10 mg per order, do a bowel assessment, and call the physician for further orders (document in nurses notes)."</p>						

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	<p>The 2013 July treatment record indicated the resident did not have a bowel movement for the following time period:</p> <p>July 19, 20, 21, 22, and 23, 2013 - 11 shifts without a recorded bowel movement.</p> <p>The nursing notes and treatment record lacked any information related to juice having been given on July 22 or July 23, after 11 shifts without a recorded bowel movement.</p> <p>During an interview with LPN #6 on 8/22/13 at 3:49 p.m., additional information was requested related to the lack of bowel monitoring and interventions having been completed for the time period.</p> <p>During an interview with LPN #6 on 8/22/13 at 4:04 p.m., she indicated she had no additional information to provide related to the lack of bowel monitoring and interventions having been completed for the time period noted previously.</p> <p>5.)The clinical record for Resident #46 was reviewed on 8/20/13 at 3:05 p.m.</p>			

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	<p>Diagnoses for Resident #46 included, but were not limited to, lung cancer, hypertension, and debility.</p> <p>The clinical record for Resident #46 did not contain documentation for individual hospice nursing visits.</p> <p>During an interview with LPN #1 on 8/22/13 at 10:48 a.m., she indicated she could not find the hospice nurse visit documentation in the resident's clinical record.</p> <p>6.) The clinical record for Resident #158 was reviewed on 8/21/13 at 10:03 a.m.</p> <p>Diagnoses for Resident #158 included, but were not limited to, left hemiparesis, hypertension, and depression.</p> <p>The clinical record for Resident #158 indicated she had been seen by the physician on 4/5/13 and 7/18/13.</p> <p>The clinical record for Resident #158 lacked signed physician orders.</p> <p>During an interview with the Director of Nursing, on 8/22/13 at 9:14 a.m., a copy of the most recent signed physician orders were requested.</p>			

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	<p>The facility failed to provide any additional information related to the signed physician orders as of exit on 8/23/13.</p> <p>7.) During an interview with the Administrator on 8/23/13 at 8:40 a.m., he indicated the facility had not implemented a plan of action related to the billing information for Resident #'s 71, 154, and 139. He indicated the facility's Quality Assurance and Assessment Committee had not identified problems with physicians not being notified of laboratory results timely, of the facility not following the bowel protocol for residents, of hospice notes not being a part of a resident's clinical record and of physicians not signing orders timely.</p> <p>3.1-52(b)(2)</p>			

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F009999 SS=D	<p>3.1-22 PHYSICIAN SERVICES</p> <p>(c) The physician must do the following: (3) Sign and date all orders. Verbal orders shall be countersigned and dated on the clinical record the next physician's visit. The use of facsimile to transmit physicians orders is permissible. All matters of privacy and confidentiality of records shall be maintained.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure physician orders were signed signed timely for 1 of 5 residents reviewed for unnecessary medications. (Resident #158)</p> <p>Findings include:</p> <p>The clinical record for Resident #158 was reviewed on 8/21/13 at 10:03 a.m.</p> <p>Diagnoses for Resident #158 included, but were not limited to, left hemiparesis, hypertension, and depression.</p>	F009999	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident # 158's clinical record was seen by the Nurse Practitioner and the Medical Director has signed the current recaps. She was seen by her attending physician with a review of her medication regimen and orders signed. 2. All residents have the potential to be affected, thus this plan of correction applies to all residents. Medical records coordinator audited all clinical records for signed physician orders and found no other concerns. 3. Medical records staff have implemented a new plan to assure all clinical records are signed timely and are in compliance. 4. A performance improvement tool "Signed Clinical Record" during monthly review of Recap/Rewrites (Physician orders) will be utilized by the Unit Managers during the chart audit. The DON or designee will monitor the findings weekly and shall report to the QAPI committee</p>	09/22/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		
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	<p>The clinical record for Resident #158 indicated she had been seen by the physician on 4/5/13 and 7/18/13.</p> <p>The clinical record for Resident #158 lacked signed physician orders.</p> <p>During an interview with the Director of Nursing, on 8/22/13 at 9:14 a.m., a copy of the most recent signed physician orders were requested.</p> <p>The facility failed to provide any additional information related to the signed physician orders as of exit on 8/23/13.</p>		monthly for 6 months to track and trend outcomes for compliance.		