STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00119089. Complaint IN00119089 - Substantiated. Federal/State deficiencies related to the allegations are cited at F364. Survey dates: November 26, 27, 28, 29, 30, 2012 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Survey team: Ginger McNamee, RN, TC Betty Retherford, RN Karen Lewis, RN Census bed type: SNF/NF: 63 SNF: 8 Total: 71 Census payor type: Medicare: 12 Medicaid: 49 Other: 10 Total: 71	F0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 12/10/12 by Suzanne Williams RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on record review and interview, the facility failed to ensure call lights were answered timely for 3 of 23 residents interviewed in regard to timely call light response. [Resident #'s 88, 2, 24] Findings include: 1. Resident #88's clinical record was reviewed on 11/28/12 at 9:52 a.m. The resident had a 10/10/12, admission Minimum Data Set Assessment indicating the resident scored a 12 on his Brief Interview for Mental Status indicating the resident had moderate cognitive impairment. The assessment indicated the resident required the extensive assistance of one for transfers and toileting and limited assistance with ambulation in his room. During an interview with the resident on 11/27/12 at 9:10 a.m., the resident indicated he has on occasion had wait up to one half hour for his call light to be answered. He indicated he	F0241	1. The concern cited has occurred in the past and is unable to be corrected. 2. All residents have the potential to be affected.3. All staff inserviced on the call light policy. Five residents will be interviewed each shift to determine staff is responding to resident's needs, times four weeks, then monthly times three, and quarterly thereafter.4. DON/designee will audit timeliness of call lights daily times two weeks, then three times a week for one month, then monthly times three, and quarterly thereafter. Concerns will be reported to QA Committee for action.5. Completion Date - 12/30/12.	12/24/2012

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	could use the large wall clock at the foot of his bed to time the staff's response to his call light. He indicated he has been incontinent a few times due to the long waits. 2. The clinical record for Resident #B was reviewed on 11/28/12 at 2:25 p.m. Diagnoses for the resident included, but were not limited to, chronic respiratory failure, chronic pain, and congestive heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 10/26/12, indicated Resident #B had no cognitive impairment. The assessment indicated she understood others and was easily understood by others. During an interview on 11/27/12 at 12:45 p.m., Resident #B indicated she had to wait over 20 minutes for her call light to be answered at least "20 times" per week. She indicated the staff sometimes turn her call light off and say they will be back and then not return. She indicated there was a clock in her room and she was able to determine the length of time the call light was on prior to being answered.			

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	3. The clinical record for Resident #2 was reviewed on 11/29/12 at 1:00 p.m. Diagnoses for the resident included, but were not limited to, osteoarthritis, chronic pain, hypertension, and esophageal reflux. A quarterly MDS assessment, dated 10/26/12, indicated the resident had moderate cognitive impairment but understood others and was easily understood by others. The clinical record indicated the resident received Lasix (a diuretic) 60 milligrams daily for edema. During an interview on 11/27/12 at 1:55 p.m., Resident #2 indicated she had to wait to go to the bathroom on many occasions. She indicated 15 minutes was the average wait, but often it would be longer. She indicated sometimes she was incontinent of urine while waiting for assistance. She indicated sometimes the staff would come in, turn the light off, say they will return, and then not return. She indicated there was a clock in her room and she was able to determine the length of time the call light was on prior to being answered.			

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	4. During a review of the resident council minutes, dated from January 10th through November 13, 2012, the following was noted: 10/9/12 "...Resident council concerns consist of: Nursing-...having to wait a long time for call lights to get answered 30 minutes or longer wait time and sometimes they walk past the light and ignore it, or they come in and turn the call light off and walk away...." 11/13/12 "Nursing concerns-still waiting too long for call lights to be answered...." 5. Review of the current facility policy, dated 4/12, titled "CALL LIGHT," provided by the Administrator on 11/30/12 at 7:50 a.m., included, but was not limited to, the following: "Purpose: To respond to the resident's requests and needs in a timely manner. Performed by: All Staff... ...Procedure: 1. Answer call light promptly and turn off light after entering room.... ...4. Respond to the request. If an			

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	item is not available, the request is questionable, or the staff member answering light is unable to fulfill resident's request, get assistance from the appropriate staff. Return to the resident with a prompt reply as needed...." 3.1-3(t)			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review and interview, the facility failed to follow resident's preferences in regards to times of rising and going to bed for 2 of 23 resident interviewed in regards to making choices. [Resident #'s 131, 88] Findings include: 1.) Resident #131's clinical record was reviewed on 11/28/12 at 9:11 a.m. A review of an Admission/Readmission Nursing Observation dated 11/19/12, indicated the resident's usual time of rising was 8:00 a.m. During an interview with Resident #131 on 11/26/12 at 1:41 p.m., she indicated she was not able to choose the time she gets up in the morning. She indicated the facility wanted her to get up at 6:30 a.m., and breakfast is not served until 8:00 a.m.	F0242	1. Resident #88 has been discharged. Resident #131 was interviewed and her choices will be honored. 2. All residents have the potential to be affected. All interviewable residents have been interviewed and choices will be reviewed with each care plan review.3. All current residents and new residents will be interviewed upon admission for what time they would like to arise and what time they would like to go to bed. Those choices will be honored. Staff will be inserviced on resident's rights to make choices. 4. DON/Social Service/Designee will interview five residents per week times three months, monthly times three months, then quarterly through QA thereafter, to determine choices are being honored. Concerns will be reported to QA Committee for actions. 5. Completion Date - 12/30/12.	12/30/2012

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	During an interview on 11/28/12 at 8:37 a.m., the resident indicated that morning she was gotten up at 6:00 a.m. She indicated she had only been at the facility for about a week. She indicated she was at the facility for therapy and would be returning home when it is completed. She indicated she would stay up until midnight at home and continues to do so at the facility. She indicated she did not get up until about 9:00 a.m. in the mornings at home. She indicated the facility did not discuss with her what time she would like to get up in the mornings. She indicated other than going to therapy before lunch, she just sits in her chair all day and her bottom gets tired from sitting all day. She indicated she is a fall risk and has to call for help for transferring, toileting, and ambulation. During an 11/28/12, 8:55 a.m., interview with LPN #2, she indicated residents are asked on admission what their preferences for going to bed at night and getting up in the morning are. She indicated Resident #131 was interviewable and said she normally got up around 8 am. 2.) Resident #88's clinical record was reviewed on 11/28/12 at 9:52 a.m. The resident had a 10/10/12,			

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	admission Minimum Data Set Assessment indicating the resident scored a 12 on his Brief Interview for Mental Status. The score of 12 indicated the resident had moderate cognitive impairment. The assessment indicated the resident required the extensive assistance of one for transfers and toileting and limited assistance with ambulation in his room. The resident had an "Admission/Readmission Nursing Observation" dated 10/3/12, which indicated the resident's usual bedtime was 11:00 p.m. and usual rising time 9:00 a.m. During an interview with Resident #88 on 11/27/2012 at 8:46 a.m., he indicated "they kick me out of bed at 6:30 a.m. and I have to sit for an hour and a half before breakfast and then have to sit here until lunch." He indicated he has to go to bed at 7:00 p.m. and he would prefer to stay up until 9:00 p.m. The resident indicated he was at the facility for therapy and would be returning back to his own home. During an 11/28/12, 8:55 a.m., interview with LPN #2 and CNA #5, LPN #2 indicated residents are asked			

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	on admission what their preferences for going to bed at night and getting up in the morning are. CNA #5 indicated the resident had not said he did not want to get up early. During an interview with the RN Consultant and the Administrator on 11/28/12 at 9:55 a.m., they both indicated the residents' wishes should be followed related to bedtime and arise time preferences. 3.1-3(u)(1)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview, the facility failed to develop a comprehensive health care plan for 1 of 10 residents reviewed for unnecessary medications. (Resident #67) Findings include: The clinical record for Resident #67 was reviewed on 11/29/12 at 9:28 a.m. Diagnoses for the resident included, but were not limited to, diabetes	F0279	1. Resident #67's care plan has been updated. 2. All residents with the diagnosis of diabetes have the potential to be affected. The care plans of these residents will be reviewed and updated as indicated. 3. Nursing staff have been inserviced on the care plan process. 4. DON/designee will review five care plans per week times four, then ten care plans per month times three, and quarterly through QA thereafter. Concerns will be reported to QA Committee for action. 5. Completion Date - 12/30/12.	12/30/2012

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	mellitus, dementia, hypertension, and hyperlipidemia. Resident #67 had physician's orders for the following, A. Lantus (insulin) 100 units/milliliter (ml) inject 8 units subcutaneous once a day at bedtime. The original date of the order was 11/9/12. B. Monitor blood glucose levels twice daily at 7:00 a.m. and 5:00 p.m. The original date of this order was 6/13/12. C. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below, 60 -200 = 0 units 201 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 8 units If glucometer less than 60 call the physician. If glucometer greater than 401 call the physician. The original date of this order was 6/13/12. The resident had a 9/14/12, Significant Change Minimum Data			

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	Set Assessment. The assessment indicated the resident had diabetes mellitus and received insulin injections seven days a week. The clinical record for Resident #67 lacked any comprehensive health care plan having been developed related to his diagnosis of diabetes mellitus requiring the need for insulin and blood glucose monitoring. During an interview with the Director of Nursing on 11/30/12 at 9:05 a.m., additional information was requested related to the lack of a comprehensive health care plan having been developed for Resident #67's diagnosis of diabetes mellitus. During an interview with RN #1 on 11/30/12 at 9:48 a.m., she indicated Resident #67 did not have a health care plan related to his diagnosis of diabetes mellitus. Review of the current facility policy, dated 6/10, titled "CAA Process and Care Planning," provided by RN #1 on 11/30/12, at 9:59 a.m., indicated the following: The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives			

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	and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. 3.1-35(a)			

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F0309 SS=G	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.			
	Based on record review and interview, the facility failed to ensure a resident with ear drainage was monitored and assessed and medications to treat an ear infection with drainage were started promptly after ordered by the physician to prevent potential pain and allow for the resident with hearing loss to return to wearing her hearing aide, for 1 of 1 resident reviewed with purulent ear drainage. (Resident #41) Findings include: The clinical record for Resident #41 was reviewed on 11/27/12 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, the following: dementia, diabetes mellitus, hearing loss, and history of brain cancer. The clinical record indicated the resident was admitted to the facility on 10/18/12.	F0309	1. Resident #41 no longer resides at the facility. 2. All residents have the potential to be affected. An audit/review of physician progress notes written in the past 30 days was completed. A daily audit/review is completed on all new physican progress notes written.3. Nurses have been inserviced on the assessment policy and starting medications timely. DON/designee will review physician progress notes daily for any orders written in the notes. DON or designee will review progress notes daily for any needed follow-up assessments and documentation.4. DON/designee will audit five records five times per week times four weeks, then monthly times three, and quarterly through QA, thereafter for follow-up documentation and timely physician orders. Concerns will be reported to the QA Committee for action.5. Completion Date - 12/30/12.	12/30/2012

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	An Internal Medicine history and physical, dated 10/18/12, indicated the resident had been seen due to difficulty with gait and bilateral lower extremity edema. The note also indicated the resident was having a problem with left ear pain which had improved following treatment with antibiotic ear drops. An admission Minimum Data Set assessment, dated 10/25/12, indicated the resident was severely cognitively impaired, required a hearing aide for adequate hearing, and required extensive assistance with all activities of daily living. The clinical record indicated the resident was not receiving any ear drops at the time of admission to the facility. A nursing note, dated 11/18/12 at 6:12 p.m., indicated a CNA had called the nurse to the resident's room due to left ear drainage being noted. The note indicated the resident had tan-yellow drainage in outer ear and this was cleaned with a gauze square. The note indicated the resident's husband told the nurse the resident had had problems with drainage in her ears for "some time". The note indicated the husband took the resident's hearing aid home and she was not wearing one at the present			

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	time. The resident's temperature was taken and was within normal limits. The next nursing note, dated 11/19/12 at 1:34 p.m., indicated "Resident's husband stated that she has some drainage out of her left ear. He said that in the past, it was treated with ear gtts [drops], but he did not know what kind they were. He said he brought some from home and wanted to know if he could put them in. Nurse explained to him that [name of physician] would need to order the medication. Nurse spoke with [name of physician] and he stated that he looked at resident's ears last week and did not see any drainage at that time. He stated he would look again tomorrow when he does rounds." The note lacked any assessment by the nurse related to ear drainage, possible ear pain, and/or vital signs having been taken. There were two nursing note entries for 11/20/12 and they both pertained to a blood blister on the resident's left lower leg. There were no assessments for ear drainage, abnormal vital signs, and/or possible ear discomfort noted in the nursing notes for 11/18, 11/19, and 11/20/12.			

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	A physician's progress note, dated 11/21/12 at 12:25 p.m., indicated the physician had visited the resident and noted copious purulent drainage from the left external canal. His "assessment" indicated she had "external otitis, possible related to the use of a hearing aid." The note indicated Cortisporin otic [ear] drops [an anti-inflammatory/antibiotic ear drop] were ordered four times daily for ten days and the resident would be re-evaluated at that time. The Medication Administration Record for Resident #41 lacked any information related to Cortisporin ear drops having been initiated on 11/21/12 or given through 11/27/12. During an interview with the resident's husband on 11/27/12 at 3:10 p.m., he indicated he had concerns related to his wife's ear drainage. He indicated he had talked to the staff and the physician about it and thought ear drops were supposed to have been ordered. He indicated his wife was not receiving any ear drops and the drainage problem continued. He indicated he had taken his wife's hearing aid in for cleaning/repair due to the ear drainage, but she could not wear it again until the ear drainage			

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	problem was resolved. He indicated her hearing was extremely poor without the hearing aide. He indicated she had a long history of ear problems. During an interview on 11/27/12 at 3:40 p.m. with LPN #4, additional information was requested related to any ear drops having been ordered for Resident #41. On 11/27/12 at 4:05 p.m., LPN #3 provided a physician's order, dated 11/27/12, which indicated the resident was to receive Cortisporin otic drops 4 times daily to left ear for 10 days. A nursing note, dated 11/27/12 at 2:10 p.m., indicated "[name of physician] was approached by QMA stating husband would still like resident to have ear drops. [name of physician] stated he previously had written that in notes last week. Progress note had not been noted. [name of physician] aware and said to start ear drops today...." This indicated a delay of six days from the date the order was first received until the ear drops would be initiated. There were no nursing notes for 11/22, 11/23, 11/24, 11/25, and 11/26/12. The clinical record			

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	lacked any nursing assessment related to possible ear drainage and/or ear pain or assessment of the resident's vital signs on those dates noted above. During an interview with the Director of Nursing on 11/29/12 at 1:00 p.m., additional information was requested related to the lack of monitoring and timely initiation of treatment for Resident #41 in regard to the left ear drainage noted on 11/18/12 and continuing through 11/27/12. The facility failed to provide any additional information as of exit on 11/30/12. Review of the current facility policy, dated 1/12, titled "ADMINISTRATIVE PHYSICIAN'S ORDERS," provided by the RN Consultant on 11/30/12 at 8:50 a.m., included, but was not limited to, the following: "Purpose: To provide general guidelines when receiving, transcribing, notification, and care planning physician's orders. Performed by: Licensed Nursing... ...5. Following a physician visit, a licensed nurse will: Check for any orders that require			

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	verification. The orders will be verified by the nurse and the instructions for the order will be completed. Check the paper chart for any new written physician orders and transcribe them into the electronic medical record...." 3.1-37(a)			

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on record review and interview, the facility failed to ensure food was served at the proper temperature for 4 of 23 residents interviewed in regards to food palatability. (Resident #'s B, D, C, and E) Findings include: 1.) The clinical record for Resident #B was reviewed on 11/28/12 at 2:25 p.m. Diagnoses for the resident included, but were not limited to, chronic respiratory failure, chronic pain, and congestive heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 10/26/12, indicated Resident #B had no cognitive impairment. The assessment indicated she understood others and was easily understood by others. During an interview on 11/27/12 at	F0364	1. Unable to correct as the alleged deficiency occurred in the past. 2. All residents have the potential to be affected. 3. Staff have been inserviced on serving food at the proper temperature. DON/designee will interview five residents at each meal times four weeks, once a week times one month, and quarterly thereafter. Test trays will be checked weekly in each area times three, then monthly times three, then quarterly thereafter. Any item not at proper temperature will be replaced or warmed.4. DON/designee will review interviews and report concerns to the QA Committee for action. 5. Completion Date - 12/30/12.	12/30/2012

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	12:45 p.m., Resident #B indicated she received cold food at least 5 times a week. 2.) The clinical record for Resident #D was reviewed on 11/28/12 at 1:00 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, cardiovascular disease, and arthritis. A quarterly MDS assessment, dated 9/7/12, indicated Resident #D had no cognitive impairment. The assessment indicated she understood others and was easily understood by others. During an interview on 11/26/12 at 11:00 a.m., Resident #D indicated she was served cold food at least 3 or 4 times a week. She indicated she ate her meals in the dining room and "the potatoes and french fries are always cold." 3.) The clinical record for Resident #C was reviewed on 11/29/12 at 10:15 a.m. Diagnoses for the resident included, but were not limited to, anxiety state,			

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	bipolar disorder, and depressive disorder. An annual MDS assessment, dated 9/7/12, indicated Resident #C had no cognitive impairment. The assessment indicated she understood others and was easily understood by others. During an interview on 11/26/12 at 11:15 a.m., Resident #C indicated she received cold food at least once daily. 4.) The clinical record for Resident #E was reviewed on 11/28/12 at 10:43 a.m. An annual minimum data assessment, dated 9/21/12, indicated Resident #E had a BIMS (Brief Interview for Mental Status) of 14/15, and no problems with her ability to understand others. During an interview with Resident #E on 11/27/12 at 11:01 a.m., information was requested regarding facility meals and food service. Resident #E indicated she ate her meals in her room. She indicated the food was cold and too bland. 5.) During a review of the resident council minutes, dated from January			

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	10th through November 13, 2012, the following was noted: 7/10/12 "...Resident concerns consisted of: ...Dietary-...food cold upon arrival." 10/09/12 "Dietary - residents desire warm food served especially at supper...." This federal tag relates to Complaint IN00119089. 3.1-21(a)(2)			

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F0428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on record review and interview, the facility failed to ensure the consultant pharmacist reviewed medication orders to ensure the dosages did not exceed the maximum daily dose 1 of 10 residents reviewed for unnecessary medications. [Resident #26] Findings include: Resident #26's clinical record was reviewed on 11/29/12 at 8:20 a.m. The resident's current Physician's Orders were signed and dated by the physician on 11/27/12. The resident's orders included, but were not limited to, acetaminophen 1000 mg by mouth every 4 hours as needed for pain. The resident had the potential to receive 6000 mg of acetaminophen in a 24 hour period. Review of the "2010 Nursing Spectrum Drug Handbook" indicated the adult dose for 1000 mg is 3 or 4 times a day and	F0428	1. Resident #26 has never received more than 4000 mg/day. The order was clarified to include that the resident is not to receive more than 4000 mg of acetaminophen per day. 2. All residents who receive acetaminophen have the potential to be affected. 3. Nurses have been inserviced on the dosage limitations of acetaminophen in twenty-four hours. Consultant Pharmacist reviewed all residents with acetaminophen orders to ensure the dosages do not exceed the maximum daily dose. Pharmacy recommendations have been followed through with orders updated.4. DON/designee will review pharmacy recommendations monthly and with the pharmacy consultant through QA quarterly. Any concerns will be reported to the QA Committee for actions. 5. Completion Date - 12/30/12.	12/30/2012

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	4000 mg a day is the maximum dose. Review of the Pharmacy recommendations indicated the pharmacist had reviewed the resident's record on 9/6/12, 10/14/12, and 11/9/12, with no recommendations related to the acetaminophen. During an interview with the Director of Nursing on 11/29/12 at 1:05 p.m., she indicated the resident could only have 4 doses of the acetaminophen without exceeding the recommended limits of the medication. She indicated the pharmacist had reviewed the resident's medications every month and had not made any recommendations related to the potential for the resident to receive an excessive amount of acetaminophen. 3.1-25(h)			

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F0465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interviews, the facility failed to ensure the kitchen environment had no open floor drains, no broken electrical outlet plates and properly functioning faucets at the preparation sink for 1 of 2 dietary observations. This deficient practice had the potential to affect 70 residents that receive their meals from the kitchen. Findings include: During an observation of the kitchen on 11/30/12 from 11:05 a.m. to 11:35 a.m., with the Certified Dietary Manager [CDM] and the Registered Dietician present, there was an uncovered drain in the floor by the back left hand corner of the stove. There was a broken electrical outlet faceplate on the wall to the left of the stove. The faucet on the preparation [prep] sink would not turn off and water ran constantly. The Registered dietician indicated she had turned in a work order for the prep sink faucet a few weeks ago. The CDM indicated he had informed maintenance verbally about the open drain and the	F0465	1. The electrical outlet faceplate, the open drain was covered, and the sink faucet was replaced immediately. 2. All residents have the potential to be affected. 3. The work order protocol will be followed by all staff to ensure that any concerns are fixed as soon as possible. 4. Maintenance Director will complete preventive maintenance tasks weekly. All issues will be documented via work order, and any concerns will be reported to QA Committee for action. Work orders are reviewed weekly by HFA and Maintenance Director and any concerns will be reported to QA monthly times three and quarterly thereafter.5. Compliance Date - 12/30/12.	12/30/2012

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	prep sink faucet prior to this week. He indicated maintenance had worked on the faucet but was not able to fix it. During an interview with the Maintenance Director on 11/30/12 at 12:30 p.m., he indicated he was going to order a new faucet for the prep sink. 3.1-19(f)			