

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2013
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NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN 47454
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00129338.</p> <p>Complaint IN00129338 -Substantiated, Federal/state deficiencies related to the allegations were cited at F225 and F226.</p> <p>Survey Dates: July 10, 11, 12, 15, 16, 17, 2013</p> <p>Facility Number: 000226 Provider Number: 155333 AIM Number: 100267730</p> <p>Survey Team: Martha Saull, RN TL Terri Walters, RN 7/15, 7/16, 7/17, 2013 Dorothy Watts, RN</p> <p>Census Bed Type: SNF: 14 SNF/NF: 79 Total: 93</p> <p>Census Payor Type: Medicare: 21 Medicaid: 63 Other: 9 Total: 93</p>	F000000	<p>This plan of correction is to serve as Paoli Heath and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	

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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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2.			

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F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	1. Resident T, U, V, and Z have	08/16/2013			

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	<p>review, the facility failed to report immediately an allegation of abuse to the state agency for 2 of 3 abuse allegations that had been reviewed and reported to the state agency. Resident T, Resident U, Resident V, Resident Z</p> <p>Findings include:</p> <p>1. A facility report entitled "RESIDENT ABUSE INVESTIGATION REPORT" of incident dated 1/13/13 at 1:20 P.M., had been received and reviewed on 7/17/13 at 10:20 A.M.</p> <p>The report indicated "...Resident Z stated Resident T got upset c (with) him over the TV being loud. Resident T verbally threatened him, threw the TV remote & H2O (water) on the floor..."</p> <p>The report indicated the Administrator had been notified of the incident on 1/13/13 at 1:20 P.M. The report also indicated the ISDH (Indiana State Department of Health) had not been notified until 1/13/13 at 10:38 P.M., which was over 9 hours when incident had occurred.</p> <p>2. Another RESIDENT ABUSE INVESTIGATION REPORT" dated</p>		<p>had no further allegations of abuse.</p> <p>2. All allegations of abuse are reported immediately to the state agency.</p> <p>3. The systemic change will include that the facility's policy and procedure has been updated and revised to include that all allegations of abuse are reported immediately to the state agency. In addition, the Administrator and/or Director of Nursing immediately report any allegation of abuse to the state agency. All Unusual Occurrences are reviewed at the morning meeting – Monday through Friday for notation of immediate reporting to the state agency. Education will be provided to staff regarding the systemic change, with emphasis on immediate reporting to the state agency.</p> <p>4. The Administrator or designee will audit all allegations of abuse daily, for 30 days, for immediate notification to the state agency. This audit will then continue 5 days a week for duration of 12 months. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>3/25/13, had been received and reviewed on 7/17/13 at 10:20 A.M.</p> <p>The report indicated, "...Resident U reported that Resident V was yelling at her & cussing at her. She stated 'I want another room.' ..."</p> <p>The report indicated the Administrator had been notified of the incident on 3/25/13 at 5:30 P.M. The report also indicated the ISDH (Indiana State Department of Health) had been notified on 3/26/13 at 4:04 P.M.</p> <p>3. On 7/17/13 at 4:15 P.M., the Administrator was interviewed regarding not reporting to the state agency promptly the above allegations of abuse. She indicated she had thought she had a 24 hour time period to report to the state agency any allegation of abuse.</p> <p>This Federal Tag related to Complaint IN00129338.</p> <p>3.1-28(c)</p>		Completion Date: August 16, 2013				

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F000226 SS=C	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the facility's abuse policy indicated the state agency was to be notified immediately of an allegation of abuse.</p> <p>On 7/15/13 at 10:00 A.M., the facility's abuse policy entitled "ABUSE PREVENTION" (revised policy date 1/12) was reviewed.</p> <p>The policy included, but was not limited to, the following:</p> <p>"...#1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. When an allgeded or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident when applicable: a. The</p>	F000226	<ol style="list-style-type: none"> All allegations of abuse are reported to state agency immediately. The facility's abuse policy and procedure has been updated to include notifying the state agency immediately for any allegation of abuse. The facility's abuse policy and procedure has been updated to include notifying the state agency immediately regarding any allegations of abuse and the verbiage has been changed regarding the timeline for reporting the results of the investigation. Staff has been offered education regarding the updated policy and procedure for allegations of abuse and immediate notification to the state agency. The Administrator or designee will audit all allegations of abuse daily, for 30 days, for immediate notification to the state agency per the updated facility policy and procedure for abuse. This audit will then continue 5 days a week for duration of 12 months. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility 	08/16/2013			

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	<p>State licensing/certification agency responsible for surveying the facility; ..."</p> <p>"...#13. Should the investigation reveal the abuse occurred, the administrator, or designee, will report such findings to local police department, the ombudsman, the state licensing agency and others as may be required by state or local laws within 24 hours of the results of the completion of the investigation..."</p> <p>On 7/17/13 at 3:20 P.M., the Administrator was interveiwed regarding the facility's abuse policy. The policy was reviewed. The Administrator indicated at that time the policy was incorrect in regard to the 13. information. She indicated any abuse allegation should be reported to ISDH (Indiana State Department of Health) within 24 hours of the allegation, not 24 hours after the allegation had been investigated and abuse had been determined.</p> <p>On 7/17/13 at 3:20 P.M., the Administrator was made aware the section of the policy above #1 had not included the time period required for the state agency notification.</p> <p>On 7/17/13 at 3:20 P.M., the</p>		<p>Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Completion Date: August 16, 2013</p>		

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	<p>Administrator was made aware the state agency needed to be notified immediately if an allegation of abuse had been reported to the Administrator. The Administrator indicated at that time she had just remembered she had been made aware (last week) the state agency needed to be notified immediately in regard to an allegation of abuse.</p> <p>This Federal Tag relates to Complaint IN00129338.</p> <p>3.1-28(a)</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 interview and record review, the facility failed to ensure the plan of care was followed for a Hospice resident in regards to receipt of spiritual services by Hospice for 1 of 1 resident reviewed with Hospice services.</p> <p>Resident #33</p> <p>Findings include:</p> <p>On 7/15/13 at 4 P.M., the clinical record (maintained by the facility) of Resident #33 was reviewed. The resident was admitted to the facility on 1/17/13. Admitting orders included, but were not limited to, the following: "Resident with (name of Hospice), diagnosis: uterine cancer.</p> <p>A plan of care (maintained by the facility) was edited on 5/17/13 and addressed the problem of "Terminal illness...Receives Hospice Services." Approaches included, but were not limited to, the following: "Hospice to see resident and care to be given by nurses and CNAs (certified nursing assistants) and by facility nurses and</p>	F000282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <ol style="list-style-type: none"> The family for Resident #33 have elected to change hospice providers and the plan of care is being followed. The resident has not elected to receive spiritual services at this time. No other residents are receiving hospice services at this time. The systemic change includes: <ul style="list-style-type: none"> Any hospice services will provide written and verbal communication with each visit and signed by the hospice provider and either the charge nurse or Director of Nursing or designee Hospice will provide a copy of all care plans for use at the facility Hospice will be invited to all care conferences and will either attend or be updated via phone of any changes in the plan of care to coordinate the plan of care and delivery of services per the plan of care, including spiritual services. Education will be provided to facility and hospice staff regarding the systemic change. 	08/16/2013			

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	<p>CNAs."</p> <p>On 7/17/13 at 12:44 P.M., the DON was interviewed. She indicated the resident was admitted with Hospice services provided by (name of Hospice) on 1/17/13. The DON indicated the facility had a meeting with the Hospice nurse on 7/16/13. The DON indicated the Hospice nurse indicated the following regarding documentation of Spiritual care: The resident had behaviors towards men and Hospice had two male chaplains. A female chaplain completed the resident's spiritual care report on 1/15/13. The Hospice nurse indicated that was the reason there was no spiritual follow up for the resident since 1/30/13. The goal documented on the "Support Services Progress Form" dated 1/15/13 and 1/30/13, included the following: "to offer spiritual support to pt (patient). Plan 1- 2 x (times) a mo (month)."</p> <p>At the time, the DON indicated Hospice was invited to the resident's care plan meetings. The DON indicated someone from Hospice came to a care plan meeting one time. The DON indicated the facility was revising their process involving Hospice. She indicated the facility will now require a hard copy of the</p>		<p>4. The Director of Nursing or designee will review all hospice documentation and communication daily (5 days a week) for 30 days for evidence of communication with facility staff. This review will then continue weekly for a duration of 12 months of monitoring. In addition, the Director of Nursing or designee will review for following the plan of care for a Hospice resident and provision of services per the plan of care weekly for 4 weeks, then monthly for a duration of 12 months. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Completion Date: August 16, 2013</p>		

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	<p>Hospice staff's visit to be in the facility. She indicated the new process will include all Hospice departments which visit the resident. The DON also indicated Hospice did not currently have copies of their care plans in the facility and the Hospice nurse indicated on 7/16/13 the resident care plans were at the Hospice office.</p> <p>On 7/17/13 at 2:40 P.M., the DON was interviewed. The DON indicated the facility updates their care plans and she was unaware how the Hospice service maintains their care plans. At the time, she provided a current copy of facility policy for "Hospice Program." This policy was revised April 2009. The policy included, but was not limited to, the following: "...The facility and hospice will identify the specific services that will be provided by each entity and this information will be communicated in the plan of care. The Hospice and facility will communicate with each other when any changes are indicated or made to the plan of care..."</p> <p>3.1-35(g)(2)</p>				

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F000310 SS=D	<p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on interview and record review, the facility failed to ensure a resident who was continent of bowel, was provided the opportunity to toilet and/or given alternative interventions to maintain bowel continence for 1 of 1 resident reviewed for bowel incontinence. Resident #28</p> <p>Findings include:</p> <p>On 7/12/13 at 10 A.M., the clinical record of Resident #28 was reviewed. Diagnoses included, but were not limited to, the following: benign prostatic hypertrophy without obstruction and osteoarthritis. The most recent MDS (minimum data set assessment) dated 4/8/13 indicated the following: moderately impaired cognition; no toileting program in place for bowel or bladder; always continent of urine; occasionally</p>	F000310	<p>F310 483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <ol style="list-style-type: none"> Resident #28 has been reassessed for his toileting needs, including an interview regarding his toileting preferences. His plan of care has been updated to include his preferred method of toileting and toileting plan. All residents with bowel continence have been identified, and their bowel assessment has been reviewed for accuracy and inclusion of opportunity for toileting and/or alternative interventions to maintain bowel continence. The systemic change includes: <ul style="list-style-type: none"> All residents will have a bowel assessment completed upon admission, quarterly and with a significant change in bowel function. Significant changes in status are discussed daily (Monday through Friday) at the morning 	08/16/2013			

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	<p>incontinent of bowel; extensive assist required for toilet use. The resident's current weight was 283 lbs, height of 68 inches (5 feet 8 inches).</p> <p>On 7/11/13 at 9:40 A.M., Resident #28 was interviewed. He indicated he doesn't get on the toilet because he's "too big." Resident #28 indicated he was aware when he had to have a BM. He also indicated he had to have a BM in his "diaper" because he's " too big to sit on a commode." Resident #28 indicated staff had to use a lift to get him out of bed and he had bowel movements in his "diaper."</p> <p>On 7/15/13 at 10 A.M. a current copy of the facility CNA (certified nursing assistant) assignment sheet was received from LPN #21. The form indicated the resident was "incontinent" in regards to toileting schedule and required assist of 2 staff and a (name of lift) for transfers.</p> <p>On 7/16/13 at 1:40 P.M., CNA #12 was interviewed. She indicated Resident #28 will let staff know "when he is wet." She indicated "he's never not called us when he's wet, he can't toilet because he can't walk." She indicated staff utilized a mechanical lift to get the resident out of bed. CNA #12 indicated at night the</p>		<p>clinical meeting and the need for updating an assessment.</p> <ul style="list-style-type: none"> · Upon completion of the assessment, a plan of care will be developed based upon the assessment and the resident's preferences (if applicable) · The C.N.A. assignment sheet will be updated with any change in the plan of care <p>Education will be provided to nursing staff regarding the systemic change.</p> <p>4. The Unit Manager or designee will audit for accuracy of bowel assessment, accuracy and delivery of the plan of care and accurate C.N.A. assignment sheet for 1 resident per hall, 5 days a week for 4 weeks, then 1 resident per hall weekly for 4 weeks, then 1 resident monthly for a duration of 12 months of monitoring. In addition, the Director of Nursing or designee will interview 1 resident per hallway weekly for 4 weeks, then 1 resident monthly for satisfaction with their toileting plan, for a duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p>		

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	<p>resident uses a urinal but "it usually goes everywhere."</p> <p>On 7/17/13 at 12:30 P.M. the DON was interviewed. She indicated the resident was alert and oriented "for the most part." She indicated the resident can't hold on to the stand up lift because his arms hurt too much.</p> <p>On 7/17/13 at 4:11 P.M., the DON was interviewed. She indicated the quarterly nursing assessment date 4/8/13 indicated the resident was always continent of bowel and frequently of bladder. She indicated the information was obtained based on what the CNAs (certified nursing assistants) enter into the facility computer. The DON indicated at the time, the resident usually just tells the DON when he needs to be changed. She indicated the resident had a urinal in his room. The DON indicated she didn't think the resident would use a bedpan if he were to be offered one. The DON also provided current copies of the following care plans: 12/5/12: Resident has potential decline in ADL (activities of daily living) ability. Approaches included, but were not limited to, the following: "Monitor resident for any changes in ability to perform ADLs"; 7/9/13 Resident experiences bladder</p>		Completion Date: August 16, 2013				

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	<p>incontinence episodes...Approaches:...provide assistance for toileting..."</p> <p>Documentation was lacking in the clinical record of alternate interventions to be attempted in an effort to assist the resident in maintaining bowel continence.</p> <p>3.1-38(a)(2)(C)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to ensure a resident was provided interventions to be attempted and/or provide opportunity to toilet in an attempt to promote bladder continence for 1 of 3 residents reviewed for bladder incontinence. Resident #28</p> <p>Findings include:</p> <p>On 7/12/13 at 10 A.M., the clinical record of Resident #28 was reviewed. Diagnoses included, but were not limited to, the following: benign prostatic hypertrophy without obstruction and osteoarthritis. The most recent MDS (minimum data set assessment) dated 4/8/13 indicated the following: moderately impaired cognition; no toileting program in place for bowel or bladder; always</p>	F000315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. Resident #28 has been reassessed for his toileting needs, including an interview regarding his toileting preferences. His plan of care has been updated to include his preferred method of toileting and toileting plan. 2. All residents requiring assistance with toileting have been identified, and their bladder assessment has been reviewed for accuracy and inclusion of opportunity for toileting and/or alternative interventions to maintain bladder continence. 3. The systemic change includes: · All residents will have a bladder assessment completed upon admission, quarterly and with a significant change in bladder function. Significant changes in status are discussed daily (Monday through Friday) at the morning clinical meeting and a need for an updated assessment. · Upon	08/16/2013

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	<p>continent of urine; occasionally incontinent of bowel; extensive assist required for toilet use. The resident's current weight was 283 lbs, height of 68 inches (5 feet 8 inches).</p> <p>On 7/11/13 at 9:40 A.M., Resident #28 was interviewed. He indicated he doesn't get on the toilet because he's "too big." Resident #28 indicated he was aware when he had to void. He also indicated he had to void in his "diaper" because he's "too big to sit on a commode." Resident #28 indicated staff had to use a lift to get him out of bed and he voids and has bowel movements in his "diaper."</p> <p>On 7/15/13 at 10 A.M., a current copy of the facility CNA (certified nursing assistant) assignment sheet was received from LPN #21. The form indicated the resident was "incontinent" in regards to toileting schedule and required assist of 2 staff and a (name of lift) for transfers.</p> <p>On 7/16/13 at 1:40 P.M., CNA #12 was interviewed. She indicated Resident #28 will let staff know "when he is wet." She indicated "he's never not called us when he's wet, he can't toilet because he can't walk." She indicated staff utilized a mechanical lift to get the resident out of bed.</p>		<p>completion of the assessment, a plan of care will be developed based upon the assessment and the resident's preferences (if applicable) regarding a toileting plan. The C.N.A. assignment sheet will be updated with any change in the plan of care Education will be provided to nursing staff regarding the systemic change. 4. The Unit Manager or designee will audit for accuracy of bladder assessment, delivery of the plan of care and updated C.N.A. assignment sheet for 1 resident per hall, 5 days a week for 4 weeks, then 1 resident per hall weekly for 4 weeks, then 1 resident monthly for a duration of 12 months of monitoring. In addition, the Director of Nursing or designee will interview 1 resident per hallway weekly for 4 weeks, then monthly for satisfaction with their toileting plan, for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Completion Date: August 16, 2013</p>				

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	<p>CNA #12 indicated at night the resident uses a urinal but "it usually goes everywhere."</p> <p>On 7/17/13 at 12:30 P.M., the DON was interviewed. She indicated the resident was alert and oriented "for the most part." She indicated the resident can't hold on to the stand up lift because his arms hurt too much.</p> <p>On 7/17/13 at 4:11 P.M., the DON was interviewed. She indicated the quarterly nursing assessment date 4/8/13 indicated the resident was always continent of bowel and frequently of bladder. She indicated the information was obtained based on what the CNAs (certified nursing assistants) enter into the facility computer. The DON indicated at the time, the resident usually just tells the DON when he needs to be changed. She indicated the resident had a urinal in his room. The DON indicated she didn't think the resident would use a bedpan if he were to be offered one. The DON also provided current copies of the following care plans: 12/5/12: Resident has potential decline in ADL (activities of daily living) ability. Approaches included, but were not limited to, the following: "Monitor resident for any changes in ability to perform ADLs";</p>			

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	<p>7/9/13 Resident experiences bladder incontinence episodes...Approaches:...provide assistance for toileting..."</p> <p>Documentation was lacking in the clinical record of alternate interventions to be attempted in an effort to assist the resident in maintaining bladder continence.</p> <p>3.1-41(a)(2)</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 interview and record review, the facility failed to ensure anti-anxiety medications were reviewed routinely for gradual dose reductions for 1 of 10 residents reviewed for unnecessary drugs. Resident #80</p> <p>Findings include:</p> <p>The clinical record of Resident #80 was reviewed on 7/18/13 at 10:00 A.M. Resident #80 had diagnoses</p>	F000329	F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1. Resident #80 has been reviewed for a gradual dose reduction 2. All residents on anti-anxiety medications have been identified and reviewed for a gradual dose reduction. 3. The systemic change includes: · All new orders, including new admissions, are reviewed at the morning clinical meeting. Social Services will be notified of any new orders for anti-anxiety medication. · Social Services will maintain a log of all residents	08/16/2013	

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	<p>which included, but were not limited to, Alzheimer's dementia, major depressive disorder and situational anxiety. Resident #80 had been receiving an anti-anxiety medication, Librium 25 mg(milligrams) po (by mouth) twice daily since her admission to the facility on 10/15/12. Since Resident #80's admission to the facility, the monthly pharmacy reviews lacked recommendations from the consulting pharmacist for Resident #80's physician to consider a gradual dose reduction for the anti-anxiety medication Librium. Her current July 2013 physician orders included, but were not limited to, Librium (an anti-anxiety medication) 25 mg, take 1 capsule by mouth twice daily.</p> <p>According to guidelines provided by Centers for Medicare and Medicaid Services (CMS), "...For a sedative that is used routinely, the facility should attempt to taper the medication quarterly unless contraindicated by the physician..." Documentation for Resident #80 was lacking of the physician addressing the gradual dose reduction.</p> <p>The facility's policy and procedure for monitoring anti-anxiety medication and/or gradual dose reduction of</p>		<p>receiving anti-anxiety medications, including the date of the last gradual dose reduction and when the next gradual dose reduction is due. · All residents receiving anti-anxiety medications will be reviewed at least quarterly at the facility's At Risk Meeting for continued use of the medication and when a gradual dose reduction is warranted or due. · The Unit Manager or designee will notify the attending physician for a review of an anti-anxiety medication when a gradual reduction is due. Education will be provided to Social Services personnel and licensed nurses regarding the systemic change.</p> <p>4. The Social Service Director or designee will review all residents receiving anti-anxiety medications weekly for 4 weeks, then monthly for a gradual dose reduction for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Completion Date: August 16, 2013</p>		

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	<p>anti-anxiety medication was not provided.</p> <p>During an interview with the Director of Nursing (DON) on 7/17/13 at 3:24 P.M., the DON indicated she had looked at Resident #80's chart twice and that the documentation for a gradual dose reduction of Librium was not in the chart. The DON indicated that the pharmacy consultant was responsible for monitoring and recommending whether and when a gradual dose reduction should be communicated to the physician. The DON indicated that the pharmacy consultant was contacted and the pharmacy consultant indicated that the option of gradually reducing Resident #80's Librium dosage had not been reviewed.</p> <p>3.1-48(a)(2)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure beverage service for the residents' dining in the main dining room was performed in a manner that would prevent the spread of food borne illness. This had the potential to affect 20 of 20 people served.</p> <p>During an observation on 7/10/13 at 11:32 A.M., Food Service #1 (FS #1) was observed pushing a service cart in the dining room with (8) 32 ounce carafes of iced tea and ice water. FS #1 was delivering 1 carafe of iced tea and 1 carafe of ice water to each table in the dining room. FS #1 stopped at each table and picked up each carafe from the service cart by the open rim of the carafe with the palm of her hand. FS #1 delivered each of the 8 carafes to tables in the dining room in that manner.</p> <p>During an observation in the main dining room on 7/10/13 at 11:55 A.M., FS #1 returned to the dining room</p>	F000371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <ol style="list-style-type: none"> Food Service #1 is no longer employed at this facility. Staff providing beverage service for residents in the dining room have been identified and offered education regarding the procedure for beverage service in a manner that would prevent the spread of food borne illness. The systemic change includes: <ul style="list-style-type: none"> Any newly hired staff that will provide beverage service for residents in the dining room will receive education regarding the procedure for beverage service in a manner that would prevent the spread of food borne illness. Food Service staff will complete a competency check at least annually for beverage service in the dining room on the procedure for beverage service in a manner that will not spread food borne illness. <p>Education will be provided to staff providing beverage service for residents in the dining room regarding the systemic change.</p>	08/16/2013	

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	<p>pushing a foodservice cart with coffee, milk, juice and other drinks. FS #1 stopped at the first table where 3 residents were seated. FS #1 picked up one of the resident's knives from the flatware place setting and stirred the iced tea in the carafe and then returned the knife to the resident's flatware place setting. FS #1 then proceeded to pour the iced tea for one of the other residents at the table by grasping the top of the open rimmed glass with her hand.</p> <p>FS #1 moved to a table where 3 residents were seated. One resident was in a wheelchair and was sitting away from the table. FS #1 grasped the handles of the resident's wheelchair and repositioned the resident's wheelchair next to the table. Without sanitizing her hands, FS #1 picked up one of the resident's knives from the flatware place setting and stirred the iced tea in the carafe and then returned the knife to the resident's flatware place setting. FS #1 then proceeded to pour the iced tea into another resident's glass while grasping the open rimmed glass with bare hands.</p> <p>FS #1 moved to a table where 4 residents were sitting. FS #1 filled each one of the residents'</p>		<p>4. The Dietary Manager or designee will monitor the dining room daily (Monday through Friday), at random meals for following the procedure for beverage service for the residents in a manner that would prevent the spread of food borne illness. This audit will be completed daily (five days a week) for 4 weeks, then weekly for duration of 12 months of monitoring. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Completion Date: August 16, 2013</p>	

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	<p>glasses with ice. While filling the glasses with ice, FS #1 took the ice scoop and dipped it into the ice bucket. While moving the ice from the bucket to the residents' glasses, FS #1 shielded the open end of the scoop with her bare hand so as not to drop any of the ice before it reached the glasses. FS #1 then returned the ice scoop to the ice bucket. FS #1 picked up one of the resident's knives from the flatware place setting and stirred the iced tea in the carafe and then returned the knife to the resident's flatware place setting. FS #1 then proceeded to pour the iced tea into the resident's glass.</p> <p>During an interview with the Food Service Manager (FSM) on 7/17/13 at 9:25 A.M., the FSM indicated that it was not acceptable practice to hold drink glasses or to deliver carafes by the rims. FSM indicated the open end of the ice scoop should not come in contact with the server ' s hand.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to</p>	F000441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	08/16/2013			

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	<p>ensure proper hand washing techniques and/or housekeeping and/or dietary cleaning practices were followed for a resident in contact isolation for 1 of 2 residents reviewed in contact isolation. Resident # 103</p> <p>B. Based on observation interview and record review the facility failed to ensure foodservice carts were cleaned with anti- bacteriaicidal solution that was effective in killing Clostridium difficile (C. diff.) This had the potential to affect residents who resided on 3 of 5 halls. Resident #103</p> <p>Findings include:</p> <p>A. On 7/16/13 at 11:34 A.M., Resident #103 was observed sitting in a wheelchair at her bedside. The resident had a sign on her door, indicating to check with the nurse before entering the room. CNA #12 was observed in the room, with disposable gown and gloves on. The resident's bed had been stripped of sheets.</p> <p>On 7/16/13 at 11:40 A.M., CNA #12 was interviewed. She indicated she was waiting for housekeeping to come clean the resident's bed as the</p>		<p>1. Proper hand washing techniques and/or housekeeping and/or dietary cleaning practices are being followed for Resident #103. Food service carts are cleaned with anti-bacteriacidal solution effective in killing Clostridium difficile.</p> <p>2. All residents in contact isolation have been identified and proper hand washing techniques and/or housekeeping and/or dietary cleaning practices are being followed. In addition, food service carts are cleaned with anti-bacteriacidal solution effective in killing Clostridium difficile.</p> <p>3. The systemic change includes:</p> <ul style="list-style-type: none"> · The policy and procedure for utilizing a 1:10 bleach solution to clean the food service carts has been updated to reflect this change. · The policy and procedure for housekeeping room cleaning procedure for a resident in contact isolation with an active C-Dif infection has been updated to include cleaning practices for sweeping and disinfecting the housekeeping equipment. · A competency check for hand-washing in a contact isolation room will be completed upon hire and at least annually for housekeeping and nursing staff. Education will be provided to food service staff, housekeeping staff and nursing staff regarding the systemic change. In addition, this education 		

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	<p>resident had "had an accident" and there was BM all over the resident's bed.</p> <p>On 7/16/13 at 11:50 A.M., Housekeeper #5 arrived to the room. She put on a disposable gown and gloves. After cleaning the resident's bed, she was observed to remove the broom from her cart and used it to sweep the room. When Housekeeper #5 was finished sweeping, she returned the used broom directly to her cart. Housekeeper #5 removed her gown and gloves. She then used the small hand held dust pan and broom to sweep up the debris, which she had accumulated in the doorway of the room. Housekeeper #5 then replaced the dust pan and hand held broom directly to her cart. She then pushed her cart down the hall to the next room, without hand washing. She was observed to enter Room 205.</p> <p>On 7/16/13 at 11:52 A.M., CNA #12 was observed in Resident #103's room removing her gown, gloves and mask at the doorway of the room. CNA #12 left the isolation room, without hand washing, and walked down the hall to a public bathroom to wash her hands.</p>		<p>will be provided to food service staff, housekeeping staff and nursing staff upon hire to the facility.</p> <p>4. The dietary manager or designee will monitor for cleaning of the food service carts with anti-bacterial solution effective in killing Clostridium difficile daily (5 days a week) for 4 weeks, then weekly for a duration of 12 months of monitoring. The housekeeping supervisor or designee will monitor for following the updated policy and procedure for cleaning practices of sweeping and disinfecting the housekeeping equipment as well as hand-washing prior to leaving a contact isolation room daily (5 days a week) for 4 weeks, then weekly for a duration of 12 months of monitoring. The Staff Development Coordinator or designee will monitor for staff handwashing prior to leaving a contact isolation room daily (Monday through Friday) for 4 weeks, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Completion Date: August 16, 2013</p>				

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	<p>On 7/16/13 at 12 P.M., CNA #12 was interviewed. She indicated Resident #103 had "just had an accident." CNA #12 indicated there was BM "all over the bed, remote, side rails" but indicated there was no BM on the floor. CNA #12 indicated Resident #103 was in contact isolation for "c diff (clostridium difficile)."</p> <p>On 7/16/13 at 12:26 P.M. Housekeeper #5 was interviewed. She indicated she did not clean the broom and dust pan after using it in the isolation room and before replacing it to her cart. Housekeeper #5 also indicated at the time, she did not wash her hands after removing her gloves and before leaving the room.</p> <p>On 7/17/13 at 9:18 A.M. the current policy and procedure for "Isolation-Categories of Transmission-Based Precautions" was received from the DON (Director of Nursing). The policy was dated revised 1/2012. The policy included, but was not limited to, the following: "...remove gloves before leaving the room and wash hands immediately..."</p> <p>On 7/17/13 at 9:18 A.M. a current copy of the policy and procedure for "Clostridium Difficile" was received</p>			

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	<p>from the DON. The policy was revised 1/2012. The policy included, but was not limited to, the following: "...Due to the persistence of clostridium difficile spores for prolonged periods of time, all fecal-contaminated articles must be considered potentially infectious and disinfected with a disinfecting agent recommended for clostridium difficile..."</p> <p>On 7/17/13 at 9:33 A.M. the Infection Control Nurse was interviewed. She indicated after removing gown and gloves in an isolation room, staff should wash their hands in the room before leaving.</p> <p>On 7/17/13 at 10 A.M., the Housekeeping Supervisor was interviewed. She reviewed a current copy of the policy and procedure for "Equipment and supplies used during isolation" which was provided by the DON on 7/17/13 at 9:18 A.M. The policy included, but was not limited to, the following: "Environmental service staff shall be responsible for cleaning and sanitizing such equipment before it is returned to Central Supply or to designated storage areas." At the time, the Housekeeping Supervisor indicated the housekeeping staff should not have returned the broom</p>			

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	<p>and dustpan used to clean an isolation room, directly back to the housekeeping cart without cleaning first.</p> <p>B. During an interview with the Food Service Manager (FSM) on 7/10/13 at 10:55 A.M., the FSM indicated the food carts, which were used to deliver meal trays to the residents' rooms and return the trays after the residents had eaten, were cleaned with Sani-T-10 Plus (sanitizing solution). That was the same solution used to sanitize the food preparation areas in the kitchen.</p> <p>During a telephone interview with a representative from Spartan Chemical Company, which manufactures Sani-T-10 Plus on 7/17/13 at 2:00P.M., the representative indicated Sani-T-10 Plus does not kill Clostridium difficile (C. diff.) C. diff. is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.</p> <p>The facility's Environmental Sanitation/Infection Control Policy 9.18 was reviewed on 7/17/13 at 3:18 P.M. The policy and procedure read as follows: "All carts used in the</p>			

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	<p>dining service area and for tray delivery are cleaned and sanitized after each use and thoroughly cleaned daily. ... All surfaces are washed with hot cleaning solution, using a brush if needed. The areas cleaned include the underside of the shelves, tray glides, latches and doors."</p> <p>On 7/16/13 at 1:15 P.M., CNA #12 was observed removing the food tray from Resident #103's bedside table and placing the food tray on the tray glides of the food service cart.</p> <p>The clinical record of Resident #103 was reviewed on 7/17/13 at 10:00 A.M. Resident #103 had diagnoses which included, but were not limited to, Clostridium difficile.</p> <p>During an interview with CNA #44 on 7/10/13 at 12:30 P.M., CNA #12 indicated that any resident in isolation would receive their food tray after all the other residents' food trays had been delivered. CNA #12 indicated that when a resident in isolation finished eating, the food tray belonging to that resident would be handed out of the room to a waiting CNA and then placed on the food cart to be returned to the kitchen.</p>						

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	<p>During an interview with the Food Service Manager (FSM) on 7/17/13 at 3:00 P.M., the FSM indicated that using Sani-T-10 Plus 10 solution for cleaning the foodservice carts had been the facility's policy. The FSM indicated that she did not know that the use of Sani-T-10 Plus would not kill C. difficile bacterium. The FSM indicated that today the staff had changed the solution for cleaning the food delivery cart from the Sani-T-10 Plus to a facility prepared solution of 1 part chlorine bleach t 10 parts water.</p> <p>The Mayo Clinic's website, www.mayoclinic.com, was the source of the following information. "Illness from C. difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after the use of antibiotic medications. However, studies show increasing rates of C. difficile infection among people traditionally not considered high risk, such as younger and healthy individuals without a history of antibiotic use or exposure to health care facilities. Each year, more than a half million people get sick from C. difficile, and in recent years, C. difficile infections have become more frequent, severe and difficult to treat. In any setting, all surfaces</p>			
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	<p>should be carefully disinfected with a product that contains chlorine bleach. C. difficile spores can survive routine cleaning products that don't contain bleach."</p> <p>3.1-18(b)(1) 3.1-18(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 interview and record review, the facility failed to ensure clinical records for a Hospice resident were easily and readily accessible to facility staff for 1 of 1 Hospice residents reviewed.</p> <p>Resident #33</p> <p>Findings include:</p> <p>On 7/15/13 at 4 P.M., the clinical record (maintained by the facility) of Resident #33 was reviewed. The resident was admitted to the facility on 1/17/13. Admitting orders included, but were not limited to, the following: "Resident with (name of Hospice), diagnosis: uterine cancer.</p> <p>On 7/15/13 at 4:30 P.M., the Hospice</p>	F000514	F514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 1. Resident #33 has elected to change hospice providers and the clinical records are easily and readily accessible to facility staff. 2. No other residents are receiving Hospice services at this time. 3. The systemic change includes: Hospice services will provide clinical records of each visit; plan of care, and any updates in the plan of care. These clinical records will be easily and readily accessible to facility staff. Education will be provided to nursing staff, Social Services, and hospice staff regarding the systemic change. 4. The Director of Nursing or designee will review all hospice documentation daily (5 days a week) for 30 days for presence of clinical records of visits and plan of care, easily and	08/16/2013

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	<p>clinical record (hard copy of the chart) was reviewed. The record included, but was not limited to, the following: most recent Hospice staff visit as followed: Hospice aide dated 6/18/13; Nursing documentation dated 5/28/13; Hospice social service note dated 5/15/13; and Spiritual Care note dated 1/30/13.</p> <p>On 7/16/13 at 1:30 P.M., Hospice CNA #1 was interviewed. She indicated she visits the resident on Tuesdays and Thursday. Hospice CNA #1 indicated she documented all their information (care provided, etc) on the electronic tablet (a portable hand held electronic device). She indicated the electronic tablet was provided by hospice and the Hospice staff carry it with them.</p> <p>On 7/16/13 at 1:40 P.M., LPN #20 (the facility nurse) was interviewed. She indicated she was the nurse caring for Resident #33. She indicated after the Hospice staff visit the resident, they will tell her if "anything is going on." LPN #20 the indicated she signs the electronic tablet. LPN #20 indicated they do not have a paper copy of the Hospice staff's visit as the Hospice documentation was all electronic. LPN #20 indicated she wasn't sure</p>		<p>readily accessible to facility staff, in the facility's medical record. This review will continue weekly for an addition 30 days, then monthly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Completion Date: August 16, 2013</p>		

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	<p>how long ago the Hospice documentation went to electronic records.</p> <p>On 7/16/13 at 2:30 P.M., the DON (Director of Nursing) was interviewed. She indicated she just found out today the Hospice program "went paperless" and she will be making a call to them today. She indicated prior to "going paperless", Hospice staff would complete a triplicate type form of details of the visit and leave one copy at the facility. She indicated at the time, it was her expectation to have a hard copy of the Hospice staff visits easily accessible in the facility.</p> <p>On 7/17/13 at 8:30 A.M., the DON (Director of Nursing) provided a current copy of the "...Hospice Agreement..." The agreement was signed on May 1, 2012 by the facility Director of Clinical Operations and the Vice President of Business Development of (name of Hospice). The agreement included, but was not limited to, the following: "Coordination of Care...Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to</p>			

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	<p>ensure that the needs of Hospice Patients are met... "...Creation and Maintenance of Records...Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party..."</p> <p>On 7/17/13 at 12:44 P.M., the DON was interviewed. She indicated the resident was admitted with hospice services provided by (name of Hospice) on 1/17/13. She indicated Hospice began documenting their information on the electronic tablet in June 2013. The DON indicated Hospice maintained the electronic tablets so the facility did not have easy access to the information contained in the tablets. The DON indicated on 7/16/13, the facility had a meeting with the Hospice nurse yesterday. The DON indicated the Hospice nurse indicated the following regarding documentation of Spiritual care: The resident had behaviors towards men and Hospice had two male chaplains. A female chaplain completed the resident's spiritual care report on 1/15/13. The Hospice nurse indicated that was the reason there was no spiritual follow up for the resident since 1/30/13. The goal</p>			

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	<p>documented on the "Support Services Progress Form" dated 1/15/13 and 1/30/13, included the following: " to offer spiritual support to pt (patient). Plan 1- 2 x (times) a mo (month)."</p> <p>At the time, the DON indicated Hospice was invited to the resident's care plan meetings. The DON indicated someone from Hospice came to a care plan meeting one time. The DON indicated the facility was revising their process involving Hospice. She indicated the facility will now require a hard copy of the Hospice staff's visit to be in the facility. She indicated the new process will include all Hospice departments which visit the resident. The DON also indicated Hospice did not currently have copies of their care plans in the facility and the Hospice nurse indicated on 7/16/13 the resident care plans were at the Hospice office.</p> <p>On 7/17/13 at 2:40 P.M., the DON was interviewed. The DON indicated the facility updates their care plans and she was unaware how the Hospice service maintains their care plans. At the time, she provided a current copy of facility policy for "Hospice Program." This policy was revised April 2009. The policy</p>			

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NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN 47454		
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	<p>included, but was not limited to, the following: "...The facility and hospice will identify the specific services that will be provided by each entity and this information will be communicated in the plan of care. The Hospice and facility will communicate with each other when any changes are indicated or made to the plan of care..."</p> <p>3.1-50(a)(1) 3.1-50(a)(3)</p>				

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F009999	<p>3.1-25 Pharmacy Services (r) Used portions of medications not released with the resident or returned for credit shall be destroyed on the premises within (7) days by the consultant pharmacist or licensed nurse with a witness.</p> <p>The state rule not met as evidenced by:</p> <p>The facility failed to ensure a discharged resident's medication that had not been returned to pharmacy had been destroyed within 7 days for 1 of 3 closed resident medical records reviewed. Resident # 99</p> <p>Findings include:</p> <p>On 7/15/13 at 1:40 P.M., Resident # 99's clinical record was reviewed. Diagnosis included but was not limited to, after care following a right hip joint replacement. The resident had been admitted to the facility on 2/18/13 and discharged home on 4/5/13.</p> <p>The April 2013 medication orders included but were not limited to: Hydroco/APAP (narcotic pain</p>	F009999	<p>F9999 FINAL OBSERVATIONS 3.1-25 Pharmacy Services</p> <ol style="list-style-type: none"> Resident #99's medications have been returned to the pharmacy and/or destroyed per facility policy. All residents discharged in the last 30 days have been identified and any medications not sent home with the resident have been returned to the pharmacy and/or destroyed per facility policy. The systemic change includes: <ul style="list-style-type: none"> All new orders, including orders to discharge a resident from the facility, are reviewed at the morning clinical meeting (Monday through Friday). All discharges are placed on the clinical board for review, including return of all medications within 7 days. Discharges are not removed from the board until the drug disposition record is reviewed. Upon discharge from the facility, any resident medications that require destruction will be brought to the morning meeting for destruction with the Director of Nursing or designee, on the next business day after discharge. The drug disposition record will then be completed for any medication that require destruction. Education will be provided to licensed nurses regarding the 	08/16/2013	

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	<p>medication) 5-325 mg take 1 tablet by mouth every 6 hours when needed for pain and Clonazepam 0.5mg tablet take 1/2 tablet (0.25 mg) twice a day.</p> <p>The controlled drug records of Resident #99 indicated 16 tabs of Hydroco/APAP and 10 tablets of Clonazepam had been destroyed on 4/22/13, 17 days after the resident had been discharged.</p> <p>On 7/16/13 at 8:05 A.M., the Director of Nursing (DON) was made aware the medications, Hydroco/APAP and Clonazepam had not been destroyed within 7 days from discharge. She indicated at that time at a previous facility she had been aware medications had been destroyed within 7 days of a resident's discharge.</p> <p>The facility policy entitled "Drug Disposal (no policy date)" was received and reviewed on 7/17/13 at 12:24 P.M. The policy included but was not limited to: "Discontinued drugs or those that remain in the facility after a resident's discharge or death (that are not house supplied or returned for credit) are to be destroyed by the facility. A record of their destruction shall be noted in the resident's medical record..." A time</p>		<p>systemic change.</p> <p>4. Medical Records will review the drug disposition record within 5 days of discharge for timely return and/or destruction of medications. In addition, the Director of Nursing or designee will review drug disposition records daily, Monday through Friday, for any resident discharged within the last 7 days. The Staff Coordinator, or designee, will monitor the medication room daily, Monday through Friday, for timely return and/or destruction of medications. Any concerns will be addressed. These reviews will continue for a duration of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Completion Date: August 16, 2013</p>				

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	<p>frame for drug destruction had been lacking in the policy.</p> <p>On 7/17/13 at 3:00 P.M., the DON was made aware of the facility drug destruction policy lacking the timeframe for destruction. She indicated at that time she had been aware the time frame for destruction had been lacking. She indicated she had thought the time frame was 7 days.</p>			