

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11049 SR 101 BROOKVILLE, IN 47012
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19, 20, 21, & 24, 2014</p> <p>Facility number: 000550 Provider number: 155480 AIM number: 100286110</p> <p>Survey team: Angel Tomlinson, RN - TC Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 8 Medicaid: 48 Other: 17 Total: 73</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 28, 2014, by Janelyn Kulik, RN.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview the facility failed to provide comfortable table positioning for 4 residents reviewed related to comfortable table positioning in a sample of 27 residents reviewed for proper positioning in the dining room. Resident' # 85, # 50, # 74 and # 49.</p> <p>Findings include:</p> <p>1. On 2/19/14 at 12:45 p.m. Resident # 85 was observed eating her lunch meal, the Resident was not positioned up to the table, she was sitting in her wheelchair approximately 1 foot away from the table and the table was above the Resident's breast area. A family member was present and assisted the Resident to eat. The family member placed food on the fork and handed it to the Resident due to the</p>	F000246	F246 Requires the facility to provide comfortable table positioning in the dining room.1. Resident #49, #50, #74 and #85 was assessed regarding proper positioning in the dining room. The residents were positioned at tables that were lower than their breast areas.2. All residents have the potential to be affected. All residents were assessed to ensure that residents are seated at tables in the dining room that provide comfortable positioning while dining. If the resident was seated at a table higher than the breast area, the resident was assessed to determine which table would provide comfortable positioning for dining. (table below the breast area) See corrective measures below:3. The staff was inserviced on the need for a resident to have comfortable table positioning during meal service. The staff was educated if a resident's table is higher than the breast area that they should contact management and the resident then be seated at a table that provides a comfortable table position. 4. The DON or her designee will monitor a meal	03/07/2014			

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	<p>Resident could not reach the food on her plate or the drinks positioned behind her plate without assistance from the family member.</p> <p>On 2/20/14 at 12:20 p.m. Resident # 85 was observed eating her lunch meal in the activities room with a family member present. The Resident was sitting in her wheelchair up close to the table with the table positioned above her breast area. Resident # 85 ate 90% of her meal and drank 100% of her drinks with assistance of her family member positioning the food within her reach.</p> <p>Review of Resident # 85's Minimum Data Set dated 11/12/13 indicated activities of daily living for eating - how resident eats and drinks. Supervision - oversight, encouragement or cueing.</p> <p>2. On 2/19/14 at 12:40 p.m. Resident # 50 was observed eating her lunch meal, she was positioned at the dinning room table, sitting in her wheelchair with table above her breast area. Resident # 50 indicated "I'm managing" while eating her meal.</p> <p>On 2/20/14 at 12:35 p.m. Resident #</p>		<p>service to ensure all residents are positioned properly at the table and the height of the table is appropriate for all residents. (table below the breast area) The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>				

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	<p>50 was observed eating lunch meal, in the dinning room, sitting in her wheelchair with the table positioned above her breast area. The Resident was leaning bowls over to see to eat out of them.</p> <p>Review of Resident # 50's Minimum Data Set dated 11/12/13 indicated activities of daily living for eating - how resident eats and drinks. Supervision - oversight, encouragement or cueing.</p> <p>3. On 2/19/14 at 12:45 p.m. Resident # 74 was observed sitting at the dinning room in her wheelchair with the dining room table positioned above her breast area eating her lunch meal. Resident # 74 was having difficulty reaching her food.</p> <p>On 2/20/14 at 12:40 p.m. Resident # 74 was observed eating her lunch meal, sitting at dinning room table in her wheelchair with the table positioned above her breast area. She was unable to eat out of her bowl and staff assisted her to eat.</p> <p>Review of Resident # 74's Minimum Data Set dated 11/12/13 indicated activities of daily living for eating - how resident eats and drinks.</p>			

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	<p>Independent - no help or oversight, at any time.</p> <p>4. On 2/19/14 at 12:30 p.m. Resident #49 was observed sitting in her wheelchair with the table positioned above her breast area eating her lunch meal. The Resident was having difficulty reaching her food, ate one bite of roast pork and staff assisted her to eat.</p> <p>On 2/20/14 at 12:50 p.m. Resident # 49 was observed eating her lunch meal, sitting in her wheelchair with the table positioned above her breast area. The Resident was trying to eat soup beans with a fork, she could not see what was in the bowl. She ate one bean with her fork and was having difficulty eating. A family member arrived and assisted the Resident to eat.</p> <p>Review of Resident # 49's Minimum Data Set dated 11/12/13 indicated activities of daily living for eating - how resident eats and drinks. Supervision - oversight, encouragement or cueing.</p> <p>On 2/21/14 at 12:55 p.m. an interview with the Director of Nursing in the dining room indicated see</p>			

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F000280 SS=D	<p>could see the tables were above Resident's # 85, # 50, # 74 and # 49's breast area and the Resident's were having difficulty reaching their food and drinks.</p> <p>3.1-19(w)(5)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review the facility failed to revise and update a resident's care plan to reflect the resident's current care needs related to receiving</p>	F000280	F280 Requires the facility to revise and update a resident's care plan to reflect the resident's current care needs.1. Resident #4 care plan was updated to reflect the resident's care needs.	03/07/2014			

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	<p>Restorative nursing therapy for Passive Range Of Motion (PROM) and splint device to bilateral hands for 1 of 1 resident reviewed for Range Of Motion of 1 who met the criteria for Range Of Motion (Resident #4).</p> <p>Finding include:</p> <p>During an observation on 2-17-14 at 10:44 a.m. Resident #4 was laying in bed. The resident's left hand was contracted with no splint device or palm protectors in place, the right hand was under a blanket and was not visible.</p> <p>During an observation on 2-18-14 at 10:15 a.m. Resident #4 was laying in bed. The resident's right and left hands were contracted with no splint device or palm protectors in place.</p> <p>Interview with LPN #6 on 2-18-14 at 10:45 a.m. indicated both of Resident #4's hands were contracted. LPN #6 indicated the resident did not have splint devices or receive Range Of Motion (ROM) services. LPN #6 indicated the resident had palm protectors in place at all times except three times a day when the resident's hands</p>		<p>The care plan for PROM provided by restorative nursing was removed and the intervention for bilateral splint devices was D'Cd and the palm protector to be worn at all times was added to the plan of care.2. All residents have the potential to be affected. All resident's care plans were reviewed to ensure the care plans to reflect the resident's current care needs. See corrective measures below:3. The Care Plan Development and Review Policy and Procedure was reviewed with no changes made. (See attachment B) The staff was inserviced on the above policy. 4. The DON or her designee will monitor care plans and ensure that all current needs of the resident is updated on the care plan in a timely manner. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>		

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	<p>were washed. LPN #6 indicated the resident use to have splint devices to her hands but the resident would not leave them on. LPN #6 indicated the resident no longer wears the hand splints.</p> <p>During an observation on 2-19-14 at 9:20 a.m. Resident #4 was laying in bed with both hands pulled up to her chest. The resident's hands were contracted with no splint device or palm protectors in place.</p> <p>Review of the record of Resident #4 on 2-19-14 at 9:28 a.m. indicated the resident's diagnoses included, but were not limited to, Parkinson Disease, Alzheimer's Disease, dementia, dysphasia (difficulty swallowing), aphagia (partial or total loss of the ability to communicate), hallucinations, depression, psychosis and chronic pain.</p> <p>The Significant Change Minimum Data Set (MDS) Assessment for Resident #4 dated, 11-20-13 indicated the following: speech clarity-no speech, cognitive skills for daily decision making-severely impaired, dressing-total dependence of one person, personal hygiene-total dependence of one person and functional limitation in</p>			

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	<p>Range Of Motion-impairment on both sides of the upper extremities.</p> <p>The care plan dated 11-27-13 for Resident #4 indicated the resident required special attention to oral care. The intervention included, but were not limited to, continue with Passive Range Of Motion (PROM) with restorative nursing.</p> <p>The care plan dated 2-1-14 for Resident #4 indicated the resident had contractures to bilateral hands. The interventions included, but were not limited to, bilateral hand splints six hours per day.</p> <p>During an observation on 2-19-14 at 9:55 a.m. CNA #3 and CNA #4 were providing oral care to Resident #4. Resident #4's hands were contracted and had no splint or palm protectors in place. Requested CNA #4 to show Resident #4's bilateral palms and there were no skin issues observed. When queried why the resident did not have on a splint or palm protectors, CNA #3 indicated it was the responsibility of Restorative Nursing to apply palm protectors for Resident #4.</p> <p>Interview with Restorative Aide #8 on 2-19-14 at 12:15 p.m. indicated</p>				

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	<p>Resident #4 was not on a restorative program. The Restorative Aide indicated the resident's restorative program was discontinued around a month ago. The Restorative Aide indicated MDS staff were responsible to update the care plan's when the restorative program was discontinued.</p> <p>Interview with the Director Of Nursing (DON) on 2-19-14 at 1:00 p.m. indicated Resident #4 did not have splint devices for her hands. The DON indicated the resident was discontinued from the PROM restorative program in January 2014. The DON indicated it was the responsibility of the Assistant Director Of Nursing (ADON) to keep the care plan's updated.</p> <p>The care plan development and review procedure provided by the DON on 2-24-14 at 11:15 a.m. indicated the care plans were revised as changes in the resident's condition dictated. The changes in the resident's care or condition must be addressed on the care plan including, but not limited to, therapy changes. The care plans are reviewed and revised as changes occur.</p>			

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F000282 SS=D	<p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to follow a physician's order for palm protectors at all times to bilateral hand contractures and hourly mouth care for 1 of 1 resident reviewed for hydration and Range of Motion for 1 who met the criteria for Range of Motion and hydration (Resident #4).</p> <p>Finding include:</p> <p>1. During an observation on 2-17-14 at 10:44 a.m. Resident #4 was laying in bed. The resident's left hand was contracted with no palm protectors in place, the right hand was under a blanket and was not visible. The resident's mouth was open and her lips and mouth were dry.</p>	F000282	F282 Requires the facility to follow physician's orders.1. Resident #4 physician orders were reviewed and staff made aware of all treatment orders. Palm protectors are to be placed at all times and oral care done once per shift per the physician order. 2. All residents have the potential to be affected. All resident's physician orders were reviewed and the the staff was made aware of all current treatment orders. Staff made aware of residents orders for oral care and palm protectors. See corrective measures below:3. The Physician's Order policy and procedure was reviewed with no changes made. The staff was inserviced on the above procedure and the need to follow through with all orders. 4. The DON or her designee will monitor all new physician orders to ensure that staff is providing	03/07/2014	

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	<p>During an observation on 2-18-14 at 10:10 a.m. Resident #4 was laying in bed with her mouth open. The resident's mouth and lips were dry.</p> <p>During an observation on 2-18-14 at 10:15 a.m. Resident #4 was laying in bed. The resident's right and left hand were contracted with no palm protectors in place.</p> <p>Interview with LPN #6 on 2-18-14 at 10:45 a.m. indicated both of Resident #4's hands were contracted. LPN #6 indicated the resident did not have splint devices or receive Range Of Motion (ROM) services. LPN #6 indicated the resident had palm protectors in place at all times except three times a day when the resident's hands were washed.</p> <p>During an observation on 2-19-14 at 9:20 a.m. Resident #4 was laying in bed with both hands pulled up to her chest. The resident's hands were contracted with no palm protectors in place. The resident was asleep with her mouth open. The resident's mouth appeared dry.</p> <p>Review of the record for Resident #4 on 2-19-14 at 9:28 a.m. indicated</p>		<p>the care per the order. Rounds will be conducted ensuring oral care and palm protectors are being provided to the resident per the physician order. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>		

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	<p>the resident's diagnoses included, but were not limited to, Parkinson Disease, Alzheimer's Disease, dementia, dysphasia (difficulty swallowing), aphagia (partial or total loss of the ability to communicate), hallucinations, depression, psychosis and chronic pain.</p> <p>The Significant Change Minimum Data Set (MDS) Assessment for Resident #4 dated, 11-20-13 indicated the following: speech clarity-no speech, cognitive skills for daily decision making-severely impaired, dressing-total dependence of one person, personal hygiene-total dependence of one person and functional limitation in Range Of Motion-impairment on both sides of the upper extremities.</p> <p>The physician orders for Resident #4 dated, February 2014 indicated the following: the resident was to have nothing by mouth and received fibersource 60 milliliters per hour for 18 hours a day, the resident was to have palm protectors to bilateral hands at all times and biotene mouthwash for mouth care every hour.</p> <p>During an observation on 2-19-14 at 9:55 a.m. CNA #3 and CNA #4 were</p>						

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	<p>providing oral care to Resident #4 using toothettes. The CNA's was able to clean a large amount of thick white substance out of the resident's mouth. When queried how often mouth care is provided for Resident #4, CNA #3 and CNA #4 indicated three times a shift. CNA #3 indicated their shift was from 6:00 a.m. to 2:00 p.m. Resident #4's hands were contracted and had no palm protectors in place. Requested CNA #4 to show Resident #4's bilateral palms and there were no skin issues observed. When queried why the resident did not have on palm protectors, CNA #3 indicated it was the responsibility of Restorative Nursing to apply palm protectors for Resident #4.</p> <p>Interview with Restorative Aide #8 on 2-19-14 at 10:10 a.m. indicated it was not the responsibility of Restorative to apply palm protectors to Resident #4's hands. The Restorative Aide indicated it was nursing responsibility to apply to the palm protectors.</p> <p>Interview with the Director Of Nursing (DON) on 2-19-14 at 1:00 p.m. indicated Resident #4 did not have splint devices for her hands, the resident had palm protectors.</p>			

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	<p>The DON indicated it was the responsibility of the nurse to apply the palm protectors.</p> <p>Interview with LPN #6 on 2-19-14 at 1:15 p.m. indicated it was the responsibility of the CNA's to provide hourly mouth care to Resident #4 and she signed the Medication Administration Sheet (MAR) for mouth care because she was responsible to ensure it was done. LPN #6 indicated she also signed the MAR that the palm protectors were in place for Resident #4 but she had forgotten to put them on.</p> <p>The most recent "Physician's Orders Procedure" provided by the Director of Nursing on 2/24/14 at 12:15 P.M., indicated the following: "Purpose: To ensure accurate and complete physician's orders. Procedure: Telephone or Verbal Orders - 1.) Transcribe new orders on physician's T/O form. If order is received after physician has made rounds and signed rewrites, a new Telephone order form must be used. Never add orders to a rewrite after the physician has signed that he/she has reviewed the order. 2.) Medication orders must include: medication, dose, amount, frequency and route. 3.) Flag the</p>			

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	<p>order so the physician will sign on the next visit or pull the original copy of the order to either be signed on the next visit or taken to the physician's office for signatures. 4.) Notify the resident/responsible party of the new order and make a notation in the nurse's notes that the resident/responsible party was notified. 5.) Transcribe new order on MAR or TAR as indicated. Follow order through to completion - make appointments, order labs, notify pharmacy, etc. 6.) If medication or treatment is discontinued, pull from supply and destroy or return to pharmacy for credit. 7.) if medication or treatment is changed, put "Direction Change" sticker on label. 8.) Make a notation on the 24 hour condition report so new order is passed on in report. 9.) Adjust health care plan accordingly."</p> <p>3.1-35(g)(2)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review the facility failed to have an accurate and complete wound assessment for a stage two pressure ulcer and failed to have a treatment for 7 days for the pressure ulcer for 1 of 2 residents reviewed for pressure ulcers for 2 residents who met the criteria for pressure ulcers (Resident #89).</p> <p>Finding include:</p> <p>1. Review of the record of Resident #89 on 2-21-14 at 1:32 p.m. indicated the resident's diagnoses included, but were not limited to, weakness, congestive heart failure, depression, metastatic cancer, dehydration and failure to thrive.</p> <p>The Braden scale for predicting</p>	F000314	F314 Requires the facility to have an accurate and complete wound assessment and to have a treatment for the pressure ulcer.1. Resident #89 pressure ulcer was improving. 2. All residents have the potential to be affected. A head to toe skin assessment was completed on all residents and if a new area was noted, a treatment was obtained from the physician. See corrective measures below:3. The Skin Management Program policy and procedure was reviewed with no changes made. The staff was inserviced on the above policy. 4. The DON or her designee will conduct skin rounds ensuring that if a resident has a noted skin issue an accurate and complete assessment is documented and a treatment is ordered. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks	03/07/2014			

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	<p>pressure ulcers for Resident #89 dated, 9-3-13 indicated the resident had a score of 17- high risk.</p> <p>The admission nursing assessment for Resident #89 dated, 9-3-13 indicated the resident had a 1 centimeter (cm) by 1 cm open area on the right buttocks. The record indicated no pressure ulcer flowsheet for the open area until 9-10-13.</p> <p>The physician admitting orders for Resident #89 dated, 9-3-13 indicated the resident's orders included, but were not limited to, weekly skin checks, pressure reducing cushion to wheelchair and encourage resident to keep feet up on pillows while in bed. The admission orders indicated no treatment for the resident's pressure ulcer.</p> <p>The physician order for Resident #89 dated, 9-10-13 indicated silvadene cream to buttocks every shift for excoriation.</p> <p>The Medication Administration Record (MAR) for September 3rd to September 30th 2013 indicated no treatment provided for the open area until 9-10-13.</p>		<p>times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>		

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	<p>The skin condition flowsheet for pressure related skin conditions for Resident #89 dated, 9-10-13 indicated the resident had an stage two pressure ulcer to the right buttocks measuring 1 cm by 1 cm with a depth of 0.1 cm, the area was pink and moist. The treatment was silvadene cream to buttocks every shift. The area was barely open and had no signs of infection. The next measurement dated 9-17-13 indicated the pressure ulcer measured 0.5 cm by 0.5 cm with a depth of 0.1 cm, the area was moist and pink. The next measurement dated 9-24-13 indicated the pressure ulcer measured 0.5 cm by 0.5 cm with a depth of 0.1 cm. The area was barely open and was pink and moist. The next assessment for the pressure ulcer dated 10-1-13 indicated the area was not open but very fragile.</p> <p>The pressure ulcer flowsheet provided by the Assistant Director Of Nursing (ADON) on 2-24-14 at 10:17 a.m. indicated the following: Resident #89 was admitted on 9-3-13 with a stage one on the right buttock that measured 1 cm by 1 cm. The area was moist and pink and the treatment was to monitor.</p>			

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	<p>The pressure ulcer flowsheet next measurement dated, 9-4-14 indicated the resident had a stage one measuring 1 cm by 1 cm, the area was pink and moist. The pressure ulcer flowsheet next measurement dated 9-11-14 indicated the area was not open and the facility would continue to monitor. The pressure ulcer flowsheet next assessment dated, 9-21-14 indicated the area was not open and no longer pink. The document had stage two marked under stages of pressure ulcers with "error" wrote next to it. Interview with the ADON at this time indicated both flow sheets were the same area on the right buttocks. The ADON indicated the assessment was dated incorrect with 2014 it should have been dated 2013. The ADON indicated she was unable to find any documentation for a treatment for the area until 9-10-13. The ADON indicated the facility did have the resident on a turning schedule. The ADON indicated she felt that the area on the right buttocks was excoriation but the Minimum Data Set (MDS) staff felt it was a stage two.</p> <p>Review of the copy provided by the ADON on 2-24-14 at 1:45 p.m. of</p>			

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	<p>pressure ulcer flowsheet for Resident #89 dated, 9-13-13 indicated all the 2014 dates had been changed to 2013. Interview with the ADON indicated she did not change the dates from 2014 to 2013 and was unsure who had changed them.</p> <p>Review of Resident #89's pressure ulcer flowsheet indicated guidance for staging pressure ulcers which indicated the following: Stage one pressure ulcer the skin was intact. The stage two pressure ulcer indicated the area had partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, may also present as an intact or open/ruptured serum filled blister.</p> <p>The skin management program provided by the Director Of Nursing (DON) on 2-24-14 at 11:15 a.m. included, but were not limited to, pressure ulcer flow sheet will be documented upon initial finding and at least weekly until healed. Daily documentation will be completed on all open areas related to pressure.</p> <p>3.1-40(a)(2)</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 observation, interview and record review the facility failed to implement an individualized toileting program for a resident who had a decline in bladder function for 1 of 3 residents reviewed for incontinence for 3 residents who met the criteria for incontinence (Resident #86).</p> <p>Finding include:</p> <p>During an observation on 2-19-14 at 2:20 p.m. Resident #86 was sitting at the nursing station with a family member. The resident's family member told facility staff the resident needed to use the bathroom and the staff assisted her to the bathroom.</p>	F000315	<p>F315 Requires the facility to implement an individualized toileting program for a resident with a decline in bladder function.</p> <p>1. Resident #86 had a three day voiding pattern completed and an every two hour toileting program initiated. 2. All residents have the potential to be affected. All resident's ADL flowsheets were reviewed to ensure that if a resident was experiencing a decline in incontinence that an individualized toileting program be initiated. See corrective measures below:3. The staff was inserviced on toileting programs. If the staff notes a decline in a resident's urinary status, then the staff was instructed to contact the DON so an individualized toileting program is placed to meet the need of the resident's urinary status.4. The DON or her</p>	03/07/2014
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	<p>Interview with Resident #86's family member on 2-20-14 at 9:25 a.m. indicated the resident was continent at home and used the bathroom at home.</p> <p>Interview with CNA #1 on 2-20-14 at 10:22 a.m. indicated she was caring for Resident #86. CNA #1 indicated the resident told staff when she needed to go to the bathroom. CNA #1 indicated the resident was continent of her bladder most of the time.</p> <p>Review of the record of Resident #86 on 2-20-14 at 10:26 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, anxiety, depression, coronary artery disease and dementia with psychosis.</p> <p>The elimination status dated, 8-15-13 for Resident #86 indicated the resident's perception of need to void was present. The resident was incontinent at times.</p> <p>The Admission Minimum Data Set (MDS) Assessment for Resident #86 dated, 8-16-13 indicated the resident required limited assistance of two people to use the restroom and her</p>		<p>designee will review all ADL flowsheets and note if a decline in urinary incontinence has occurred. If a decline is noted, an individualized toileting program will be implemented to meet the need of the resident's incontinence pattern. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>		

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	<p>urinary continence was occasionally incontinent.</p> <p>The Significant Change MDS Assessment for Resident #86 dated, 10-1-13 indicated the resident required extensive assistance of one person to use the restroom and her urinary continence was occasionally incontinent.</p> <p>The Significant Change MDS Assessment for Resident #86 dated, 1-1-14 indicated the resident required extensive assistance of two people to use the restroom and her urinary continence was frequently incontinent.</p> <p>The 24 hour bladder voiding diary for Resident #86 indicated on 1-24-14 the resident was not incontinent, on 1-25-14 the resident was incontinent at 12:00 a.m. and 3:00 a.m., on 1-26-14 the resident was incontinent at 12:00 a.m. and 2:00 a.m.</p> <p>The form for how a resident was found prior to toileting dated 12-2013 for Resident #86 indicated 30 days in December 2013 the resident was incontinent before breakfast and 29 days was incontinent during the night.</p>				

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	<p>The form for how a resident was found prior to toileting dated 1-2014 for Resident #86 indicated 31 days in January 2014 the resident was incontinent before breakfast and 31 days was incontinent during the night.</p> <p>The form for how a resident was found prior to toileting dated 2-2014 for Resident #86 indicated 23 out of 23 days in February 2014 the resident was incontinent before breakfast.</p> <p>The care plan for Resident #86 dated, 1-14-14 indicated the resident was incontinent of her bladder due to she required extensive assistance with toileting, had dementia with psychosis, inattention, disorganized thinking, depression, diuretic medication use, antipsychotic medication use, antianxiety medication use, anxiety and sometimes she is understood and understands. The resident was at risk for a rash, skin breakdown, social isolation and infection. The interventions included, but were not limited to, approach the resident at least every two hours and ask or check for evidence of incontinence.</p>			

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	<p>During an observation on 2-20-14 at 11:36 a.m. CNA #1 and CNA #2 assisted Resident #86 to the toilet. The resident urinated. CNA #1 and CNA #2 indicated Resident #86 was not on a scheduled toileting program and the resident told them when she needed to go to the bathroom. CNA #2 indicated the resident was continent most of the time. Resident #86 thanked the CNA's a few times for helping her to the bathroom during this observation.</p> <p>Interview with the Assistant Director Of Nursing (ADON) on 2-20-14 1:30 p.m. indicated Resident #86 was incontinent of her bladder and was not on a specific toileting schedule. When queried about my observations of the resident requesting to use the bathroom and being continent the ADON indicated the information of incontinence came from the ADL flowsheet.</p> <p>Interview with the ADON on 2-20-14 at 1:35 p.m. presented the ADL flowsheet for February 2014 for Resident #86. When queried about the resident being continent most of the time except before breakfast and wouldn't that warrant the resident to have a specific toileting program for before breakfast, the ADON</p>			

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	<p>indicated she would look more into the situation.</p> <p>Interview with the MDS coordinator on 2-20-14 at 2:10 p.m. indicated she did not put toileting programs in place for residents. The MDS coordinator indicated she was unsure who put toileting programs in place for residents. The MDS coordinator indicated she put in "at risk" care plan's for incontinence not specific toileting needs.</p> <p>Interview with the MDS coordinator on 2-20-14 at 2:50 p.m. indicated toileting programs were implemented by nursing.</p> <p>Interview with the ADON on 2-21-14 at 10:30 a.m. indicated the reason Resident #86 was not on a toileting program was because when the facility did the 24 hour voiding diary they did not see a pattern to place the resident on a toileting schedule. The ADON indicated the reason the resident's care plan indicated the resident was incontinent due to extensive assistance required to use the bathroom was because the computer automatically put that on the care plan. The ADON indicated the facility did not have a policy related to toileting programs.</p>						

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F000332 SS=D	<p>3.1-41(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility's medication administration observation resulted in an 8% medication error rate which included 2 of 6 residents observed for medication administration of 25 medication observation opportunities. (Resident #44 and #45)</p> <p>Findings include:</p> <p>1. On 2/19/14 at 12:24 P.M., LPN #7 was observed for medication administration. She provided Resident #45 with an Oyster Calcium 500 milligram (mg) with Vitamin D tablet.</p> <p>On 2/19/14 at 12:49 P.M., Resident #45's February 2014 physician's recapitulation orders were reviewed.</p>	F000332	F332 Requires the facility to ensure that it is free of medication error.1. Resident #44 and #45 medication administration record was reviewed to ensure the correct time the medication was to be administered was accurate with the telephone order. 2. All residents have the potential to be affected. All resident's medication administration record was reviewed for accuracy with the physician orders to ensure that medications are given correctly per physician orders. See corrective measures below:3. The Physician's Order policy and procedure was reviewed with no changes made. The staff was inserviced on the above procedure and the need to follow through with all orders. 4. The DON or her designee will monitor all new physician orders to ensure that staff is administering medications accurately per the physician orders. The DON or her designee will conduct at least	03/07/2014

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	<p>A physician's order on the recapitulation, initiated 10/5/10, indicated Resident #45 would receive Oyster Calcium 500 mg with Vitamin D everyday at 8:00 A.M., 2:00 P.M., and 10:00 P.M.</p> <p>On 2/19/14 at 12:50 P.M., the Assistant Director of Nursing (ADON) indicated Resident #45's February 2014 physician's recapitulation order indicated she would receive Oyster Calcium 500 mg with Vitamin D everyday at 8:00 A.M., 2:00 P.M., and 10:00 P.M.</p> <p>On 2/19/14 at 1:00 P.M., LPN #7 indicated Resident #45's Medication Administration Record (MAR) indicated the Oyster Calcium was to be given at 12:00 P.M. An observation of Resident #45's February 2014 MAR at that time indicated the number 1 had been written in ink in front of the printed number 2 for the Oyster Calcium that was to be given at 2:00 P.M.</p> <p>2. On 2/19/14 at 12:34 P.M., LPN #6 was observed for medication administration. She provided Resident #44 with 2 Acetazolamide 125 mg tablets.</p> <p>On 2/19/14 at 12:52 P.M., Resident</p>		<p>one med pass observation to ensure the medication is given at the accurate time per the order as well. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>				

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	<p>#44's February 2014 physicians's recapitulation orders were reviewed. A physician's order on the recapitulation, initiated 10/13/13, indicated Resident #44 would receive 2 Acetazolamide 125 mg tables everyday at 6:00 A.M., 2:00 P.M., and 10:00 P.M.</p> <p>On 2/19/14 at 12:54 P.M., LPN #6 indicated Resident #44 usually received the 2 tablets of Acetazolamide with all of her other noon medications because it was hard for her to swallow and she received them in applesauce. She provided Resident #44's MAR for review at that time. Resident #44's MAR indicated Resident #44's 2 tablets of Acetazolamide would be given at 6:00 A.M., 2:00 P.M., and 10:00 P.M. She indicated a resident could receive their medications up to 1 hour prior to or after their ordered time.</p> <p>The most recent "Medication Administration Policy and Procedure" provided by the Director of Nursing on 2/24/14 at 10:00 A.M., indicated the following: "Purpose: To Administer medications according to the guidelines set forth by the State and Federal regulations. Procedure: Medication</p>			

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	<p>will be administered within 60 minutes before and/or after the time ordered...."</p> <p>3.1-48(c)(1)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview the facility failed to label insulin's, eye drops, and ear drops with an open date for 5 residents for 3 of 6</p>	F000431	F431 Requires the facility to label insulin, eye drops, and ear drops with an open date.1. Resident #15, #109, #92, #53, #77, and #53 medications were destroyed	03/07/2014			

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	<p>medication carts observed for labeling.</p> <p>Findings include:</p> <p>On 2/24/14 at 9:14 A.M., the 100 Hall cart was observed with LPN #7. The medication cart contained a vial of Lantus and a vial of Humalog insulin for Resident #15 that had been opened and did not have an open date labeled. The medication cart contained a vial of Lantus insulin for Resident #109 that had been opened and did not have an open date labeled. At that time LPN #7 indicated the insulin's for Resident #15 and #109 had been opened and were not labeled with an open date. She indicated she was going to discard the insulin's.</p> <p>On 2/24/14 at 9:16 A.M., the 200 Hall cart was observed with LPN #6. The medication cart contained a vial of Lantus insulin for Resident #53 that had been opened and did not have an open date labeled. The medication cart contained a bottle of Natural Tears eye drops for Resident #92 that had been opened and did not have an opened date labeled. LPN #6 indicated the insulin for Resident #53 and the eye drops for Resident #92 had been</p>		<p>since no date open was labeled on the medication and the medication was reordered.2. All residents have the potential to be affected. All residents, who receive insulin, ear and/or eye drops, medications were reviewed to ensure that the date open was labeled on the medication. If the date was not noted, the medication was destroyed and reordered. See corrective measures below:3. The Date Open policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure and the need to follow through with all orders. 4. The DON or her designee will conduct medication cart audits ensuring that the open date is labeled on all eye medication, ear medication or insulin. If a date is not noted, the medication will be destroyed and re-ordered. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7,</p>	

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	<p>opened and were not labeled with an open date.</p> <p>On 2/24/14 at 9:20 A.M., the back part of the 300 Hall cart was observed with LPN #6. A bottle of Neomycin-Polymyxin HC ear drops for Resident #77 had been opened and did not have an open date labeled. LPN #6 indicated the ear drops had been opened and was not labeled with an open date.</p> <p>On 2/24/14 at 9:36 A.M., the Director of Nursing (DoN) indicated Resident #77's ear drops had only been ordered for 7 days and should not have been in the medication cart. She indicated the insulin's for Resident #15, #109, #53 were still good according to their delivery date but they should have been dated with an open date. She indicated she was going to check the medication refrigerator to see if the residents had any replacement medications for the ones that didn't have an open date and if not would order new medications to replace them.</p> <p>The most recent "Drug Labels" policy provided by the DoN on 2/24/14 at 10:00 A.M., indicated the following: "Policy: Drugs will be</p>		2014.		

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	<p>labeled in compliance with federal and state laws and standards of pharmacy practice. Only the dispensing pharmacist will affix, modify, or change information on the prescription labels. Procedure: ...d.) It is permissible for the medication nurse to write the date of opening in the designated area on the prescription label...."</p> <p>The most recent "Medication Expiration" policy provided by the Nurse Consultant on 2/24/14 at 10:17 A.M., indicated the following: "Policy: All medications dispensed by the pharmacy will have an expiration date or information on calculating the expiration date once the medication is mixed/opened. The location of the dating will vary depending on the type of packaging. Procedure: ...c.) Ophthalmic, otic, and nasal preparations will expire 90 days from the date of opening. d.) Multiple dose injections, such as insulin's will expire 28 days after opening unless otherwise noted by manufacturer. 2.) Any product whose expiration date depends on the date opened must be labeled with the date the product was opened."</p> <p>3.1-25(j)</p>				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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>Based on observation and interview, the facility failed to dispense</p>	F000441	F441 Requires the facility to dispense medications in a	03/07/2014			

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	<p>medications in a sanitary manner for 1 of 6 residents observed for medication pass. (Resident #45)</p> <p>Findings include:</p> <p>On 2/17/14 at 9:40 A.M., LPN #5 was approached in the middle of her medication pass. She had pills in a cup and entered a resident's room and administered the medications. She returned to her med cart and was not observed to have washed her hands. An observation began for Resident #45's medication administration. She first dispensed all Resident #45's medications in her hand, prior to dispensing them in the cup, and then administering them to the resident. The medications included, xanax 0.25 mg tablet, aspirin 81 mg chew tablet, multivitamin tablet, venlafaxine hydrochloride ER capsule, Vitamin B1-100 mg tablet, Vitamin B12-1000 mg tablet, 6 Vitamin D3-1000 unit tablets, oyster calcium 500 milligrams with D tablet, vicodin 7.5/325 mg tablet, and nitrofurantoin 100 mg capsule.</p> <p>On 2/17/14 at 10:03 A.M., LPN #5 indicated sometimes when she passed medications she put the medications in her hands and</p>		<p>sanitary manner.1. LPN #5 was given an inservice on medication administration.2. All residents have the potential to be affected See corrective measures below:3. The Medication Administration policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure and the need to follow through with all orders. 4. The DON or her designee will conduct at least one medication pass obseration daily ensuring that the medications are administered in a sanitary manner and infection control is being maintained and handwashing occuring. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.5. The above corrective measures will be completed on or before March 7, 2014.</p>				

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	<p>sometimes she didn't. She indicated when she popped the medications out of the pack sometimes the pills went flying.</p> <p>On 2/17/14 at 1:23 P.M., LPN #5 indicated she was not aware of any facility policy for placing a residents pills in her hands. She indicated she had been trying to keep the pills from flying away. She indicated she probably should have not put the pills in her hands.</p> <p>3.1-18(l)</p>			