

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2011
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN46307
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 11, 12, 13, 14, 17, and 19, 2011</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Survey team: Marcia Mital, RN-TC Kelly Sizemore, RN Regina Sanders, RN (October 11, 12, 13, 14, and 17, 2011) Sheila Sizemore, RN (October 11, 14, 17 and 19, 2011)</p> <p>Census bed type: SNF/NF: 148 Total: 148</p> <p>Census payor type: Medicare: 21 Medicaid: 84 Other: 43 Total: 148</p> <p>Sample: 24 Supplemental sample: 3</p> <p>These deficiencies also reflect state</p>	F0000	Please except this Plan of Correction as our allegation of compliance. This Plan of Correction is being submitted for the purpose of complying with regulatory requirements and in no way should be deemed as an admission of any of the allegations contained within the survey findings.	

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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F0157 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/21/11 by Suzanne Williams, RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's physician for weight loss for 1 of 24</p>	F0157	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	11/18/2011	

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	<p>residents reviewed for physician notification in a total sample of 24. (Resident #67)</p> <p>Findings include:</p> <p>1. Resident #67's record was reviewed on 10/11/11 at 12:25 p.m. Resident #67's diagnoses included, but were not limited to diabetes, anemia, and cellulitis.</p> <p>Readmission orders, dated 9/3/11, indicated an order for weekly weights and to call the physician for a 5 pound fluctuation.</p> <p>A MAR (Medication Administration Record), for 9/2011, indicated the resident's weight on 9/24 was 206 pounds.</p> <p>A MAR, for 10/2011, indicated the resident's weight on 10/1 was 186 pounds and on 10/8 was 178.1 pounds.</p> <p>A weight record indicated a reweight was done on 10/1/11 and was 186.4.</p> <p>Review of the resident's record lacked documentation the physician was notified of a weight loss of 19.6 pounds (from 9/24 to 10/1) and an 8.3 pound weight loss (from 10/1 to 10/8).</p> <p>During an interview with LPN #7, on</p>		<p>a. MD was notified on 10/3/2011 and 10/13/2011 of the weight loss. b. Nurse responsible for notifying the physician was educated and disciplined on 10/28/2011. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken a. All residents who are on weekly weights may have the potential to be affected by the alleged deficient practice. All residents on a weekly weight were checked on 10/20/2011 with no deficiencies found. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur a. Resident Weight and Re-weight Policy revised on 10/31/2011 b. All licensed nursing staff to be in-serviced on Weight and Re-weight Policy on 11/7/2011, 11/8/2011, and 11/9/2011. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. Quality of Care Audit will be completed, randomly on all shifts, weekly for four weeks, then monthly for six months, then quarterly thereafter. b. The Administrator will oversee quality assurance compliance.</p>		

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	10/11/11 at 2:05 p.m., she indicated the nurse should have called the physician on 10/1 and 10/8 with the weight losses.  3.1-5(a)(2) 3.1-5(a)(3)				

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F0225 SS=D	<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 record review and interview, the facility failed to ensure an allegation of misappropriation of a residents property was reported to the Indiana State</p>	F0225	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice a. This was repted to the surveyors during the Annual	11/18/2011	

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	<p>Department of Health (ISDH), related to a missing wedding ring, for 1 of 1 allegation of misappropriation of resident's property reviewed in a resident sample of 24. (Resident #107)</p> <p>Findings include:</p> <p>Resident #107's record was reviewed on 10/11/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and methicillin-resistant staphylococcus aureus (MRSA) of the feet and heels.</p> <p>A Social Service note, dated 09/30/11, indicated, "SS (social service) referral had been received related to resident daughter had reported a nurse telling her resident's ring would be locked in cart and when she came to pick ring up, it was not found. Spoke with staff who worked during time period resident's daughter said speaking to her, no staff recall any recent events...Unable to locate a ring, staff do not recall resident wearing any rings recently and no ring listed on inventory. Daughter updated to search and results..."</p> <p>The "Social Service Referral/Concern Form", dated 09/25/11, indicated, "...Abuse or Neglect Issues...Daughter (name) called, said she wanted to pick up wedding ring, that a nurse told her was</p>		<p>Survey beginning October 11, 2011. b. Investigation was completed on 9/30/2011. c. Residents family notified on 9/30/2011. d. Staff in-serviced2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken a. All residents who have missing property have the potential to be affected by the alleged deficient practice. b. All incidents of missing property that meet the criteria of misappropriation of resident property were reviewed on 10/28/2011.3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur a. Abuse and Neglect of a Resident Policy revised on 11/02/2011 b. Abuse and Neglect of a Resident Policy will be in-serviced to all professional nurses on 11/7/11, 11/8/11, and 11/9/11. c. Misappropriation of property audit created.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. The Misappropriation of property audit will be conducted weekly for four weeks, monthly for six months, and quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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F0226 SS=D	<p>locked up in box . Checked both med (medication) carts and narc (narcotic) boxes cannot find. Said it was 3 days ago when she talked to the nurse. Does not know name of nurse. Ring was gold c/ (with) diamonds." The form indicated staff were interviewed and three staff members had indicated they had not spoke with the resident's daughter.</p> <p>During an interview on 10/13/11 at 12:15 p.m., the Director of Social Service indicated she had not reported the missing ring to the ISDH. She indicated she did not report the ring missing because with her investigation she could not find a staff member who had phoned the resident's daughter.</p> <p>3.1-28(c)</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. Based on record review and interview, the facility failed to follow their policy related to reporting allegations of misappropriation of residents property to the Indiana State Department of Health (ISDH) for 1 of 1 allegation of misappropriation of residents property reviewed in a sample of 24. (Resident #107)</p>	F0226	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice a. The investigation of the missing ring completed on 09/30/2011. b. Resident and family notified on 9/30/2011. c. This was reported to the surveyors during the Annual Survey beginning October 11th, 2011. d. This was reported on</p>	11/18/2011	

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	<p>Findings include:</p> <p>Resident #107's record was reviewed on 10/11/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and methicillin-resistant staphylococcus aureus (MRSA) of the feet and heels.</p> <p>A Social Service note, dated 09/30/11, indicated, "SS (social service) referral had been received related to resident daughter had reported a nurse telling her resident's ring would be locked in cart and when she came to pick ring up, it was not found. Spoke with staff who worked during time period resident's daughter said speaking to her, no staff recall any recent events...Unable to locate a ring, staff do not recall resident wearing any rings recently and no ring listed on inventory. Daughter updated to search and results..."</p> <p>The "Social Service Referral/Concern Form", dated 09/25/11, indicated, "...Abuse or Neglect Issues...Daughter (name) called, said she wanted to pick up wedding ring, that a nurse told her was locked up in box . Checked both med (medication) carts and narc (narcotic) boxes cannot find. Said it was 3 days ago when she talked to the nurse. Does not know name of nurse. Ring was gold c/</p>		<p>11/3/2011.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All incidents of missing property that meet the criteria of misappropriation of resident property were reviewed on 10/28/2011.b. All residents who have missing property have the potential to be affected by the alleged deficient practice.3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur. Abuse and Neglect of a Resident Policy will be in-serviced to all professional nurses on 11/7/2011, 11/8/2011, and 11/9/2011.b. A misappropriation of property audit created4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placea. The Misappropriation of property audit will be conducted weekly for four weeks, monthly for six months, and quarterly thereafter.b. This will be monitored by the Health Facility Administrator for compliance.</p>	

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	<p>(with) diamonds." The form indicated staff were interviewed and three staff members had indicated they had not spoke with the resident's daughter.</p> <p>During an interview on 10/13/11 at 12:15 p.m., the Director of Social Service indicated she had not reported the missing ring to the ISDH. She indicated she did not report the ring missing because with her investigation she could not find a staff member who had phoned the resident's daughter.</p> <p>A facility policy, titled, "Investigation Procedure", dated 10/07/09, received from the Administrator as current, indicated, "...It is the policy of this facility to investigate all allegations of abuse...or suspected misappropriation of resident property...It is the policy of this facility to report all alleged violations and all substantiated incidents to the state agency and all other agencies pursuant to state and federal regulation..."</p> <p>3.1-28(a)</p>				

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F0280 SS=E	<p>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, record review, and interview, the facility failed to develop and update resident's plans of care related to medications, nutrition, dialysis, oxygen, fluid restrictions, and a pacemaker for 6 of 24 residents reviewed for care plans in a total sample of 24. (Residents #16, #22, #27, #58, #60, and #142)</p> <p>Findings include:</p> <p>1. Resident #27's record was reviewed on 10/13/11 at 9:56 a.m. Resident #27's diagnoses included, but were not limited to, dementia, hypertension, and anxiety.</p> <p>The resident's readmission physician's orders, dated 9/20/11, indicated the</p>	F0280	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. The care plans of residents #16 #22 #27 #58 #60 #142 were updated on 10/20/2011. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. All residents who have Medications, nutrition, dialysis, oxygen, fluid restrictions, and a pacemaker have the potential to be affected by the alleged deficient practice.</p> <p>b. All residents will have their care plan reviewed and updated to include pertinent care areas by November 18, 2011. 3. What measures will be put in place or systemic changes will be made to</p>	11/18/2011

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	<p>resident was receiving coumadin (a blood thinner) daily.</p> <p>The resident's care plans, dated 8/15/11 and updated 9/28/11, lacked documentation of a care plan for the coumadin.</p> <p>During an interview on 10/13/11 at 10:47 a.m., LPN #3 indicated the resident should have a care plan for the coumadin.</p> <p>2. Resident #142's record was reviewed on 10/14/11 at 10:34 a.m. Resident #142's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, and dementia.</p> <p>A care plan, dated 8/17/11, indicated "Skin integrity potential...related to use of oxygen..."</p> <p>The resident's physician's order recapitulation, dated 10/11, lacked documentation of an order for oxygen.</p> <p>Resident #142 was observed on 10/14/11 at 10:30 a.m., sitting in his wheelchair in his room. The resident did not have oxygen.</p> <p>During an interview on 10/14/11 at 11:43 a.m., LPN #6 indicated the resident's oxygen had been discontinued when the</p>		<p>ensure that the deficient practice does not recur a. The Comprehensive Care Plan Policy was revised on 10/31/2011. b. All licensed professional nurses will be in-serviced on the revised Comprehensive Care Plan Policy on 11/7/2011, 11/8/2011, and 11/9/2011. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. A Quality of Care Audit will be conducted randomly on all shifts, weekly for four weeks, monthly for six months, and quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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	<p>resident had been re-admitted to the facility on 3/21/11. She indicated the care plans should have been updated.</p> <p>3. Resident #58's record was reviewed on 10/14/11 at 10:25 a.m. Resident #58's diagnoses included, but were not limited to dementia, chronic obstructive pulmonary disease (COPD), and diabetes.</p> <p>Physician recapitulation orders, dated 10/2011, indicated the resident was on a 1200 cc fluid restriction.</p> <p>A clarification order, dated 10/11/11, indicated the resident was to have oxygen on at 2 liters when not on her bi-pap (breathing apparatus).</p> <p>Review of the resident's record lacked care plans for fluid restriction and oxygen therapy.</p> <p>During an interview with LPN #10, on 10/14/11 at 11:20 a.m., she indicated the resident did not have a care plan for fluid restriction.</p> <p>During an interview with Dietary Manager #11, on 10/14/11 at 11:45 a.m., she indicated she had a care plan for fluid restriction in the computer but it was not put in the chart.</p> <p>During an interview with LPN #7, on</p>				

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	<p>10/14/11 at 11:46 a.m., she indicated the resident had a care plan for CHF (congestive heart failure) ,which included oxygen therapy, in the computer but it was not in the chart.</p> <p>4. During an interview on 10/12/11 at 8:35 a.m., Resident #60 indicated her dialysis access site was in her left upper arm. An observation at the time of the interview indicated there was a dressing on the left inner upper arm. The resident continued to indicate the dressing should have come off on 10/11/11 in the evening. She indicated the dressing was supposed to come off the evenings of dialysis. She indicated the nursing staff at the facility do not check the dialysis site for functioning.</p> <p>Resident #60's record was reviewed on 10/12/11 at 10:18 a.m. The resident's diagnoses included, but were not limited to, end stage renal failure and hypertension.</p> <p>The resident's admission/5 day Minimum Data Set Assessment, dated 09/24/11, indicated the resident had a cognition of score of 15 (intact cognition).</p> <p>The resident's admission physician's orders, dated 09/19/11, indicated the resident received dialysis three times a day on Monday, Wednesday and Friday.</p>				

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	<p>There was a lack of documentation to indicate a care plan had been initiated for the care of the resident's AV (arteriovenous) Fistula (a connection between the artery and vein for dialysis).</p> <p>During an interview on 10/12/11 at 11:25 a.m., the Director of Nursing indicated there was not a care plan initiated for the resident's AV fistula care or dialysis.</p> <p>5. Resident #16's record was reviewed on 10/11/11 at 12:55 p.m. Resident #16's diagnoses included, but were not limited to, hypertension, anemia, and congestive heart failure.</p> <p>A Care Area Assessment, dated 8/08/11, indicated the facility would address the resident's nutritional status in a care plan.</p> <p>Resident #16's care plans, dated 8/04/11, lacked documentation of a nutritional care plan to address the resident's nutritional status.</p> <p>During an interview on 10/11/11 at 2:05 p.m., LPN #2 indicated she could not find a nutritional care plan for Resident #16.</p> <p>6. Resident #22's record was reviewed on 10/17/11 at 9:10 a.m. Resident #22's diagnoses included, but were not limited to, pacemaker, congestive heart failure,</p>			

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F0282 SS=E	<p>and atrial fibrillation.</p> <p>A. Resident #22's care plans, dated 7/13/11 and revised 9/13/11, lacked documentation of a care plan for the resident's pacemaker.</p> <p>An interview on 10/17/11 at 10:20 a.m., LPN #4 indicated Resident #22 did not have a care plan for the pacemaker.</p> <p>B. Resident #22's care plans, dated 7/13/11 and revised 9/13/11 indicated an undated care plan for antibiotic therapy .</p> <p>Resident #22's current October 2011 physician's orders lacked documentation Resident #22 was receiving antibiotic therapy at the present time.</p> <p>An interview on 10/17/11 at 10:20 a.m., LPN #4 indicated the care plan was an "old one" and the resident was not currently on an antibiotic.</p> <p>3.1-35(c)(1) 3.1-35(d)(2)(B)</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 observation, record review, and interview, the facility failed to ensure</p>	F0282	1. What corrective action(s) will be accomplished for those	11/18/2011	

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	<p>physician's orders were followed related to fluid restriction, support hose (TED), medications, laboratory tests, and heart rate for 10 of 24 residents reviewed for physician's orders in a sample of 24. (Residents #9, #16, #22, #58, #67, #84, #107, #127, #130, and #142)</p> <p>Findings include:</p> <p>1. Resident #107's record was reviewed on 10/11/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and methicillin-resistant staphylococcus aureus (MRSA) of the feet and heels.</p> <p>A physician's order, dated 10/06/11, indicated an order for Zyvox (antibiotic) 600 milligrams daily for 10 days.</p> <p>The resident's MAR (Medication Administration Record), dated 10/11, indicated the resident had not received the Zyvox on 10/10/11 at 8 p.m. as ordered.</p> <p>During an interview on 10/11/11 at 12:45 p.m., RN #5 indicated the Zyvox had not been administered as ordered. She indicated the Zyvox was started on 10/07/11 when the pharmacy delivered 8 pills, and 3 pills had been signed out for October 7, 8, and 9, 2011. She indicated she could not find where the Zyvox had</p>		<p>residents found to have been affected by the deficient practice</p> <p>a. The physician's orders were reviewed and corrected if able for residents #9 #16 #22 #58 #67 #84 #107 #127 #130 #142 10/20/2011. b. The nurses involved were counseled on 10/27/2011. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken a. All residents who have medications, laboratory tests, heart rate parameters, blood pressure parameters, fluid restriction and ted hose have the potential to be affected by the alledged deficient practice. b. All records reviewed for medications, laboratory tests, heart rate parameters, blood pressure parameters, fluid restriction and ted hose to ensure that physician orders are followed as ordered by.10/21/2011 c. .Direct observation for compliance for residents on fluid restriction and residents with orders for ted hose was completed 10-21-11. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur a. The Professional Standards of Quality Policy was revised on 10/31/2011. b. The licensed nurses will be in-serviced on the Professional Standards of Quality Policy on 11/7/2011, 11/8/2011,</p>		

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	<p>been given from the emergency drug kit.</p> <p>2. Resident #84's record was reviewed on 10/12/11 at 4 p.m. The resident's diagnoses included, but were not limited to, hypertension and anemia.</p> <p>The physician's recapitulation orders, dated 10/11, indicated an order for Lopressor (anti-hypertensive) 50 mg (milligrams) daily and 25 mg (to equal 75 mg) twice daily at 6 a.m. and 6 p.m. Hold if heart rate is less than 55 or blood pressure less than 130/80.</p> <p>The MAR (Medication Administration Record), dated 09/11, indicated the resident's heart rate had not been taken at 6 a.m. prior to the medication administration on September 6, 8, 9, 14, 15, 16, 17, 20, 24, 25, 26, 27, 28, 29, and 30, 2011.</p> <p>The MAR, dated 09/11, indicated the resident's heart rate had not been taken at 6 p.m., prior to the medication administration on September 1, 2, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 21, 22, 23, 24, 26, 27, and 30, 2011.</p> <p>During an interview on 10/14/11 at 9:30 a.m., LPN #8 indicated the resident's heart rate had not been taken as ordered.</p>		<p>and 11/9/2011 c. A Quality of Care Audit was created 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. A Quality of Care Audit will be conducted randomly on all shifts, weekly for four weeks, monthly for six months and quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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	<p>The resident's MAR, dated 09/11, indicated the resident's blood pressure at 6 p.m. was as follows: 09/13/11 - 126/86, 09/26/11- 125/63, 9/30/11- 112/88 The Lopressor was administered to the resident on these days.</p> <p>The resident's MAR, dated 10/11, indicated the resident's blood pressure at 6 a.m. on 10/08/11 was 121/64. The MAR indicated the resident received the Lopressor at 6 a.m.</p> <p>During an interview on 10/13/11 at 9:30 p.m., LPN #8 indicated the blood pressure medication had not been held as ordered by the physician.</p> <p>3. Resident #142's record was reviewed on 10/14/11 at 10:34 a.m. Resident #142's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, and dementia.</p> <p>The resident's physician's order recapitulation, dated 10/11, indicated "Fluid restriction- 1500 cc (cubic centimeters)/day / dietary 1000cc, NRSNG (Nursing) 500cc 7A-7P=300cc 7P-7A=200cc."</p> <p>Resident #142 was observed on 10/14/11</p>				

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	<p>at 10:30 a.m., sitting in his wheelchair in his room. There was a water pitcher on his bedside table.</p> <p>At this time, Resident #142 was observed in his room with the DoN (Director of Nursing) present, and the DoN indicated the resident should not have a water pitcher in his room.</p> <p>During an interview on 10/14/11 at 10:38 a.m., CNA #12 indicated she had just filled the resident's water pitcher. She indicated she did not know how much water the pitcher held.</p> <p>4. Resident #127's record was reviewed 10/14/11 at 11:10 a.m. Resident #127's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, and Alzheimer's disease.</p> <p>A physician's order, dated 10/3/11, indicated 1500 cc fluid restriction, 900 cc from dietary and 600cc from nursing.</p> <p>The resident's MAR, dated 10/11, indicated the resident was to get 400 cc's on the day shift and 200 cc's on the night shift.</p> <p>There was a water pitcher observed on the resident's bedside table on 10/14/11 at 11:45 a.m.</p>				

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	<p>During an interview on 10/14/11 at 11:50 a.m., LPN #6 indicated the resident should not have a water pitcher when she was on a fluid restriction.</p> <p>5. Resident #9's record was reviewed on 10/11/11 at 2:05 p.m. Resident #9's diagnoses included, but were not limited to, congestive heart failure, chronic renal insufficiency, and COPD (chronic obstructive pulmonary disease).</p> <p>A physician's order, dated 10/9/11, indicated to discontinue the 2000 cc a day fluid restriction.</p> <p>The resident's MAR, dated 10/11, indicated fluid restriction -2000cc/day dietary =1200 cc, nursing =800 cc (7A-7P) 500 cc &amp; (7P-7A) 300cc was initialed as followed 10/1/11 through 10/12/11 on the 7a-7p shift.</p> <p>During an interview on 10/12/11 at 10:48 a.m., LPN #3 indicated the fluid restriction was discontinued but was still on the MAR.</p> <p>6. During the initial tour on 10/11/11 at 10:10 a.m., LPN #2 indicated Resident #16 did not have any splints or assistive devices such as ted hose or geri sleeves. Resident #16 was sitting up in her wheelchair in her room. Resident #16 did</p>				

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	<p>not have any ted hose on.</p> <p>Resident #16 was observed without ted hose on 10/11/11 at 11:50 a.m., 12:50 p.m., and 1:15 p.m.</p> <p>During an interview on 10/11/11 at 1:20 p.m., QMA #13 indicated she did not know the resident wore ted hose. QMA #13 indicated the resident did not have her ted hose on.</p> <p>During an interview on 10/11/11 at 1:48 p.m., CNA #14 indicated she had gotten the resident up. She indicated she had thought the nurse put the ted hose on.</p> <p>During an interview on 10/11/11 at 2:05 p.m., LPN #2 indicated the resident did not have her ted hose on.</p> <p>Resident #16's record was reviewed on 10/11/11 at 12:55 p.m. Resident #16's diagnoses included, but were not limited to, hypertension, anemia, and congestive heart failure.</p> <p>An October 2011, physician's orders recapitulation indicated "Knee high ted hose on in AM / off PM."</p> <p>7. Resident #22's record was reviewed on 10/17/11 at 9:10 a.m. Resident #22's diagnoses included, but were not limited</p>			

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	<p>to, pacemaker, congestive heart failure, and atrial fibrillation.</p> <p>A physician's order recapitulation, dated October 2011, indicated "Fluid restriction - 1500cc/day (960 - dietary, 540 nursing)."</p> <p>Resident #22 was observed sitting up in her wheelchair in her room on 10/17/11 at 11:25 a.m. A pitcher containing water was sitting up on her dresser. The pitcher was half full of water.</p> <p>During an interview on 10/17/11 at 11:30 a.m., the DoN indicated the pitcher was half full of water.</p> <p>During an interview on 10/17/11 at 11:30 a.m., LPN #4 indicated she had checked the room earlier and had missed the water pitcher.</p> <p>8. Resident #130's record was reviewed on 10/17/11 at 9:35 a.m. Resident #130's diagnoses included, but were not limited to, diabetes, hypertension, and osteoporosis.</p> <p>Physician recapitulation orders, dated 10/2011, indicated an order, dated 9/2/11, for blood glucose monitoring 4 times a day and to give novolog (insulin) 100 units/milliliter subcutaneous per sliding scale (insulin given based on blood sugar</p>				

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	<p>result) of:</p> <p>180-210= 2 units 211-240= 4 units 241-270= 6 units 271-300= 8 units 301-330= 10 units 331-360= 12 units 361-400= 14 units</p> <p>A Medication Administration Record (MAR), dated 9/2011, indicated the resident's blood sugar result on 9/18 at 6 a.m. was 187 and 4 units of insulin was given.</p> <p>During an interview with LPN #3, on 10/17/11 at 11 a.m., she indicated 4 units of insulin was given. She indicated 2 units of insulin should have been given.</p> <p>9. Resident #67's record was reviewed on 10/11/11 at 12:25 p.m. Resident #67's diagnoses included, but were not limited to diabetes, anemia, and cellulitis.</p> <p>A physician's order, dated 9/3/11, indicated "clarification: HgbA1c (blood test to measure blood sugars) Q (every) 3 months start 9-6-11..."</p> <p>The resident's record lacked HgbA1c results for 9/6/11.</p>				

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	<p>During an interview with LPN #16 indicated she called the lab and a HgbA1c was done on 9/28/11 but not on 9/3/11. She indicated the order was not followed.</p> <p>10. Resident #58's record was reviewed on 10/14/11 at 10:25 a.m. Resident #58's diagnoses included, but were not limited to dementia, chronic obstructive pulmonary disease (COPD), and diabetes.</p> <p>Physician recapitulation orders, dated 9/2011, indicated the resident was on Coumadin (blood thinner medication) and had an order for a PT/INR (pro-time and international normalized ratio) (test for blood clotting time for Coumadin) every 2 weeks due 9/6/11.</p> <p>The resident's record lacked PT/INR results for 9/6/11. The record had PTT (test for blood clotting time for Heparin) results.</p> <p>During an interview with LPN #7, on 10/14/11 at 12:15 p.m., she indicated "We marked it wrong on the lab requisition. We marked PTT and it should have been PT."</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident with a pacemaker had routine pacemaker checks completed for 1 of 3 residents with pacemakers (Resident #22) and failed to assess the functioning of a dialysis port for 1 of 1 resident with dialysis ports (Resident #60) from a sample of 24.</p> <p>Findings include:</p> <p>1. Resident #22's record was reviewed on 10/17/11 at 9:10 a.m. Resident #22's diagnoses included, but were not limited to, pacemaker, congestive heart failure, and atrial fibrillation.</p> <p>A hospital history and physical, dated 11/14/09, indicated Resident #22 had a pacemaker inserted due to slow heartrate.</p> <p>The resident's record lacked documentation of a pacemaker check being completed for Resident #22 since the insertion of the pacemaker on 11/14/09.</p> <p>During an interview on 10/17/11 at 11:00</p>	F0309	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practicea. The pacemaker for resident #22 was checked on 10/24/2011b. The fistula for resident # 60 was assessed for "thrill" and an order obtained on 10/19/2011.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takena. All residents who have a pacemaker and and AV fistula have the potential to be affected by the alleged deficient practice. b. All residents with a pacemaker and an AV fistula were reviewed to ensure that they had a pacemaker check and the AV fistula check is addressed on the Tar. This was completed on 10/20/2011. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur. The Pacemaker Management policy was created on 10/31/2011. Licensed nurses will be in-serviced on 11/7/2011, 11/8/2011, and 11/9/2011.b. AV Fistula Policy created on 10/31/2011 licensed nurses will be in-serviced on 11/7/2011,</p>	11/18/2011

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	<p>a.m., Bus Driver #18 indicated she had been trying to get a scheduled appointment for the resident since 9/30/11 for the pacemaker check. Bus Driver #18 indicated the family was unsure of who the resident's cardiologist was. She indicated when she had found out who had inserted the pacemaker she had called the cardiologist. She indicated the cardiologist office had said the family needed to make the appointment. She indicated she called the family on 10/14/11 to schedule an appointment.</p> <p>During an interview on 10/17/11 at 11:20 a.m., LPN #4 indicated a nurse had realized the resident had not had a pacemaker check at the end of last month, September 2011.</p> <p>During an interview on 10/17/11 at 11:40 a.m., LPN #6 indicated she was not sure if the resident had had a pacemaker check. She indicated one was scheduled for 3/10/10 but the resident went to the hospital on 3/07/10. She indicated the resident returned to the facility on 3/10/10 and she did not know if the resident had the pacemaker check. LPN #6 indicated she had just made an appointment for a pacemaker check on 10/24/11.</p> <p>During an interview on 10/17/11 at 2:35 p.m., LPN #6 indicated the resident did</p>		<p>11/8/2011, and 11/9/2011.c. A Quality of Care Audit was created on 10/31/2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placea. A Quality of Care Audit will be conducted randomly on all shifts weekly for four weeks, monthly for six months and quarterly thereafter.b. The Health Facility Administrator will monitor for compliance</p>		

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	<p>not have physician's orders to check the pacemaker in her chart.</p> <p>A facility policy, dated 2/20/10 and titled "Pacemaker Management," indicated "...This policy is intended to outline the elements of a safe and uniform method of management for cardiac pacemaker care. Procedure: 1. Upon admission or following pacemaker insertion the following information, as it is available, will be gathered and documented in the Admission Assessment or Nursing Notes: a. Type of device (demand or set rate) b. Number and type of leads. c. Related diagnosis. d. Frequency of pacemaker checks and name of company completing the checks. 2. If resident is admitted with a pacemaker in place but does not have knowledge of pacemaker specifics, the nurse will contact the resident's cardiologist requesting such information and document the request in the resident's medical record. 3. The nurse will complete a physician verbal telephone order noting pacemaker diagnosis, frequency of pacemaker checks and name of diagnostic company performing the checks. 4. Future appointments will be scheduled with a cardiac diagnostic company. The resident and family will be advised of this schedule."</p> <p>2. During an interview on 10/12/11 at</p>			

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	<p>8:35 a.m., Resident #60 indicated her dialysis access site was in her left upper arm. An observation at the time of the interview indicated there was a dressing on the left inner upper arm. The resident continued to indicate the dressing should have come off on 10/11/11 in the evening. She indicated the dressing was suppose to come off the evenings of dialysis. She indicated the nursing staff at the facility do not check the dialysis site for functioning.</p> <p>Resident #60's record was reviewed on 10/12/11 at 10:18 a.m. The resident's diagnoses included, but were not limited to, end stage renal failure and hypertension.</p> <p>The resident's admission/5 day Minimum Data Set Assessment, dated 09/24/11, indicated the resident had a cognition of score of 15 (intact cognition).</p> <p>The resident's admission physician's orders, dated 09/19/11, indicated the resident received dialysis three times a day on Monday, Wednesday and Friday.</p> <p>The resident's admission Nurses' Note, dated 09/19/11 at 4:08 p.m., indicated the resident had an AV (arteriovenous) Fistula (a connection between the artery and vein for dialysis).</p>				

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	<p>There was a lack of documentation on the resident's Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 09/11 and 10/11, to indicate the resident's AV fistula had been monitored for functioning (thrill-vibration felt &amp; bruit-sound heard over the fistula site).</p> <p>The resident's Nurses' Notes, dated 09/20/11, 09/21/11, 09/27/11, 09/29/11, 10/02/11, 10/04/11, 10/06/11, 10/08/11, and 10/11/11 lacked documentation to indicate the resident's AV fistula had been monitored for functioning.</p> <p>There was a lack of documentation to indicate a care plan had been initiated for the care of the resident's AV fistula.</p> <p>During an interview on 10/12/11 at 11 a.m., LPN #1 indicated a daily assessment of the AV fistula should be on the resident's TAR. She indicated the AV fistula assessment was not on the resident's TARs or MARs and it had not been getting assessed daily for functioning.</p> <p>3.1-37(a)</p>				

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F0328 SS=E	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered for 4 of 8 residents reviewed with oxygen (Resident's #9, #58, #67, and #137) and a resident who was left with a nebulizer treatment on and unattended by a licensed professional for an hour and twenty-five minutes for 1 of 5 residents reviewed with nebulizer treatments (Resident #19) in a total sample of 24.</p> <p>Findings include:</p> <p>1. Resident #58's record was reviewed on 10/14/11 at 10:25 a.m. Resident #58's diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), and diabetes.</p> <p>A clarification order, dated 10/11/11, indicated the resident was to have oxygen on at 2 liters when not on her bi-pap (breathing apparatus).</p>	F0328	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. The nurse for resident #19 was counseled on 10/27/2011</p> <p>b. The oxygen rate was corrected for resident #s 9,58,67,137</p> <p>c. An in-service provided for all nursing staff by AMOS was completed on 10/12/2011, 10/13/2011, and 10/14/2011</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. Residents who are on Oxygen and Nebulizers have the potential to be affected by the alleged deficient practice</p> <p>b. All oxygen rates were checked for accuracy on 10/20/2011.</p> <p>c. The nurse for resident #19 was counseled.</p> <p>3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur</p> <p>a. All nurses were in-serviced on 10/12/2011, 10/13/2011, and 10/14/2011 by oxygen provider related to</p>	11/18/2011	

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	<p>During an observation on 10/11/11 at 10:15 a.m. with LPN #9 present, Resident #58 was sitting in her wheelchair in her room. The resident's oxygen was being administered by a nasal cannula at two liters. LPN #9 indicated during the observation the resident's oxygen should be set at six liters.</p> <p>During an observation, on 10/14/11 at 10:15 a.m., Resident #58 was in her room in her wheelchair watching T.V. and her oxygen was on at 3 liters per nasal cannula on the portable oxygen tank. She did not have her bi-pap on.</p> <p>During an observation, on 10/14/11 at 10:55 a.m., Resident #58 was in her room in her wheelchair and was now on the oxygen concentrator. Her oxygen was on 4.5 liters. She did not have her bi-pap on.</p> <p>During an interview with LPN #10, on 10/14/11 at 11 a.m., she indicated the resident's oxygen was on 4.5 liters and then put it down to 2 liters. She indicated the resident is supposed to be on 2 liters.</p> <p>2. Resident #67's record was reviewed on 10/11/11 at 12:25 p.m. Resident #67's diagnoses included, but were not limited to, diabetes, anemia, and cellulitis.</p> <p>The physician's recapitulation orders,</p>		<p>accurate oxygen delivery rates. b. All Licensed Professional staff to be in-serviced on administering nebulizer medication following Alliance Pharmacy Policy #02-026 on 11/7/2011, 11/8/2011, and 11/9/2011. c. All licensed professional staff to be in-serviced on Oxygen Therapy Policy on 11/7/2011, 11/8/2011, and 11/9/2011. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. A Quality of Care Audit was developed to monitor oxygen delivery and nebulizer administration. The audit will be conducted randomly on all shifts, weekly for four weeks, monthly for six months, then quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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	<p>dated 10/2011, indicated an order for oxygen at 3 liters/minute per nasal cannula continuously.</p> <p>During an observation, on 10/11/11 at 1:45 p.m., Resident #67 was in bed asleep and his oxygen was on at 2 liters per nasal cannula on the oxygen concentrator.</p> <p>During an observation, on 10/12/11 at 9:10 a.m., Resident #67 was up in his wheelchair in his room and his oxygen was on 4 liters on the portable oxygen tank.</p> <p>During an interview with LPN #16, on 10/12/11 at 9:15 a.m., she indicated the resident is supposed to be on 3 liters and then changed the oxygen to 3 liters.</p> <p>A facility policy titled "Oxygen Therapy," dated 5/13/05, received as current from the ADoN (Assistant Director of Nursing) on 10/13/11 at 12:20 p.m., indicated "Policy/Procedure: Obtain order...turn oxygen delivery system on and adjust to prescribed liter flow..."</p> <p>3. During the initial tour on 10/11/11 at 10:25 a.m., with LPN #2, Resident #19 was observed lying in her bed with a nebulizer mask covering her mouth. The medication holder was empty and the nebulizer machine was running. LPN #2 indicated she was the nurse who gave the</p>				

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	<p>resident the nebulizer treatment. LPN # 2 indicated she had started the nebulizer treatment at 9:00 a.m. LPN #2 indicated she had been training a new nurse and had forgotten about the nebulizer. This was 1 hour and 25 minutes after the nebulizer treatment had been started.</p> <p>Resident #19's record was reviewed on 10/13/11 at 9:16 a.m. Resident #19's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and congestive heart failure.</p> <p>A physician's order, dated 09/02/11, indicated "Albuterol neb 0.083% (breathing medication), use 1 nebule via nebulizer every 4 hours."</p> <p>A quarterly MDS (Minimum Data Set) assessment indicated Resident #19 cognitive status was scored as a five which indicated her cognitive status was severely impaired.</p> <p>4. Resident #9's record was reviewed on 10/11/11 at 2:05 p.m. Resident #9's diagnoses included, but were not limited to, congestive heart failure, chronic renal insufficiency, and COPD (chronic obstructive pulmonary disease).</p> <p>A physician's order recapitulation, dated 10/11, indicated oxygen at 2 liters per</p>				

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	<p>nasal cannula continuously.</p> <p>Resident #9 was observed on 10/11/11 at 12:05 p.m. and 1:55 p.m. and 10/12/11 at 8:55 a.m., with his oxygen on at 4 liters.</p> <p>During an interview on 10/15/11 at 9:33 a.m., LPN #15 indicated she had put the resident's oxygen on 2 liters.</p> <p>5. Resident #137's record was reviewed on 10/12/11 at 2:35 p.m. Resident #137's diagnoses included, but were not limited to, end stage COPD, hypertension, and dementia.</p> <p>The resident's physician's order recapitulation, dated 10/11, indicated oxygen at 4 liters a minute per nasal cannula.</p> <p>Resident #137 was observed on 10/11/11 at 1:50 p.m. with her oxygen on 3.5 liters.</p> <p>During an interview on 10/11/11 at 1:56 p.m., LPN #6 indicated the resident's oxygen was not on 4 liters as ordered.</p> <p>Resident #137 was observed on 10/12/11 at 9 a.m. with her oxygen on 3.5 liters. LPN #17 at the time of the observation indicated the resident's oxygen was not on 4 liters and changed the oxygen to 4 liters.</p>				

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F0385 SS=D	<p>3.1-46(a)(2)</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on record review and interview, the facility failed to ensure a physician provided medical care to a resident when the resident's physician had not responded to the facility staff to treat high blood sugars, for 1 of 24 residents reviewed for physician responding for medical care in a total sample of 24. (Resident #45)</p> <p>Findings include:</p> <p>Resident #45's record was reviewed on 10/12/11 at 8:55 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The physician's recapitulation orders, dated 10/11/11, indicated an order dated 08/19/11 to check the resident's blood sugar and to call the resident's physician if the resident's blood sugar was less than 60 or higher than 400.</p> <p>A Nurses' Note, dated 08/22/11 at 9 p.m.,</p>	F0385	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practicea. The resident was treated when the physician returned the call on 8/23/2011 at 12:00am and on 8/29/2011 at 12:02amb. The nurse was counseled on the notification of physician policy2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takena. The residents with notification of physician of elevated blood sugars have the potential to be affected by the alleged deficient practiceb. All charts were audited to ensure the physician was notified of elevated blood sugars this was completed on 10/20/2011.3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recurc. Change of Condition/Notification of Physician Policy was revised on</p>	11/18/2011	

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	<p>indicated the resident's blood sugar was 403 and the resident's physician had been paged.</p> <p>A Nurses' Note, dated 08/23/11 at 12 a.m., indicated the physician had returned the page to the facility and had given orders to treat the high blood sugar.</p> <p>A physician's telephone order, dated 08/23/11 at 12 a.m., indicated an order to give an additional 10 units of novolin regular insulin.</p> <p>A Nurses' Note, dated 08/28/11 at 9 p.m., indicated the resident's blood sugar was 404 at 8 p.m. and the resident's physician had been paged and the nurse was waiting for the physician to call back.</p> <p>A Nurses' Note, dated 08/28/11 at 10:45 p.m., indicated the resident's physician had been paged again and the nurse was waiting for the physician to call back.</p> <p>A Nurses' Note, dated 08/29/11 (sic) at 11:30 p.m., indicated the physician had been paged again and the facility had no return call from the physician.</p> <p>A Nurses' Note, dated 08/29/11 at 12:40 a.m. indicated the physician returned the page to the facility and an order was received to treat the high blood sugar.</p>		<p>10/31/2011.b. All licensed professional staff to be in-serviced on Resident Change of Condition/Notification of Physician Policy on 11/7/2011, 11/8/2011, 11/9/2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placea. A Quality of Care Audit, including blood glucose out of parameters, was developed.b. The audit will be conducted randomly on all shifts, weekly for four weeks, monthly for six months and quarterly thereafter. c. This will be monitored by the Health Facility Administrator for compliance.</p>		

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	<p>This was four hours and forty minutes after the physician had first been paged.</p> <p>A physician's telephone order, dated 08/29/11 at 12:40 a.m. indicated to discontinue the resident's 12 units of levemir insulin daily at 8 p.m. and to increase the insulin to 18 units every evening.</p> <p>During an interview on 10/12/11 at 9:40 a.m., LPN #1 indicated if the physician does not call back to the facility, they are supposed to call the Medical Director.</p> <p>A facility policy, dated 08/13/10, titled, "Resident Change of Condition and Notification of Primary Physician/Notification of Medical Director", received as current from the Assistant Director of Nursing as current, indicated, "...If primary physician does not respond within a reasonable amount of time notify the Medical Director of needs..."</p> <p>3.1-22(a) 3.1-22(a)(1) 3.1-22(a)(2)</p>				

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure medication disposition was completed for 3 of 3 discharged residents in a sample of 24 residents. (Residents #149, #150, and #151)</p> <p>Findings include:</p> <p>1. Resident #151's closed record was reviewed on 10/17/11 at 10:30 a.m. Resident #151's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and hypertension.</p> <p>A physician's order, dated 9/8/11, indicated Norco (a narcotic pain medication) 10/325 milligram (mg) one</p>	F0425	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. Resident #151 #149, #150 were discharged, Unable to locate Norco for resident #151, unable to locate Lorazepam for resident #149, Unable to locate Megace and Lidoderm patches for resident #150. b. Nurse no longer employed at Wittenberg. c. Reported to the state on 10/17/2011</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. Residents with medication to be disposed of have the potential to be affected by the alleged deficient practice. b. All drug disposition records</p>	11/18/2011	

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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN46307		
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	<p>tablet as needed for pain every 4 hours.</p> <p>A physician's order, dated 9/25/11, indicated the resident was sent to the hospital for evaluation and treatment.</p> <p>The resident's re-admission orders, dated 9/27/11, indicated the physician had not ordered the Norco.</p> <p>A controlled drug disposition form indicated on 9/25/11 there were 24 tablets of Norco left. The form had DC'd (discontinued) hand written on it. There was a lack of documentation to indicate what had happened to the 24 tablets of Norco.</p> <p>During an interview on 10/17/11 at 2:00 p.m., LPN #3 indicated she was not able to find out what had happened to the 24 tablets of Norco.</p> <p>2. Resident #149's closed record was reviewed on 10/17/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and chronic obstructive pulmonary disease.</p>		<p>were reviewed for accuracy on 10/20/2011. 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur a. All professional licensed nurses will be in-serviced on 11/7/2011, 11/8/2011, and 11/9/2011 following Alliance Pharmacy Policy Handling Scheduled Narcotics #01-010. b. All professional licensed nurses will be in-services on 11/7/11, 11/8/11, and 11/9/11 following Alliance Pharmacy Policy Handling Scheduled Narcotics Franeworks #01-046. c. All professional licensed nurses will be in-serviced on the Medication Disposal Policy on 11/7/11, 11/8/11, and 11/9/11. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. A Quality of Care Audit regarding drug disposition was created and will be completed randomly on all shifts, every week for four weeks, monthly for six months and quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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	<p>The record indicated the resident had passed away in the facility on 10/02/11 at 7:30 a.m.</p> <p>The physician's recapitulation orders, dated 09/11, indicated an order for lorazepam (anti-anxiety) 0.5 mg (milligram) every six hours as needed for anxiety.</p> <p>A pharmacy packing slip, dated 09/16/11, indicated the pharmacy had delivered 30 tablets of the lorazepam to the facility.</p> <p>There was a lack of documentation to indicate the lorazepam had been destroyed by the facility after the resident's death.</p> <p>During an interview on 10/17/11 at 10:40 a.m., the Director of Nursing indicated the lorazepam was not on the resident's medication destruction record.</p> <p>3. Resident #150's record was reviewed on 10/17/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and weight loss. The resident was discharged to the hospital on 08/22/11.</p> <p>The resident's Medication Administration Record, dated 08/11, indicated the resident received lidoderm (pain medication) patches to his back for 12</p>				

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	<p>hours a day and Megace (appetite stimulant) 400 mg daily.</p> <p>There was a lack of documentation on the resident's medication destruction record, dated 08/30/11, to indicate the lidoderm patches and the Megace had been disposed of.</p> <p>During an interview on 10/17/11 at 10:40 a.m., the Director of Nursing indicated the medications were not on the medication destruction record.</p> <p>3.1-25(a)</p>				

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F0431 SS=D	<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 record review and interview, the facility failed to ensure an accurate account of a controlled drug was maintained and reconciled, related to the amount of Roxanol (Morphine Sulfate) (narcotic pain medication) destroyed after a resident was discharged for 1 of 3 closed records reviewed in a sample of 24.</p>	F0431	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. Unable to reconcile narcotic record b. Nurse no longer employed at Wittenberg c. Reported to the state 10/17/2011</p> <p>2. How other residents having the potential to</p>	11/18/2011

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	<p>(Resident #149)</p> <p>Findings include:</p> <p>Resident #149's closed record was reviewed on 10/17/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and chronic obstructive pulmonary disease. The record indicated the resident had passed away in the facility on 10/02/11 at 7:30 a.m.</p> <p>A physician's telephone order, dated 10/01/11 at 6:20 p.m., indicated an order for Roxanol 20 mg (milligrams) per milliliters (ml), give 0.25 ml every four hours as needed for air hunger or pain.</p> <p>The resident's Medication Administration Record, dated 10/11, indicated the resident received the Roxanol 0.25 ml on 10/02/11 at 6 a.m.</p> <p>The emergency drug kit slip, dated 10/02/11, indicated morphine oral solution (roxanol) 10mg/5 ml was removed from the emergency drug kit and 2.5 ml was given.</p> <p>There was a lack of documentation to indicate the 2.5 ml of Roxanol left had been destroyed.</p>		<p>be affected by the same deficient practice will be identified and what corrective action(s) will be taken a. All residents with narcotics have the potential to be affected by the alleged deficient practice. b. All schedule 2 narcotics have been reconciled on 10/20/2011 3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur a. All professional licensed nurses will be in-serviced on 11/7/11, 11/8/11, and 11/9/11 following Alliance Pharmacy Policy Handling Scheduled Narcotics #01-046. b. All professional licensed nurses will be in-serviced on 11/7/11, 11/8/11, and 11/9/11 following Alliance Pharmacy Policy Handling Scheduled Narcotics Frameworks - #01-046. c. All professional licensed nurses will be in-serviced on Facility Medication Disposal Policy on 11/7/11, 11/8/11, and 11/9/11. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place a. A Quality of Care Audit was developed, including narcotic count, and will be done randomly on all shifts, weekly for four weeks, monthly for six months, and quarterly thereafter. b. The Health Facility Administrator will monitor for compliance.</p>		

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F0504 SS=D	<p>During an interview on 10/17/11 at 10:40 a.m., LPN #3 indicated no one knows what happened to the 2.5 ml of Roxanol left.</p> <p>3.1-25(m)</p> <p>The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were completed only as ordered by the physician for 2 of 24 residents reviewed for laboratory services in a total sample of 24. (Residents #27 and #137)</p> <p>Findings include:</p> <p>1. Resident #137's record was reviewed on 10/12/11 at 2:35 p.m. Resident #137's diagnoses included, but were not limited to, end stage COPD (chronic pulmonary obstructive disease), hypertension, and dementia.</p> <p>The resident's re-admission physician's orders, dated 9/9/11, indicated "No labs hospice."</p> <p>The resident's record contained a chem 8 (test for electrolytes) and CBC (complete blood count), dated 9/22/11. Handwritten on the laboratory test was "MD aware...no</p>	F0504	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>a. Physician updated on labs performed with no orde for resident #27 and Resident #137.</p> <p>b. Correct lab was drawn</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. All residents with lab orders may be affected by the alleged deficient practice</p> <p>b. All residents were audited for accuracy of labs on 10/20/2011 and corrected as needed.</p> <p>3. What measures will be put in place or systemic changes will be made to ensure that the deficient practice does not recur</p> <p>a. The Lab Specimen Policy was revised on 10/31/2011</p> <p>b. All licensed professional nurses will be in-serviced on Lab Specimens Policy and the Daily Order Verification Policy on 11/7/11, 11/8/11, and 11/9/11.</p> <p>4. How the corrective action(s) will</p>	11/18/2011	

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	<p>labs hospice..."</p> <p>During an interview on 10/12/11 at 3:22 p.m., LPN #16 indicated the laboratory test should not have been done.</p> <p>2. Resident #27's record was reviewed on 10/13/11 at 9:56 a.m. Resident #27's diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism.</p> <p>The resident's re-admission orders, dated 9/20/11, indicated "PT/INR (pro-time and international normalized ratio) (laboratory blood clotting test) M/W?F (Monday/Wednesday/Friday)." There were no orders for liver profile.</p> <p>A physician's order, dated 10/3/11, indicated "D/C (discontinue) the PT/INR M,W, F. PT/INR Q (every) 2 wks (weeks) begin 10/17/11."</p> <p>The resident's record contained a PT/INR, dated 10/7/11 and a liver profile, dated 10/3/11.</p> <p>During an interview on 10/13/11 at 10:35 a.m., LPN #4 indicated the laboratory tests should not have been drawn. She indicated the laboratory just kept drawing them.</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>a. A Quality of Care Audit was revised and will be conducted randomly on all shifts, weekly for four weeks, monthly for six months, and quarterly thereafter.</p> <p>b. The Health Facility Administrator will monitor for compliance.</p>		

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	3.1-49(f)(1)				