

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2014
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NAME OF PROVIDER OR SUPPLIER  ALLISONVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: June 23, 24, 25, 26 and 27, 2014</p> <p>Facility number: 012466 Provider number: 155786 AIM number: 201014060</p> <p>Survey team: Gloria Bond, RN--Team Coordinator Michelle Hosteter, RN (June 23, 24, 25 and 26, 2014) Sandra Nolder, RN Janet Stanton, RN</p> <p>Census bed type: SNF--25 SNF/NF--124 Total--149</p> <p>Census payor type: Medicare--25 Medicaid--108 Other--16 Total--149</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by</p>	F000000	F000000 The creation and submission of the plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan Of Correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of a post survey visit on or after July 23,2014.	

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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F000157 SS=D	<p>Tammy Alley RN on July 2, 2014.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the Physician</p>	F000157	<b>F0157</b> - <i>What corrective action(s) will be accomplished for</i>	07/23/2014			

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	<p>of a change in condition for 2 of 2 resident's who did not have a bowel movement after 3 days, and one resident whose blood sugar was less than 70. (Residents #109, #194 and #121)</p> <p>Findings include:</p> <p>1. Resident #109's record was reviewed on 6/26/14 at 6:00 P.M. Diagnoses included, but were not limited to, Parkinsonism, dementia with Lewy bodies, depressive disorder, esophageal reflux, and constipation.</p> <p>The resident had a Care Plan dated 8/5/13 that addressed the problem he was at risk for constipation related to he had a history of chronic constipation and decreased mobility. The approaches indicated "...8/5/13--Administer medications as ordered...8/5/14--Monitor bowel function, 8/5/13--Notify MD if no BM [bowel movement] after 3rd day."</p> <p>The BM record indicated the resident did not have a BM or lacked documentation of a BM on the following dates: 1/5/14-1/7/14-None 1/8/14-1/9/14-No documentation 1/10/14-None 6/10/14-None 6/11/14-No documentation 6/12/14-None</p>		<p><b>those residents found to have been affected by the deficient practice.</b></p> <p>Residents #109 &amp; #194 will have BM status documented daily. If no BM by 3rd day resident will be given a laxative per physicians order; if no BM on the 4th day MD will be notified per facility policy. Resident #121 will have blood glucose checks per the MD orders. MD will be notified as a result of her blood glucose reading per MD orders.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</b></p> <p>All residents have the potential to be affected.</p> <p>Licensed nurses received education on or by 7/16/14 from the DNS/designee on bowel management, notification of MD, and policy on blood glucose testing with notification to MD. The nursing staff was educated on the importance of documentation requirements for bowel management on or by 7/9/14 by the DNS/designee. All residents records were audited by DNS/Designee to ensure resident physician was notified per physician order for bowel movements. Resident with blood glucose charts were audited by DNS/Designee to ensure physician orders were followed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the</b></p>				

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	<p>6/24/14-6/26/14-None</p> <p>The resident's Annual MDS (Minimum Data Set) assessment dated 3/19/14, indicated bowel incontinence was frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement in the last 7 days) and his functional status for toilet use was extensive assist with one person physical assistance.</p> <p>The resident's record lacked documentation the Physician was notified that the resident did not have a BM after three days.</p> <p>2. Resident #194's record was reviewed on 6/25/14 at 2:42 P.M. Diagnoses included anorexia, urinary tract infection, dementia, constipation, osteoporosis, and acute cystitis.</p> <p>The resident had a Care Plan dated 8/17/12, that addressed the problem she was at risk for constipation related to she had a decline in mobility and weakness issues and she had displayed small bowel movements for days at a time. The approaches indicated "...8/17/12--Administer medications as ordered...8/17/12--Monitor bowel function, 8/17/12--Notify MD if no BM</p>		<p><b>deficient practice does not recur.</b></p> <p>Licensed nurses received education on or by 7/16/14 from the DNS/designee on bowel management, notification of MD, and policy on blood glucose testing with notification to MD. The nursing staff was educated on the importance of documentation requirements for bowel management on or by 7/9/14 by the DNS/designee.</p> <p>Evening licensed nurses will review the BM report and will administer a laxative per MD order if the resident has had no BM for 3 days. The DNS/designee will run the BM management report the next morning to review those residents with no BM for 3 days and review for appropriate follow up. For residents with no BM after 3 days, the MD will be notified per facility policy.</p> <p>Licensed nurses received education on blood glucose testing, notification of MD and documenting on the blood glucose monitoring form on or by 7/16/14. The nurse managers will review the glucose monitoring records daily for documentation of glucose testing per MD order and notification of MD, as ordered. Licensed staff not adhering to policies will receive education and, if necessary, disciplinary action up to and including termination of their employment.</p> <p><b>How the corrective action will be</b></p>		

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	<p>[bowel movement] after 3rd day."</p> <p>The BM record indicated the resident did not have a BM or lacked documentation of a BM on the following dates: 1/4/14--none 1/5/14-1/7/14-no documentation 2/13/14-2/14/14-none 2/15/14-no documentation 3/11/14-3/13/14-none 3/19/14-none 3/20/14-no documentation 3/21/14-none 4/4/14 to 4-6/14-none 4/7/14-no documentation 4/8/14-none 5/7/14-5/9/14-none 6/23/14-6/25/14-none</p> <p>The resident's Quarterly MDS assessment dated 6/4/14, indicated she was occasionally incontinent (one episode of bowel incontinence over the last 7 days) and her functional status for toilet use was limited assistance with one person physical assist.</p> <p>The resident's record lacked documentation the Physician was notified that the resident did not have a BM after three days.</p> <p>During an interview on 6/26/14 at 6:30 P.M., LPN #6 indicated the facility</p>		<p><b>monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>The Bowel Elimination CQI tool will be completed by the DNS/designee weekly x 4, monthly x 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p>To ensure compliance with blood glucose testing, the DNS/designee will review the blood glucose monitoring for residents weekly x 4 weeks, monthly x 6 months then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the reviews will be presented at the monthly CQI meeting overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p><b>By what date the systemic changes will be completed – 7/23/2014</b></p>		

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	<p>charted by exception only, so if there were no problems with the resident, then there would be no documentation in the progress notes.</p> <p>During an interview on 6/27/14 at 8:20 A.M., the DNS (Director of Nursing Services) indicated if the BM record had none documented, it indicated the resident did not have a BM for that date. She indicated if there was a date missing for BM documentation the staff did not document the BM for that date. She indicated the evening shift was responsible for monitoring whether the resident had a BM. She indicated the CNA's usually were the staff who put the BM's in the computer, but anyone could.</p> <p>During an interview on 6/27/14 at 11:45 P.M., the DNS indicated the staff should have followed the care plan and notified the Physician.</p> <p>3. The record for Resident #121 was reviewed on 6/25/2014 at 4:10 P.M. Diagnoses included, but were not limited to, history of acute CVA (Cerebral Vascular Accident / stroke), dementia, and diabetes.</p> <p>The resident's physician's order recapitulation (recap) for June 2014 indicated, but was not limited to, the following:</p>			

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	<p>"12/04/13, accuchecks twice daily call MD for blood sugar &lt;[less than] 70 or &gt;[greater than] 450"</p> <p>During March 2014, the following days blood glucose reading indicated the physician's orders were not followed: March 19 -- 6 A.M., 60 mg/dL (milligram / deciliter), PRN (as needed) treatment OJ (orange juice), MD notified--No March 23 -- 6 A.M., 66 mg/dL, PRN treatment OJ, MD notified--No March 31-- 6 A.M., 69 mg/dL, PRN treatment OJ, MD notified--No</p> <p>During an interview with RN #7 on 6/27/2014 at 3:37 P.M., she indicated the flow sheets, "Capillary Blood Glucose Monitoring Tool", were used to record the blood sugar monitoring.</p> <p>The, "Capillary Blood Glucose Monitoring Tool" dated 9/04 indicated the following: "Record each capillary blood glucose obtained, units of insulin given, and /or PRN[as needed] treatment. Notify MD of all blood sugars as indicated by call orders or signs/symptoms of high or low blood sugar...."</p> <p>3.1-5(a)(2)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow care plans for 2 of 31 resident's care plans reviewed and failed to follow Physician orders for 1 of 31 resident's records reviewed for Physicians orders. (Residents #109, #194 and #121)</p> <p>Findings include:</p> <p>1. Resident #109's record was reviewed on 6/26/14 at 6:00 P.M. Diagnoses included, but were not limited to, Parkinsonism, dementia with Lewy bodies, depressive disorder, esophageal reflux, and constipation.</p> <p>The resident had a Care Plan dated 8/5/13 that addressed the problem he was at risk for constipation related to he had a history of chronic constipation and decreased mobility. The approaches indicated "...8/5/13--Administer medications as ordered...8/5/14--Monitor bowel function, 8/5/13--Notify MD if no BM [bowel movement] after 3rd day."</p> <p>The BM record indicated the resident did</p>	F000282	<p><b>F 0282 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Residents #109 &amp; #194 will have BM status documented daily. If no BM by 3rd day resident will be given a laxative per physician order; if no BM on the 4th day MD will be notified per facility policy and per physician plan of care.. Resident #121 will have blood glucose checks per the MD orders and plan of care. MD will be notified as a result of her blood glucose reading per MD orders.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <p>All residents have the potential to be affected.</p> <p>Licensed nurses received education on or by 7/16/14 from the DNS/designee on bowel management, notification of MD, and policy on blood glucose testing with notification to MD. The nursing staff was educated on the importance of documentation requirements for bowel</p>	07/23/2014			

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	<p>not have a BM or lacked documentation of a BM on the following dates: 1/5/14-1/7/14-None 1/8/14-1/9/14-No documentation 1/10/14-None 6/10/14-None 6/11/14-No documentation 6/12/14-None 6/24/14-6/26/14-None</p> <p>The resident's Annual MDS (Minimum Data Set) assessment dated 3/19/14, indicated bowel incontinence was frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement in the last 7 days) and his functional status for toilet use was extensive assist with one person physical assistance.</p> <p>The resident's record lacked documentation the Physician was notified that the resident did not have a BM after three days.</p> <p>2. Resident #194's record was reviewed on 6/25/14 at 2:42 P.M. Diagnoses included anorexia, urinary tract infection, dementia, constipation, osteoporosis, and acute cystitis.</p> <p>The resident had a Care Plan dated 8/17/12, that addressed the problem she</p>		<p>management on or by 7/9/14 by the DNS/designee. All residents records were audited by DNS/Designee to ensure resident physician was notified per physician order for bowel movements. Resident with blood glucose charts were audited by DNS/Designee to ensure physician orders were followed.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></b></p> <p>Licensed nurses received education on or by 7/16/14 from the DNS/designee on bowel management, notification of MD, and policy on blood glucose testing with notification to MD. The nursing staff was educated on the importance of documentation requirements for bowel management on or by 7/9/14 by the DNS/designee.</p> <p>Evening licensed nurses will review the BM report and will administer a laxative per MD order if the resident has had no BM for 3 days. The DNS/designee will run the BM management report the next morning to review those residents with no BM for 3 days and review for appropriate follow up per plan of care. For residents with no BM after 3 days, the MD will be notified per facility policy.</p> <p>Licensed nurses received education on blood glucose</p>				

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	<p>was at risk for constipation related to she had a decline in mobility and weakness issues and she had displayed small bowel movements for days at a time. The approaches indicated "...8/17/12--Administer medications as ordered...8/17/12--Monitor bowel function, 8/17/12--Notify MD if no BM [bowel movement] after 3rd day."</p> <p>The BM record indicated the resident did not have a BM or lacked documentation of a BM on the following dates: 1/4/14--none 1/5/14-1/7/14-no documentation 2/13/14-2/14/14-none 2/15/14-no documentation 3/11/14-3/13/14-none 3/19/14-none 3/20/14-no documentation 3/21/14-none 4/4/14 to 4-6/14-none 4/7/14-no documentation 4/8/14-none 5/7/14-5/9/14-none 6/23/14-6/25/14-none</p> <p>The resident's Quarterly MDS assessment dated 6/4/14, indicated she was occasionally incontinent (one episode of bowel incontinence over the last 7 days) and her functional status for toilet use was limited assistance with one person physical assist.</p>		<p>testing, notification of MD and documenting on the blood glucose monitoring form on or by 7/16/14. The nurse managers will review the glucose monitoring records daily for documentation of glucose testing per MD order and plan of care, and notification of MD, as ordered. Licensed staff not adhering to policies will receive education and, if necessary, disciplinary action up to and including termination of their employment.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b> The Bowel Elimination CQI tool will be completed by the DNS/designee weekly x 4, monthly x 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance. To ensure compliance with blood glucose testing, the DNS/designee will review the blood glucose monitoring for residents weekly x 4 weeks, bimonthly x 2 months then</p>				

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	<p>The resident's record lacked documentation the Physician was notified that the resident did not have a BM after three days.</p> <p>During an interview on 6/26/14 at 6:30 P.M., LPN #6 indicated the facility charted by exception only, so if there were no problems with the resident, then there would be no documentation in the progress notes.</p> <p>During an interview on 6/27/14 at 8:20 A.M., the DNS (Director of Nursing Services) indicated if the BM record had none documented, it indicated the resident did not have a BM for that date. She indicated if there was a date missing for BM documentation the staff did not document the BM for that date. She indicated the evening shift was responsible for monitoring whether the resident had a BM. She indicated the CNA's usually were the staff who put the BM's in the computer, but anyone could.</p> <p>During an interview on 6/27/14 at 11:45 P.M., the DNS indicated the staff should have followed the care plan and notified the Physician.</p> <p>3. The record for Resident #121 was reviewed on 6/25/2014 at 4:10 P.M. Diagnoses included, but were not limited</p>		<p>quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the reviews will be presented at the monthly CQI meeting overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p><b>By what date the systemic changes will be completed</b> -7/23/2014</p>		

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	<p>to, history of acute CVA (Cerebral Vascular Accident / stroke), dementia, and diabetes.</p> <p>The resident's current care plan indicated the following: "Resident is at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and / or diagnosis of diabetes mellitus. Goal: the resident will not experience symptoms of hyperglycemia[high blood sugar] or hypoglycemia [low blood sugar]...Document abnormal findings and notify MD. Medication as ordered. Monitor blood sugars as ordered...."</p> <p>The resident's Physician's order recapulation (recap) for June 2014 indicated the resident was receiving, but was not limited to, the following medication: " 10/29/2013, Humalog 100 U[Units]/ml[milliliter] inject sub-q [subcutaneous] per sliding scale: 3 times daily 10 minutes before meals. 201-250 = 4 Units 251-300 = 6 Units 301-350 = 8 Units 351-400 = 10 Units 401-450 = 12 Units call &lt;[less than] 50 or &gt;[greater than] 450"</p>			

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NAME OF PROVIDER OR SUPPLIER  ALLISONVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10312 ALLISONVILLE RD FISHERS, IN 46038
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	<p>The resident's physician's order recapulation (recap) for June 2014 indicated, but was not limited to, the following: "12/04/13, accuchecks twice daily call MD for blood sugar &lt; 70 or &gt; 450"</p> <p>The resident's MAR (Medication Administration Record) for June 2014 indicated the following note for: " Humalog 100 U[Units]/ml[milliliter], inject sub-q[subcutaneous] per sliding scale: 3 times daily, 10 minutes before meals--see flow sheet...."</p> <p>During an interview with RN #7 on 6/27/2014 at 3:37 P.M., she indicated the flow sheets, "Capillary Blood Glucose Monitoring Tool," were used to record the blood sugar monitoring and sliding scale insulin amounts given.</p> <p>The resident's flow sheets for March, April, May and June were provided on 6/27/2014 at 3:15 P.M., by the DNS (Director of Nursing Service).</p> <p>The March 2014, flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M., daily in March.</p> <p>During March 2014, the following days blood glucose reading indicated the Physician's orders were not followed:</p>			

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	<p>March 19-- 6 A.M., 60 mg/dL (milligram / deciliter), PRN (as needed) treatment OJ (orange juice), MD notified--No</p> <p>March 23-- 6 A.M., 66 mg/dL, PRN treatment OJ, MD notified--No</p> <p>March 29-- 6 A.M., 209 mg/dL, Units of SQ insulin--there was no insulin amount given documented.</p> <p>March 31-- 6 A.M., 69 mg/dL, PRN treatment OJ, MD notified--No</p> <p>Resident # 121's April 2014 flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M., daily.</p> <p>During April 2014 the following days blood glucose readings indicated the Physician's orders were not followed: April 6-- 4 P.M., the record lacked a blood glucose reading. April 13-- 6 A.M., the record lacked a blood glucose reading. April 25-- 4 P.M., a crossed out recording of 209 with initials under nurse signature, but no further documentation.</p> <p>During May 2014 the blood glucose flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M., from May 1 to May 20. May 21 thru May 27 it was obtained four times per day.</p> <p>During May 2014, the following days</p>						

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F000329 SS=D	<p>blood glucose readings were not found documented on the "Capillary Blood Glucose Monitoring Tool":</p> <p>May 21-- 6 A.M., the record lacked a blood glucose reading.</p> <p>May 27--11 A.M., the record lacked a blood glucose reading.</p> <p>May 27-- 9 P.M., the record lacked a blood glucose reading.</p> <p>During June 2014 the record indicates blood glucose monitoring was done at 6 A.M. and 4 P.M., and not three times daily as ordered.</p> <p>In an interview on 6/27/2014 at 3:40 P.M., with RN #7, she indicated the orders for the number of times the blood sugar had been monitored for Resident #121 had varied each month, due to different MD orders each month. In response to the days that were missing, she was unable to find an explanation for them.</p> <p>3.1-35(g)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate</p>			

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	<p>monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to adequately monitor sliding scale insulin administration for a resident receiving insulin based on a sliding scale dosage. This deficient practice affected 1 of 5 residents reviewed for unnecessary medications. ( Resident #121)</p> <p>Findings include:</p> <p>The record for Resident #121 was reviewed on 6/25/2014 at 4:10 P.M. Diagnoses included, but were not limited to, history of acute CVA (Cerebral Vascular Accident / stroke), dementia, and diabetes.</p> <p>The resident's Physician's order</p>	F000329	<p><b><i>F 0329 -What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></b></p> <p>Resident #121 will have blood glucose checks per MD orders and will have notification completed per the MD orders on daily. Will have sliding scale insulin orders followed and administered per MD orders.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</i></b></p> <p>All residents with orders for glucose monitoring have the potential to be affected.</p> <p>Licensed nurses received education on the importance of blood glucose testing, notification of MD and documenting on the blood glucose</p>	07/23/2014

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	<p>recapitulation (recap) for June 2014 indicated the resident was receiving, but was not limited to, the following medication: " 10/29/2013, Humalog 100 U[Units]/ml[milliliter] inject sub-q [subcutaneous] per sliding scale: 3 times daily 10 minutes before meals. 201-250 = 4 Units 251-300 = 6 Units 301-350 = 8 Units 351-400 = 10 Units 401-450 = 12 Units call &lt;[less than] 50 or &gt;[greater than] 450"</p> <p>The resident's physician's order recapitulation (recap) for June 2014 indicated, but was not limited to, the following: "12/04/13, accuchecks twice daily call MD for blood sugar &lt; 70 or &gt; 450"</p> <p>The resident's MAR (Medication Administration Record) for June 2014 indicated the following note for: Humalog 100 U/ml inject sub-q per sliding scale: 3 times daily, 10 minutes before meals--see flow sheet.</p> <p>During an interview with RN #7 on 6/27/2014 at 3:37 P.M., she indicated the flow sheets, "Capillary Blood Glucose Monitoring Tool", were used to record</p>		<p>monitoring form on or before 7/16/14. Resident with blood glucose charts were audited by DNS/Designee to ensure physician orders were followed per plan of care.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></b> Licensed nurses received education on blood glucose testing, notification of MD and documenting on the blood glucose monitoring form on or by 7/16/14. The nurse managers will review the glucose monitoring records daily for documentation of glucose testing per MD order and notification of MD, as ordered. Licensed staff not adhering to policies will receive education and, if necessary, disciplinary action up to and including termination of their employment.</p> <p><b><i>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</i></b> To ensure compliance with blood glucose testing, the DNS/designee will review the blood glucose monitoring for residents weekly x 4 weeks, monthly x 6 months then quarterly</p>		

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	<p>the blood sugar monitoring and sliding scale insulin amounts given.</p> <p>The resident's flow sheets for March, April, May and June were provided on 6/27/2014 at 3:15 P.M., by the DNS (Director of Nursing Service).</p> <p>The March 2014, flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M., daily in March.</p> <p>During March 2014, the following days blood glucose reading indicated the physician's orders were not followed: March 19 -- 6 A.M., 60 mg/dL (milligram / deciliter), PRN (as needed) treatment OJ (orange juice), MD notified--No March 23 -- 6 A.M., 66 mg/dL, PRN treatment OJ, MD notified--No March 29 -- 6 A.M., 209 mg/dL, Units of SQ insulin--there was not insulin recorded. March 31-- 6 A.M., 69 mg/dL, PRN treatment OJ, MD notified--No</p> <p>Resident # 121's April 2014 flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M., daily.</p> <p>During April 2014, the following days blood glucose reading indicated the physician's orders were not followed:</p>		<p>until continued compliance is maintained for 2 consecutive quarters. The results of the reviews will be presented at the monthly CQI meeting overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p><b>By what date the systemic changes will be completed -7/23/2014</b></p>				

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	<p>April 6 -- 4 P.M., the record lacked a blood glucose reading.</p> <p>April 13 -- 6 A.M., the record lacked a blood glucose reading.</p> <p>April 25 -- 4 P.M., a crossed out recording of 209 with initials under nurse's signature, but no further documentation.</p> <p>During May 2014, the blood glucose flow sheet indicated the resident's blood glucose was obtained at 6 A.M. and 4 P.M. from May 1 to May 20th. May 21st thru May 27th it was obtained 4 times per day.</p> <p>During May 2014 the following days blood glucose readings were not found documented on the "Capillary Blood Glucose Monitoring Tool":</p> <p>May 21-- 6 A.M., the record lacked a blood glucose reading.</p> <p>May 27--11 A.M., the record lacked a blood glucose reading.</p> <p>May 27-- 9 P.M., the record lacked a blood glucose reading.</p> <p>During June 2014, the record indicates blood glucose monitoring was done at 6 A.M. and 4 P.M., and not three times daily as ordered.</p> <p>In an interview on 6/27/2014 at 3:40 P.M., with RN #7, she indicated the</p>			

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F000356 SS=C	<p>orders for the number of times the blood sugar had been monitored for Resident # 121 had varied each month. In response to the days that were missing, she was unable to find an explanation for them.</p> <p>3.1-48(a)(3)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul>			

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	<p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post nurse staffing data on a daily basis, for 3 days. This deficiency had the potential to affect 149 of 149 residents currently living in the facility.</p> <p>Findings include:</p> <p>On entrance to the facility on 6/23/14 at 9:40 A.M., the nurse staffing data sign was observed to be posted on a counter at the Nurses Station. The form was dated for 6/19/14, indicating the nurse staffing data was for that day.</p> <p>In an interview at that time, the Executive Director indicated the nurse staffing data for 6/23/14 was just being posted. He did not know where the data for the previous 3 days' posting might be.</p> <p>In an interview on 6/24/14 at 9:00 A.M., the Executive Director indicated the Scheduler, CNA #2, was responsible for posting the nurse staffing data.</p>	F000356	<p><b><i>F0356- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></b></p> <p>No residents were affected. The daily nursing staff hours report is current and posted daily.</p> <p><b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</i></b></p> <p>All residents have the potential to be affected. The scheduler and nurse managers were inserviced by ED on 6/30/14 regarding the posting of daily nursing hours worked.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></b></p> <p>The nurse scheduler will post the daily nursing staff data Monday through Friday. The nurse manager will be responsible for posting the daily nursing staff data on Saturdays and Sundays. The nurse scheduler</p>	07/23/2014	

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	<p>In an interview on 6/26/14 at 10:35 A.M., CNA #2 indicated she just worked a 5-day week, and did not work on the week-ends. She indicated she used the previous day's resident population/census numbers, then added the current day's nurse staffing numbers for the form posted each week-day. CNA #2 indicated she did not know who was responsible for posting the week-end nurse staffing data, and thought it was "maybe the Nurse Manager." Following a week-end, someone was supposed to turn in the week-end forms to her on Monday. She did not know about the Friday, 6/20/14 nurse staffing data form, and indicated she would look for that one as well as the ones for Saturday and Sunday.</p> <p>In an interview on 6/26/14 at 10:54 A.M., the Director of Nursing indicated the week-end supervisor, LPN #3, was responsible for posting the nurse staffing data form on Saturdays and Sundays. That person only worked on the week-ends, but was supposed to coming in to help with some physician re-writes. The Director of Nursing was not sure when the supervisor would be in, but would have her come to discuss matter.</p> <p>In an interview on 6/26/14 at 11:11 A.M., LPN #3, the week-end supervisor,</p>		<p>and the nurse manager will update the information for changes in census and staffing.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>The Administration CQI tool will be completed by the ED/designee weekly x 4 weeks, monthly x 2 months and quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed in the monthly CQI meeting. If the threshold of 100% is not met, an action plan will be developed.</p> <p><b>By what date the systemic changes will be completed -7/23/2014</b></p>				

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F000371 SS=F	<p>indicated CNA #2 would give her the completed nurse staffing forms with the projected staffing. On each day of the week-end, she (LPN #3) would then adjust/correct the numbers for the actual staff in the building on Saturday and Sunday.</p> <p>She indicated that CNA #2 had not given her the forms for the past week-end.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to follow procedures for the required concentration of a sanitation solution for food prep areas, and sanitation procedures for the storing of food items to prevent possible contamination. This deficit practice had the potential to affect 146 of 146 residents receiving meals from the kitchen.</p> <p>Findings included:</p> <p>An observation of the kitchen was made</p>	F000371	<p><b><i>F0371 – What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</i></b></p> <p>The sanitation issues found with concentration of the sanitation solution for food prep areas and the storing of food items to prevent possible contamination were immediately corrected. The</p>	07/23/2014

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	<p>on 6/23/14 at 9:50 A.M. The freezer had 4 boxes stacked on the floor. There was a box of frozen hamburger patties that the lid was open and the plastic baggy inside that was open to air exposing the frozen hamburger patties. Cook # 4 indicated at that time the boxes should not be on the floor and the patties should not be exposed.</p> <p>The sanitation solution for the cook's prep table was checked. Cook #4 indicated she had recently mixed it. She indicated she thought it was 400 ppm (parts per million), the strip was bright green, which according to the color guide on the test strips indicated 400 ppm, but there were some streaks of orange and light green in it. Cook #4 indicated it should read 200 ppm.</p> <p>On 6/23/14 at 10:15 A.M., the dry storage area had a bottle of apple cider vinegar with no lid on it. The Dietary Services Manager indicated at that time there was a fly in it. The dry milk bin had a large measuring scoop in it. She indicated the scoop should not be in there.</p> <p>3.1-21(i)(3)</p>		<p>exposed hamburger patties, the apple cider vinegar and the dry milk were disposed of. No residents were directly affected as a result of the alleged deficiency.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</b></p> <p>All residents residing in the facility have the potential to be affected by the alleged deficient practice. All dietary staff members will be inserviced on or by 7/16/14 regarding the sanitation solution for food prep areas, as well as the proper sanitation of storing food items to prevent possible contamination.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>The Dietary manager/Designee will check daily the sanitation solution</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>for food prep areas as well as the proper sanitation procedures for the storing of food items to prevent possible contamination. The dietary manager/Designee will monitor daily the dry storage room and the freezer area for proper storage of food.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>The CQI sanitation tool will be performed by the dietary manager/designee daily to ensure that proper kitchen sanitation and storing of food items is maintained. To ensure compliance the Registered Dietician will complete the kitchen sanitation CQI tool weekly for four weeks, monthly x 6 and then quarterly to maintain compliance. The results will be reviewed monthly at the CQI meeting. If the threshold of 100% is not met an action plan will be developed to assure.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2014
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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</p>		<p><b><i>By what date the systemic changes will be completed -7/23/2014</i></b></p>	
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	<p>of infection.</p> <p>Based on observation, interview and record review the facility failed to follow infection control procedures during a wound care dressing change for 1 of 1 residents observed for wound care and a dressing change. (Resident # 247)</p> <p>Findings include:</p> <p>The record was reviewed on 6/25/2014 at 2:15 P.M. Resident #247's diagnoses included, but were not limited to, bilateral lower extremity fractures with a soft immobilizer to the right lower extremity and external fixator (device connected to the bone with bone screws/pins that are on either side of the broken bone to hold it in place) to the mid left shin area.</p> <p>On 6/27/2014 at 10:00 A.M., LPN #1 was observed placing wound care supplies on the resident's bare rolling over-bed table without wiping it off nor setting up a clean field for the wound care supplies.</p> <p>LPN #1 was observed going and washing her hands for 10 seconds in the resident's bathroom. She returned with gloves on and asked for smaller gloves. While she waited for another pair of gloves, she touched the closet door knob,</p>	F000441	<p><b><i>F0441 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 224 will have dressing changes performed per MD orders following the facility policy/procedure for dressing changes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</i></b> All residents with orders for dressing changes have the potential to be affected. No other residents were found to be affected. Licensed nurses received education on or before 7/16/14 from the DNS/designee on dressing changes following the facility policy/procedure. The CEC will perform skills validations on licensed nursing staff for dressing changes per facility policy on or before 7/16/14.</p> <p><b><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</i></b> Licensed nurses received education on or before 7/16/14 from the DNS/designee on dressing changes following the facility policy/procedure. The CEC will perform skills validations on licensed nursing staff for dressing changes per facility policy on or before 7/16/14.</p>	07/23/2014	

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	<p>touched the resident, straightened the urinary catheter tubing, touched and moved the resident's remote control to the TV.</p> <p>After LPN #1 received a change of gloves, she threw the first pair of gloves into the trash can, which was approximately 4 to 5 feet across and slightly at an angle to the area where she was standing.</p> <p>She removed the old gauze dressing and threw it across the area into the trash. She cleansed the pin sites with sterile cotton swabs and after using the long cotton swabs, she threw them across the area into the trash can, missing the trash can at least once. LPN #1 had failed to place the trash can near to where she was doing the dressing change.</p> <p>Next, she removed a long gauze like strip and wrapped it around the resident's leg and secured it at the end. Without changing her gloves nor sanitizing her hands she opened a couple skin prep pads and wiped the resident's heel.</p> <p>On 6/27/2014 at 11:11 A.M., a half hour or more after the dressing change observation, and with Unit Manager / LPN #6 in attendance the cotton swab was observed still on the floor about 10</p>		<p>DNS/Designee will conduct rounds on all three shifts to ensure proper infection control techniques for wound care dressing changes is performed per facility policy. Licensed staff not adhering to policies will receive further education and, if necessary, disciplinary action up to and including termination of their employment. <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>DNS/designee will validate 5 licensed nursing staff divided between each shift weekly x 4 weeks, monthly x 6 and then quarterly until compliance is maintained x 2 consecutive quarters. CEC will review these validations in the monthly CQI meeting overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to assure compliance. <b>By what date the systemic changes will be completed –7/23/2014</b></p>				

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	<p>inches from the trash can.</p> <p>During an interview at this time, LPN #6 indicated the trash can should have been placed near the dressing change area.</p> <p>A nursing policy and procedure dated 9/2012 was provided by the DNS (Director of Nursing Service) and reviewed on 6/27/2014 at 11:40 A.M. The following procedure was listed: "...3. Place a trash receptacle next to the bed or a disposable plastic bag at the foot of the bed (or on chair) to dispose of potentially infectious material during procedure. 4. Wash hands. 5. Set up clean or sterile field to ensure easy access to supplies during procedure. 6. Put on gloves. 7. Remove old dressing from residents and put directly in trash receptacle. 8. Remove gloves and discard. 9. Perform hand hygiene. 10. Put on gloves. 11. Initiate wound care according to the physician order...13. Remove gloves and discard. 14. Perform hand hygiene. 15. Put on gloves. 16. Apply new dressing according to the physician orders. 17. Date and initial new dressing. 18. Remove gloves and discard. 19. Tie trash receptacle/disposable bag...."</p> <p>3.1-18(l)</p>			