STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155283	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 S EDGEWOOD DR KNOX, IN 46534

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 12, 13, 14, 15, and 16, 2014 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860 Survey Team: Heather Hite, RN - TC Jennifer Redlin, RN Caitlyn Doyle, RN Julie Ferguson, RN Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 15 Medicaid: 25 Other: 3 Total: 43 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on May 19, 2014, by Janelyn Kulik, RN.	F000000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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

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

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F000157 SS=D	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). The facility must also promptly notify the			

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	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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the physician as ordered for blood sugar and blood pressure readings outside of the specified call parameters for 2 of 5 residents reviewed for unnecessary medications. (Resident #49 and #28) Findings include: 1. Resident #49's record was reviewed on 5/14/14 at 12:10 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus, hypertension, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of the current Physician Orders indicated an order for, "Accuchecks (blood glucose test) 3x (three times)/day, call MD (physician) if < (less than) 60 or > (greater than) 400." Review of the April 2014 Blood Glucose	F000157	Resident #49 and #28 did not experience any negative outcome for the alleged deficient practice. The primary care physician for Resident #49 has been updated on the blood glucose levels being outside of call parameters. Resident #28 is no longer at the facility.All residents with call parameters for their blood glucose levels or blood pressure results have the potential to be affected. Their clinical records have been reviewed and the physician updated if indicated.The facility's policy for Physician Notification has been reviewed and no changes are indicated at this time (See Attachment A). The nurses have been re-educated on Physician notification with a special focus on notification if blood glucose or blood pressure readings are outside call parameters (See Attachment B). A MAR/TAR/Order Review form has been initiated (See Attachment C).The DON or designee will be responsible for	05/30/2014

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	Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 4/9/14 at 730 a.m. - BS (blood sugar) 533 4/14/14 at 7:30 a.m. - BS 421 4/16/14 at 12:00 p.m. - BS 531 4/17/14 at 7:30 a.m. - BS 542 4/19/14 at 7:30 a.m. -BS 422 4/19/14 at 12:00 p.m. - BS 501 4/20/14 at 7:30 a.m. - BS 421 4/20/14 at 12:00 p.m. - BS 474 4/24/14 at 12:00 p.m. - BS 480 Review of the May 2014 Blood Glucose Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 5/1/14 at 12:30 p.m. - BS 481 5/3/14 at 7:30 a.m. - BS 433 5/3/14 at 12:30 p.m. - BS 419 5/3/14 at 5:30 p.m. - BS 566 5/4/14 at 7:30 a.m. - BS 446 5/8/14 at 12:30 p.m. - BS 420 5/10/14 at 5:30 p.m. - BS 419 5/12/14 at 7:30 a.m. - BS 451 Review of the Blood Glucose Monitoring/Sliding Scale Insulin Records for May 2014 and April 2014 lacked documentation that the resident's physician was notified of the blood sugar results greater than 400. Review of the Nurse's Notes, dated 3/28/14 through 5/15/14, lacked documentation that the		completing the MAR/TAR/Order Review form to ensure the Physician is being notified as ordered. These checks will be completed on scheduled work days as follows: Daily on an ongoing basis. Should a concern be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.	

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	resident's physician was notified of the blood sugar results greater than 400. During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:09 a.m., she indicated the blood sugars were over the call parameters and the physician should have been notified. 2. Resident #28's record was reviewed on 5/14/14 at 10:48 a.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke), hypertension, and coronary artery disease. Review of the April Blood Pressure and Pulse log, indicated the resident's blood pressure and pulse were to be taken every Sunday and to call the physician if systolic was < (less than) 100 or diastolic was < (less than) 50. The resident's blood pressure result for 4/13/14 was 92/67. Review of the Nurse's Notes, dated 4/4/14 through 4/21/14, lacked documentation that the resident's physician was notified of the blood pressure result outside of call parameters. During an interview with the DoN on 5/15/14 at 1:49 p.m., she indicated the blood pressure was outside the call parameters and the physician should have			

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	been notified. She further indicated blood pressure and pulse were to be completed for each resident every Sunday. She indicated there was no specific policy on this but it was a facility practice. A facility policy on Physician and Family Notification, dated 1/06, and received as current from the DoN on 5/16/14 at 9:20 a.m., indicated "...2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...4. Document the information reported to the physician in the nurses notes including the time and date of notification. Be thorough and explicit..." 3.1-5(2) 3.1-5(3)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			

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	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop a resident care plan, related to Aspirin (a medication which can thin the blood), for 1 of 5 residents reviewed for unnecessary medications. (Resident #28) Findings include: Resident #28's record was reviewed on 5/14/14 at 10:48 a.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke), hypertension, and coronary artery disease. The current Physician's Orders, indicated orders for aspirin 81 mg (milligrams) daily. Review of the May 2014 and April 2014 Medication Administration Record (MAR) indicated the resident had received the aspirin medication daily. There was a lack of documentation to indicate the resident had a care plan	F000279	Resident #28's care plan was updated to include a care plan for Aspirin usage. Since that time, the resident no longer resides at the facility and has been discharged to home.All residents have the potential to be affected. Their care plans have been reviewed and if a concern was found, the care plan was updated.The facility's policy for Care Plan Development has been reviewed and no changes are indicated at this time (See Attachment D). The DON and ADON have been re-educated on care plan development (See Attachment E). A Care Plan Review form has been implemented (See Attachment F).The DON or designee will be responsible for checking 3 resident care plans to ensure all issues are care planned and will complete the Care Plan Review form. These checks will be completed on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter on an ongoing	05/30/2014

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	and/or interventions related to the aspirin usage and risk for bleeding and bruising. During an interview on 5/15/14 at 3:04 p.m., the Assistant Director of Nursing (ADoN) indicated there was not a care plan in place for the aspirin. She indicated there should have been a care plan in place; it just must have been missed. 3.1-35(a)		basis. Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's orders and care plans, related to physician notification of blood sugar readings outside of specified call parameters, laboratory tests, blood pressure monitoring, and follow up with a pharmacy recommendation for 2 of 5 residents reviewed for unnecessary medications. (Resident #49 and #28) Findings include: 1. Resident #49's record was reviewed on 5/14/14 at 12:10 p.m. The resident's	F000282	Resident #49 and #28 did not experience any negative outcome related to the alleged deficient practice. The physician for Resident #49 has been notified regarding the blood sugars outside of the call parameters, the blood pressures not being completed and recorded, and the magnesium and digoxin levels not being completed. Resident #28 has been discharged home.All residents have the potential to be affected. Their clinical record has been reviewed and if a concern was found, the physician was notified.The facility's policy for Physician's Orders has been	05/30/2014

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	diagnoses included, but were not limited to diabetes mellitus, hypertension, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). A. Review of the current Physician Orders indicated an order for, "Accuchecks (blood glucose test) 3x (three times)/day, call MD (physician) if < (less than) 60 or > (greater than) 400." Review of the April 2014 Blood Glucose Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 4/9/14 at 730 a.m. - BS (blood sugar) 533 4/14/14 at 7:30 a.m. - BS 421 4/16/14 at 12:00 p.m. - BS 531 4/17/14 at 7:30 a.m. - BS 542 4/19/14 at 7:30 a.m. -BS 422 4/19/14 at 12:00 p.m. - BS 501 4/20/14 at 7:30 a.m. - BS 421 4/20/14 at 12:00 p.m. - BS 474 4/24/14 at 12:00 p.m. - BS 480 Review of the May 2014 Blood Glucose Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 5/1/14 at 12:30 p.m. - BS 481 5/3/14 at 7:30 a.m. - BS 433 5/3/14 at 12:30 p.m. - BS 419 5/3/14 at 5:30 p.m. - BS 566 5/4/14 at 7:30 a.m. - BS 446		reviewed and no changes are indicated at this time (See Attachment G). The nurses have been re-educated on following physician orders and care plans (See Attachment B). A MAR/TAR/Order Review form has been implemented (See Attachment C).The DON or designee will be responsible for completing the review form to ensure physician's orders and care plans are being followed. Reviews will be completed on schedule work days as follows: Daily on an ongoing basis. Should a concern be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated	

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	5/8/14 at 12:30 p.m. - BS 420 5/10/14 at 5:30 p.m. - BS 419 5/12/14 at 7:30 a.m. - BS 451 Review of the Blood Glucose Monitoring/Sliding Scale Insulin Records for May 2014 and April 2014 lacked documentation that the resident's physician was notified of the blood sugar results greater than 400. Review of the Nurse's Notes, dated 3/28/14 through 5/15/14, lacked documentation that the resident's physician was notified of the blood sugar results greater than 400. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of diabetes mellitus. The Nursing interventions included, "...monitor blood sugar as ordered and more frequently as indicated, notify physician per call parameters..." During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:09 a.m., she indicated the blood sugars were over the call parameters and the physician should have been notified. B. Review of the current Physician Orders indicated an order for " BP (blood pressure) weekly on Sundays, notify MD (physician) if SBP (systolic blood pressure) < (less than) 100 or DBP			

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	(diastolic blood pressure) < (less than) 50." Review of the April Blood Pressure and Pulse log lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of the May 2014 Medication Administration Record (MAR) lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of the Nurse's Notes, dated 4/18/14 through 4/22/14, lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of hypertension. The Nursing interventions included, "...monitor blood pressure routinely and notify MD and responsible party per call order parameters..." During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:09 a.m., she indicated she could not find documentation a blood pressure was obtained on 4/20/14. She further indicated the blood pressure should have been completed as ordered.			

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	C. Review of the current Physician's Orders indicated lab orders for magnesium level every six months in January and July. There was lack of documentation in the record to indicate the magnesium level had been completed for January 2014. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of hypertension. The Nursing interventions included, "...monitor labs as ordered..." During an interview with the Director of Nursing (DoN) on 5/15/14 at 10:35 a.m., she indicated the magnesium level was not completed as ordered for January 2014. She further indicated it was her fault and she had just missed it. D. Review of the Medication Administration Record (MAR) for 4/2014 and 5/2014, indicated an order for Digoxin (a cardiac medication) 125 mcg (micrograms) daily. The 4/2014 and 5/2014 MAR indicated the resident had received the Digoxin medication daily. There was lack of evidence in the resident record to indicate any digoxin level laboratory test had been completed from 6/2013 through 5/2014.			

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	A Pharmacy Recommendation, dated 1/27/14, indicated, "...Resident takes Digoxin. There are no lab-digoxin blood levels-ordered to monitor this patient. Please consider if this lab test is needed to help monitor the effectiveness of the medication therapy..." The Physician had signed the recommendation on 2/6/14 but there was no check mark in either the " agree or disagree " box. During an interview with the Director of Nursing (DoN) on 5/15/14 at 10:35 a.m., she indicated she had just spoke to the Physician and the Physician had wanted a Digoxin level completed per the January pharmacy recommendation. She indicated staff should have followed up with the Physician regarding the pharmacy recommendation and clarified what the Physician wanted. She further indicated a digoxin level should have been completed. 2. Resident #28's record was reviewed on 5/14/14 at 10:48 a.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke), hypertension, and coronary artery disease. Review of a Physician's Order, dated			

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	3/31/14, indicated "...depakote and ammonia level tomorrow..." Review of lab results indicated the ammonia level had been completed on 4/1/14. There was lack of documentation in the record to indicate the depakote level had been completed on 4/1/14. Review of the daily lab order tracking form for 4/1/14 indicated the ammonia level was completed. There was lack of documentation to indicate the depakote level had been completed. During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:48 a.m., she indicated the depakote level was not completed as ordered on 4/1/14. She further indicated the nurse had transcribed the order for the ammonia level to the lab tracking log but had missed the depakote level. 3.1-35(g)(2)			
F000329 SS=D	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 monitoring; or without adequate indications			

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	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. 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.			
	Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to physician notification of blood sugar readings outside of specified call parameters, laboratory tests, blood pressure monitoring, follow up with a pharmacy recommendation, no prior interventions attempted before the administration of an anti-anxiety medication, and an anti-anxiety medication given without indications for use for 2 of 5 residents reviewed for unnecessary medications. (Resident #49 and #28) Findings include: 1. Resident #49's record was reviewed on 5/14/14 at 12:10 p.m. The resident's	F000329	Resident #49 and #28 did not experience any negative outcome related to the alleged deficient practice. Resident #49's clinical record has been reviewed and the Physician has been updated. Resident #49 is free from unnecessary medications. Resident #28 no longer resides at the facility and has been discharged to home.All residents have the potential to be affected. Their clinical record has been reviewed and if a problem was found, the physician was contacted. The residents are free from unnecessary medications.The facility's policy for Antianxiety drug use has been reviewed and no changes are indicated at this time (See Attachment H). The nurses have been re-educated on the policy with a special focus on eliminating unnecessary	05/30/2014

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	diagnoses included, but were not limited to diabetes mellitus, hypertension, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). A. Review of the current Physician Orders indicated an order for, "Accuchecks (blood glucose test) 3x (three times)/day, call MD (physician) if < (less than) 60 or > (greater than) 400." Review of the April 2014 Blood Glucose Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 4/9/14 at 730 a.m. - BS (blood sugar) 533 4/14/14 at 7:30 a.m. - BS 421 4/16/14 at 12:00 p.m. - BS 531 4/17/14 at 7:30 a.m. - BS 542 4/19/14 at 7:30 a.m. -BS 422 4/19/14 at 12:00 p.m. - BS 501 4/20/14 at 7:30 a.m. - BS 421 4/20/14 at 12:00 p.m. - BS 474 4/24/14 at 12:00 p.m. - BS 480 Review of the May 2014 Blood Glucose Monitoring/Sliding Scale Insulin Record, indicated blood sugar readings over 400 for the following dates: 5/1/14 at 12:30 p.m. - BS 481 5/3/14 at 7:30 a.m. - BS 433 5/3/14 at 12:30 p.m. - BS 419 5/3/14 at 5:30 p.m. - BS 566 5/4/14 at 7:30 a.m. - BS 446		medication use (See Attachment B). A MAR/TAR/Order Review form has been implemented (See Attachment C).The DON or desinee will be responsible for completing the review form to ensure the residents are not receiving unnecessary medications. These reviews will be completed on scheduled work days as follows: Daily on an ongoing basis. Should a concern be found, immediate corrective action shall occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.	

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	5/8/14 at 12:30 p.m. - BS 420 5/10/14 at 5:30 p.m. - BS 419 5/12/14 at 7:30 a.m. - BS 451 Review of the Blood Glucose Monitoring/Sliding Scale Insulin Records for May 2014 and April 2014 lacked documentation that the resident's physician was notified of the blood sugar results greater than 400. Review of the Nurse's Notes, dated 3/28/14 through 5/15/14, lacked documentation that the resident's physician was notified of the blood sugar results greater than 400. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of diabetes mellitus. The Nursing interventions included, "...monitor blood sugar as ordered and more frequently as indicated, notify physician per call parameters..." During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:09 a.m., she indicated the blood sugars were over the call parameters and the physician should have been notified. B. Review of the current Physician Orders indicated an order for " BP (blood pressure) weekly on Sundays, notify MD (physician) if SBP (systolic blood pressure) < (less than) 100 or DBP			

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	(diastolic blood pressure) < (less than) 50." Review of the April Blood Pressure and Pulse log lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of the May 2014 Medication Administration Record (MAR) lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of the Nurse's Notes, dated 4/18/14 through 4/22/14, lacked evidence the blood pressure was completed as ordered on 4/20/14. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of hypertension. The Nursing interventions included, "...monitor blood pressure routinely and notify MD and responsible party per call order parameters..." During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:09 a.m., she indicated she could not find documentation a blood pressure was obtained on 4/20/14. She further indicated the blood pressure should have been completed as ordered.			

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	C. Review of the current Physician's Orders indicated lab orders for magnesium level every six months in January and July. There was lack of documentation in the record to indicate the magnesium level had been completed for January 2014. Review of a current care plan, updated 4/8/14, indicated the resident had a diagnosis of hypertension. The Nursing interventions included, "...monitor labs as ordered..." During an interview with the Director of Nursing (DoN) on 5/15/14 at 10:35 a.m., she indicated the magnesium level was not completed as ordered for January 2014. She further indicated it was her fault and she had just missed it. D. Review of the Medication Administration Record (MAR) for 4/2014 and 5/2014, indicated an order for Digoxin (a cardiac medication) 125 mcg (micrograms) daily. The 4/2014 and 5/2014 MAR indicated the resident had received the Digoxin medication daily. There was lack of evidence in the resident record to indicate any digoxin level laboratory test had been completed from 6/2013 through 5/2014.			

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	A Pharmacy Recommendation, dated 1/27/14, indicated, "...Resident takes Digoxin. There are no lab-digoxin blood levels-ordered to monitor this patient. Please consider if this lab test is needed to help monitor the effectiveness of the medication therapy..." The Physician had signed the recommendation on 2/6/14 but there was no check mark in either the " agree or disagree " box. During an interview with the Director of Nursing (DoN) on 5/15/14 at 10:35 a.m., she indicated she had just spoke to the Physician and the Physician had wanted a Digoxin level completed per the January pharmacy recommendation. She indicated staff should have followed up with the Physician regarding the pharmacy recommendation and clarified what the Physician wanted. She further indicated a digoxin level should have been completed. E. Review of the PRN (as needed) medication flow sheet indicated the resident received Ativan (an anti-anxiety medication) 0.5 mg (milligrams) on 5/12/14 at 5:00 p.m. for complaints of shortness of breath. There were no attempted interventions circled.			

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	Review of a Physician's Order, dated 5/12/14, indicated "...Ativan 0.5 mg PO (by mouth) give 1 tab q (every) day PRN (as needed)." There was lack of documentation of an indication for use of the medication. Review of the Nurse's Notes, dated 5/7/14 through 5/14/14, lacked evidence of any indications for use of the Ativan medication or documentation of any interventions attempted prior to administering the medication. During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:40 a.m., she indicated there should have been a behavior sheet completed prior to the administration of the PRN Ativan with attempted interventions documented. She further indicated she had just spoken to the nurse who wrote the order and the nurse indicated the order should have said the medication was for anxiety and shortness of breath. The DoN indicated she would need to clarify the Ativan order. 2. Resident #28's record was reviewed on 5/14/14 at 10:48 a.m. The resident's diagnoses included, but were not limited to cerebrovascular accident (stroke), hypertension, and coronary artery disease.			

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	Review of a Physician's Order, dated 3/31/14, indicated "...depakote and ammonia level tomorrow..." Review of lab results indicated the ammonia level had been completed on 4/1/14. There was lack of documentation in the record to indicate the depakote level had been completed on 4/1/14. Review of the daily lab order tracking form for 4/1/14 indicated the ammonia level was completed. There was lack of documentation to indicate the depakote level had been completed. During an interview with the Director of Nursing (DoN) on 5/16/14 at 11:48 a.m., she indicated the depakote level was not completed as ordered on 4/1/14. She further indicated the nurse had transcribed the order for the ammonia level to the lab tracking log but had missed the depakote level. 3.1-48(a)(6)			