STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HEALTH CARE CENTER	1850 MATADOR ST PERU, IN 46970

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint #IN00133070 Survey dates: July 23, 24, 25, 26, 29, 30, and 31, 2013 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Survey team: Julie Wagoner, RN, TC Honey Kuhn, RN (07/23, 24, 25, 29, 30, and 31, 2013) Deb Kammeyer, RN (07/23, 24, 25, 26, and 29, 2013) Lora Swanson, RN (07/23, 24, 25, 30, and 31, 2013) Census bed type: SNF: 04 SNF/NF: 65 Total: 69 Census payor type: Medicare: 08 Medicaid: 47 Other: 14 Total: 69	F000000		

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 7, 2013, by Brenda Meredith, R.N.			

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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 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 a resident's physician of a medical condition for 1 of 4 residents reviewed for notification of a change. (Resident	F000157	**The facility requests paper compliance for this citation.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided	08/30/2013

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	#32) Findings include: The clinical record of Resident #32 was reviewed on 7-29-13 at 10:25 A.M. The diagnoses included but were not limited to: depression, Alzheimer's disease, muscle weakness, excitative type psychosis, hypertension, convulsions and chronic airway obstruction. On 7-29-13 at 10:35 A.M., a review of nursing notes, dated 7-15-13, indicated the resident's urine had a foul odor. The nurse attempted to get a urine sample with a straight catheter, but was unable to obtain urine. On 7-16-13, the nurse was able to obtain a urine specimen and sent urine specimen to the lab for a urinalysis (UA). On 7-16-13, the facility received the UA results. The physician was notified and no orders were received. On 7-18-13, the nursing notes indicated "...received results of UA; forwarded to physician...." There were no further nursing notes until 7-22-13, which indicated "...MD [medical doctor] notified via phone d/t [due to] UA. Ordered ATB [antibiotic]...." On 7-29-13 at 11:08 A.M., a review of		as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** Physician for Resident #32 was notified of UA results and treatment was obtained for resident. **2) How the facility identified other residents:** An audit of abnormal labs for the last 30 days has been completed to identify any other residents affected with physician notification as indicated. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated regarding policy of physician notification. The DON/designee will audit progress notes at least 3x/week to monitor and ensure timely physician notification and physician response on abnormal labs. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly x3, and quarterly x1 for a total of 6 months. DON/Designee will oversee program.	

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	the resident's urine culture and sensitivity, dated 7-18-13, indicated the resident had a urinary tract infection treatable with an antibiotic. During an interview on 7-29-13 at 11:38 A.M., the Assistant Director of Nursing (ADON) indicated he had no explanation to why there was a delay contacting the physician by phone and getting an order for an antibiotic to treat the urinary tract infection. On 7-29-13 at 2:12 P.M., a review of a policy, dated 1/2012, and titled "Administrative/Family/Responsible Party Notification for Change in Condition" indicated physician notification was to include, "...Abnormal Lab and Diagnostic findings...." 3.1-5(a)(3)			

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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 observation, record review and interview, the facility failed to follow the care plan regarding fall prevention interventions for 1 of 3 residents reviewed for falls and accident hazards in a sample of 33. (Resident #47) Finding includes: During an interview with LPN #4, conducted on 07/25/13 at 8:45 A.M., Resident #47 was identified as having fallen twice in the last 30 days, once on 07/14/13 and once on 07/20/13.. The clinical record for Resident #47 was reviewed on 07/26/13 at 10:00 A.M. Resident #47 was admitted to the facility on 11/06/2008, with diagnoses, including but not limited to, congestive heart failure, dsypnea and respiratory abnormality, diabetes, anemia, weight loss, hypertension, sleep apnea, anxiety disorder, esophageal reflux, hypothyroidism, depressive disorder, hyperlipidemia and osteoporosis.	F000282	**The facility requests paper compliance for this citation.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** Res # 47, hospice was contacted to provide sensor pad, resident care sheets updated with care planned interventions. Nursing staff inserviced on importance of assuring proper fall interventions are in place per resident care sheets and checking for function. **2) How the facility identified other residents:** All fall risk residents were assessed for care planned interventions in place and functioning appropriately.	08/30/2013

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	On 07/26/13 at 2:42 P.M., Resident #47 was observed in her bed, no side rails were utilized on her bed, the bed was at an average height. There was a thick blue mat folded over and placed completely underneath her bed, not beside her bed. Interview with CNA #5, on 07/26/13 at 2:45 P.M., indicated a laser movement alarm was to be utilized. CNA #5 pointed to a white laser alarm, which was connected to the bedside stand at the side of the resident's bed. There was a green light noted on the laser alarm indicating the alarm was on. Resident #47 was observed , on 07/30/13 at 10:13 A.M., lying in her bed asleep. The bed was at a normal bed height, there was no light noted on the laser alarm , and the thick blue mat was again noted to be completely underneath the resident's bed. Interview with CNA #6, on 07/30/13 at 10:15 A.M., indicated the resident does not like the laser alarm and requests it not be used. CNA #6 also indicated she was not aware of any alarmed mat in use for Resident #47. She indicated perhaps the resident or the staff member who took the resident's breakfast tray to her earlier in the morning had turned the laser alarm off. LPN #7, who had		**3) Measures put into place/ System changes:** An audit will be done on 3 fall risk resident per week at varied times and results will be reviewed in clinical morning meeting. Staff not compliant with assuring interventions is in place per care plan will be addressed and will include disciplinary action up to and including termination. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. DON/Designee will be responsible for oversight of these audits.	

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	overheard CNA #6, looked in the computer and indicated the alarm mat should have been beside the resident's bed as well as the laser alarm used. CNA #6 went into the resident's room and turned on the laser alarm and a green light came on and a practice alarm sounded. The blue matt, which is battery operated, also was pulled out and put into place. CNA #6 indicated the resident did not like to get up in the mornings till about 10:30 A.M. and she had not provided any care for Resident #47 as of 10:15 A.M. Nursing progress notes, dated 05/20/13, indicated the resident had fallen in the dining room, hitting her back on a heating unit. The resident was admitted to the hospital with a L1 compression fracture (Lumbar Back), a lung contusion/pleural effusion and congestive heart failure. Nursing notes, on 07/14/13, indicated the resident was found sitting on the floor by her bed, tangled in the cords for the wheelchair and bed alarms. The resident had been attempting to transfer herself. A subsequent IDT (interdisciplinary team) note regarding the fall indicated the bed alarm was to be changed to a laser alarm.			

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	Nursing notes, on 07/20/13, indicated the resident had taken herself unassisted to the bathroom and fell in the bathroom causing a skin tear and bruising to her left hand and wrist. An IDT report, completed on 07/22/13, regarding the fall on 07/20/13, indicated the laser alarm was on but not alarming. The note also indicated the resident was known to turn off alarms because she did not like the noise. The note indicated a high/low bed and alarming mat beside the bed were to be initiated to prevent future falls. Interview with Unit Manager and Administrator, on 07/30/13 at 10:30 A.M., indicated the IDT meeting notes and care plans were updated after each fall. The unit manager indicated she had also updated Resident #47's fall care plan and the CNA assignment sheets after each fall. The care plan related to fall prevention, current through August 2013, for Resident #47, indicated a movement alarm and low bed with an alarming bed mat, along with previous interventions were on the care plan. 3.1-35(g)(2)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the resident received adequate supervision, including the use of special devices, to prevent falls for 1 of 3 residents reviewed for falls and accident hazards in a sample of 33. (Resident #47) Finding includes: During an interview with LPN #4, conducted on 07/25/13 at 8:45 A.M., Resident #47 was identified as having fallen twice in the last 30 days, once on 07/14/13, and once on 07/20/13. The clinical record for Resident #47 was reviewed on 07/26/13 at 10:00 A.M. Resident #47 was admitted to the facility on 11/06/2008, with diagnoses, including but not limited to, congestive heart failure, dsypnea and respiratory abnormality, diabetes, anemia, weight loss, hypertension, sleep apnea, anxiety disorder, esophageal reflux, hypothyroidism, depressive disorder, hyperlipidemia,	F000323	**The facility requests paper compliance for this citation.** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** Resident #47's bed was placed in low position; floor mat was placed at bed side. Alarms in place per care plan, care sheet updated. **2) How the facility identified other residents:** Residents with safety devices will be reviewed to determine appropriateness and presence of devices. **3) Measures put into place/ System changes:** Nursing staff will be re-educated regarding safety interventions, including ensuring that safety devices are in place and functioning every shift. Random observations will be completed on varied shifts for at least 5 residents identified as fall risk	08/30/2013

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	and osteoporosis. On 07/26/13 at 2:42 P.M., Resident #47 was observed in her bed, no side rails were utilized on her bed, the bed was at an average height. There was a thick blue mat folded over and placed completely underneath her bed, not beside her bed. Interview with CNA #5, on 07/26/13 at 2:45 P.M., indicated a laser movement alarm was to be utilized. CNA #5 pointed to a white laser alarm, which was connected to the bedside stand at the side of the resident's bed. There was a green light noted on the laser alarm. Resident #47 was observed , on 07/30/13 at 10:13 A.M., lying in her bed asleep. The bed was at a normal bed height, there was no light noted on the laser alarm, and the thick blue mat was again noted to be completely underneath the resident's bed. Interview with CNA #6, on 07/30/13 at 10:15 A.M., indicated the resident does not like the laser alarm and requests it not be used. CNA #6 also indicated she was not aware of any alarmed mat in use for Resident #47. She indicated perhaps the resident or the staff member who took the resident's breakfast tray to her earlier in the morning had turned the laser		per week to ensure safety devices are in place. The DNS/designee will be responsible for oversight of these audits. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1.	

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	alarm off. LPN #7, who had overheard CNA #6, looked in the computer and indicated the alarm mat should have been beside the resident's bed as well as the laser alarm used. CNA #6 went into the resident's room and turned on the laser alarm and a green light came on and a practice alarm sounded. The blue matt, which is battery operated, also was pulled out and put into place. CNA #6 indicated the resident did not like to get up in the mornings till about 10:30 A.M. and she had not provided any care for Resident #47 as of 10:15 A.M. Nursing progress notes, dated 05/20/13, indicated the resident had fallen in the dining room, hitting her back on a heating unit. The resident was admitted to the hospital with a L1 compression fracture (Lumbar Back), a lung contusion/pleural effusion and congestive heart failure. Nursing notes, on 07/14/13, indicated the resident was found sitting on the floor by her bed, tangled in the cords for the wheelchair and bed alarms. The resident had been attempting to transfer herself. A subsequent IDT (interdisciplinary team) note regarding the fall indicated the bed alarm was to be changed to a laser alarm.			

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	Nursing notes, on 07/20/13, indicated the resident had taken herself unassisted to the bathroom and fell in the bathroom causing a skin tear and bruising to her left hand and wrist. An IDT report , completed on 07/22/13, regarding the fall on 07/20/13, indicated the laser alarm was on but not alarming. The note also indicated the resident was known to turn off alarms because she did not like the noise. The note indicated a high/low bed and alarming mat beside the bed were to be initiated to prevent future falls. Interview with Unit Manager and Administrator, on 07/30/13 at 10:30 A.M., indicated the IDT meeting notes and care plans were updated after each fall. The unit manager indicated she had also updated Resident #47's fall care plan and the CNA assignment sheets after each fall. The care plan related to fall prevention, current through August 2013, for Resident #47, indicated a movement alarm and low bed with an alarming bed mat , along with previous interventions were on the care plan.			

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	3.1-45(a)(2)			

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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 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 observation, record review and interviews, the facility failed to ensure an increased in a psychoactive medication was warranted for 3 of 10 residents reviewed for unnecessary medications. (Resident 5, 84, and 90) In addition, the facility failed to ensure there was adequate monitoring of a vitamin for 1 of 10 residents reviewed for unnecessary medications. (Resident #5)	F000329	**The facility requests paper compliance for this citation.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for**	08/30/2013

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NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN 46970	

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	Finding includes: 1. During observations, conducted July 23 - 26 and 29 - 31, Resident #5 was noted to spend almost all of her day time hours in her room either lying or sitting up in her bed. The clinical record for Resident #5 was reviewed on 07/29/13 at 10:00 A.M. Resident #5 was admitted to the facility on 08/01/2006 with diagnoses, including but not limited to, history of breast cancer, insomnia with sleep apnea, chronic pain, rheumatoid arthritis, depressive disorder, vitamin D deficiency, macular degeneration, and esophageal refux. The current medication orders for Resident #5 included an order for a Vitamin D3 50, 000 units subcutaneous every two weeks. There were no Vitamin D blood levels ordered for Resident #5. Interview with Corporate nurse, RN #7, on 0729/13 at 10:30 A.M., indicated there had never been a Vitamin D level ordered. In addition, Resident #5 had a order for the hypnotic medication, Ambien 5 mg (milligrams) to be given every night. Review of the orders indicated		**those residents identified:** Resident #5 – MD was contacted regarding Vitamin D level and blood drawn done on 7/30/13 and found to be within normal lab values. Resident #90 – Resident has discharged from facility. Resident #84 - Resident behaviors are being documented when behavior occurs and being monitored by Social Services. **2) How the facility identified other residents:** An audit was done on all residents in facility receiving Vitamin D to assure lab monitoring orders were in place. Reviewed psychotropic medication increases made in last 30 days for appropriate behavior documentation. **3) Measures put into place/ System changes:** Licensed staff will be re-educated on obtaining lab orders for medications requiring monitoring. All staff was inserviced on reporting behaviors timely to	

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	the Ambien medication had been ordered to be given every other night on 10/08/12. However, it had been increased to an every night frequency on 10/20/12. Nursing progress notes, from 10/08/12 - 10/20/12, indicated the resident had complained of not resting well the previous night on 10/10/12, but she had also complained of pain and soreness. On 10/12/12 and 10/14/12, nursing staff documented she was "restless" or "up every few hours" but no alternative interventions to assist the resident to rest were mentioned. On 10/18/12, the resident complained of not sleeping well at night and requested to receive the Ambien every night. There was no documentation, from 10/14/12 - 10/18/12, of any issues with the resident not sleeping. There were also no behavior report assessments regarding insomnia type issues in October 2012. An order was received on 10/20/12 to increase the resident's Ambien 5 mg to an every night frequency. The current health care plans for Resident #5, current through August 8, 2013 indicated the resident was to be provided with soft music, a quiet environment, as well as medication.		nurse and nurse entering behaviors into electronic medical record. Social Service will audit for behaviors and use of nonpharmacological interventions during morning meeting to identify new or worsening resident behaviors non responding to nonpharmacological interventions. New medication orders will be audited at least twice weekly to ensure that appropriate lab monitoring are present for use of medications as recommended . DON/designee and Social Services is responsible for oversight of audits. Physicians will be contacted and staff will be addressed and re-educated if concerns are noted. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.	

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	There was no intervention to ensure the resident had adequate pain control or had any other need addressed prior to increasing her hypnotic medication. 2. The clinical record for Resident #90 was reviewed on 07/25/13 at 9:30 A.M. Resident #90 was admitted to the facility on 10/27/12, with diagnoses, including but are not limited to, dementia, hyperlipidemmia, malignant neoplasm of prostrate, obstructive hydrocephalus, osteoarthitis, degenerative disc disease, vascular dementia with delusions, urinary incontinence, anxiety, depressive disorder, chronic pain and hyperchylomicronemia. He was discharged to a inpatient psychiatric hospital on 12/26/12, and readmitted to the facility on 01/08/13. The physician orders, on 01/08/13, included and order for the psychotropic medication, Seroquel 25 mg to be given four times day for a total daily dose of 100 mg. On 04/01/13, a physician's order was received to increase the resident's Seroquel to 50 mg three times a day, for a total daily dose of 150 mg.			

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	Nursing progress notes, from 03/21/13 to 04/01/13, indicated there was no documentation of any behavioral or mood issues with Resident #90. A behavior assessment, completed on 03/31/13 at 9:27 P.M., indicated the resident had been resistant to care, refusing to get ready for bed. The assessment indicated the resident's behavior occurred once and he was approached in a calm manner, called by name, simple sentences were used, time was allowed for decision making, he was not confronted, and had was left alone and reapproached later. The additional note indicated the resident was allowed to sleep in his recliner. There was no further note to indicate any further outcome or other approaches. Review of health care plans for Resident #90, regarding depressive disorder rand agitation, anxiety state, initiated on 10/29/12 and revised on 07/25/13, indicated staff were to encourage ongoing family involvement, encourage the resident to participate in conversation with staff and other residents, give the resident the opportunity to communicate his feelings regarding the nursing home placement, and observe and document the resident's			

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	behaviors as necessary. A care plan related to the resident's senile dementia with delusional features and behavioral disturbances, initiated on 10/30/12 and revised on 07/25/13, indicated the resident had been resistant to care from staff and had threatened to hit staff with his cane if anyone bugs him , when found sitting on the floor in his room, has swung at staff to hit them. In addition the resident had told staff that he sat on the floor and did not fall, demonstrating how he can get up and down from floor. The Resident also refused to change (his) brief until it is saturated with urine, stating that he is wasting it if he changes it overtime he urinates in it. Finally, the resident has had hallucinations that he was reading, stating he would not be disrupted until he was finished with his book. Interventions to the behaviors included: " Accept refusal, cease interaction and attempt at a later time, provide resident with an actual book to read, call resident by name, use alternate care giver if needled, and staff will explain care and why it is needed to him." It was unclear if these interventions were attempted on 03/31/13, when the resident was resistant to care, before the physician was contacted and the			

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	Seroquel was increased. . 3. The clinical record for Resident #84 was reviewed on 07/25/13 at 1:45 P.M. Resident #84 was admitted to the facility on 02/14/12, with diagnoses, including but not limited to history of hemorrhage of rectum and anus, anemia, dementia with behavioral disturbances, chronic kidney disease stage III, history of acute venous embolism, muscle weakness, history of coronary artery bypass grafting hypothyroidism, allergic rhinitis, asthma, vascular dementia with delusions, constipation, esophageal reflux, pschotic hallucinations, anxiety state, depressive disorder, chronic fatigue syndrome, urinary incontinence and hypertension. The physician's orders upon admission, on 02/14/12, indicated an order for the antianxiety medication, Xanax to be given .5 mg twice a day for anxiety. On 01/08/13, the Xanax was decreased to .25 mg twice a day. However, on 03/05/13 the Xanax medication was increased to .25 mg three times a day. The current health care plans for Resident #84 related to anxiety,			

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	current through 07/28/13, indicated: "(Resident #84's name) at times has episodes of on and off crying/tearfulness related to depression and anxiety and at times refuses care. Resident is long term care. (Resident #84's name) has difficult time having a roommate and makes repetitive complaints when she has roommate." The goal was: "Resident will share his/her grief with caregivers/family thru the review date." The interventions included: "Accept refusal and attempt at a later time, Encourage (Resident's name) to express feelings of anger and concerns as necessary, Medications as ordered, Refer/order consult: Pastoral care, Social services, Home health care, Psychiatry, and Validate resident feelings and provide her comfort as she needs. An additional care plan for anxiety, indicated the following: "(Resident's name) uses anti-anxiety medications related to Anxiety disorder - Goal: (Resident's name) will show decreased episodes of s/sx of anxiety through the review date." Interventions included the following: "Give medications ordered by physician, Observe/document side effects and effectiveness.... Observe/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate			

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	response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol." Review of the nursing progress notes, from 02/25/13 to 03/08/13, indicated there was no mention of any anxiety or behavioral issues until 03/05/13 when the physician had made rounds and wrote orders to increase the resident's Zoloft (an antidepressant medication) and Xanax due to "increased anxiety." There was no documentation to support the increase. There was only one behavior assessment, completed 02/27/13, which indicated the resident was resistive to care but did not indicate any particular issue with anxiety. 3.1-48(a)(6)			

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F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure that staff handled and served food under sanitary conditions for 1 of 3 dining rooms. This had the potential to affect 15 of 15 residents who ate in the secured unit dining room. Findings include: On 7/23/13 at 12:05 P.M., Employee #1 was observed delivering a tray to Resident #69. After delivering the tray to the resident Employee #1 was observed pulling her hair back with her hands then picked up the Resident's roll and buttered it. Employee #1 did not wash her hands or use hand gel and continued to serve trays to other resident's. On 7/30/13 at 11:48 A.M., Employee #2 was observed opening the dietary cart door then removed the resident trays and proceeded to pull open and butter the rolls with her bare hands.	F000371	**The facility requests paper compliance for this citation.** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** In-service training to all staff on hand hygiene and appropriateness when serving meal. This in-service was in regards to facility wide meal service. No negative effects were noted on Alzheimer unit from allegations noted on 2567. **2) How the facility identified other residents:** No other meal service areas were identified.	08/30/2013

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	Employee #2 was observed touching water pitchers, door handles and resident's clothing before and after serving trays and did not wash her hands or use hand gel. Employee #3 was observed opening a door to the nurses station then he came into the dining room and assisted in serving trays to the resident's. Employee #3 was observed buttering a roll with bare hands and did not wash hands or use hand gel. On 7/30/13 at 2:20 P.M., an interview with the Dietary Manager indicated the staff should be washing their hands frequently while serving meal trays. On 7/30/13 at 12:25 P.M., record review of the current policy titled "Nutrition/Hydration Resident Tray Delivery" received from the Director of Nursing indicated "...Perform hand hygiene...Assist resident with tray preparation as needed...Staff who are serving trays are to perform hand hygiene frequently...." 3.1-21(i)(3)		**3) Measures put into place/ System changes:** All staff inserviced on proper hand hygiene when serving food trays. Random audit observations will be completed on both dining rooms twice weekly to observe for proper hand hygiene with meal service. Dietary will pre-prepare bread/rolls with butter and have non-buttered available as well. The DNS/designee will be responsible for oversight of these audits. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x 1 or until 100% compliance is met.	

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F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview the facility failed to notify the physician of a resident's diagnostic lab results in a timely manner for 1 of 10 residents reviewed for lab orders. (Resident #32) Findings include: The clinical record of Resident #32 was reviewed on 7-29-13 at 10:25 A.M. The diagnoses included but were not limited to: depression, Alzheimer's disease, muscle weakness, excitative type psychosis, hypertension, convulsions and chronic airway obstruction. On 7-29-13 at 10:35 A.M. a review of nursing notes, dated 7-15-13, indicated the resident's urine had a foul odor. The nurse attempted to get a urine sample with a straight catheter, but was unable to obtain urine. On 7-16-13, the nurse was able to obtain a urine specimen and sent urine specimen to the lab for a urinalysis (UA). On 7-16-13, the facility received the UA results. The physician was notified and no orders were received. On 7-18-13 the	F000505	**The facility requests paper compliance for this citation.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** Resident #32 – MD was contacted regarding UA results and appropriate antibiotic treatment was initiated. **2) How the facility identified other residents:** An audit was done on all residents in last 14 days with urinalysis to assure treatment had been initiated with appropriate antibiotic therapy if warranted.	08/30/2013

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	nursing notes indicated "...received results of UA; forwarded to physician...." There were no nursing notes until 7-22-13, which indicated "...MD [medical doctor] notified via phone d/t [due to] UA. Ordered ATB [antibiotic]...." On 7-29-13 at 11:08 A.M., a review of the resident's urine culture and sensitivity, dated 7-18-13, indicated the resident had a urinary tract infection treatable with an antibiotic. During an interview on 7-29-13 at 11:38 A.M., the Assistant Director of Nursing (ADON) indicated he had no explanation to why there was a delay in contacting the physician by phone and getting an order for an antibiotic to treat the urinary tract infection. On 7-29-13 at 2:02 P.M., a review of a policy, dated 5/2012, titled "Laboratory - Test Processing and Reporting" indicated,"...Test results are promptly reported to the physician or other practitioner who ordered them, and their response documented in the medical record...." 3.1-49(f)(2)		**3) Measures put into place/ System changes:** Licensed staff was inserviced on notifying MD timely for abnormal labs and receiving timely orders for treatment. The DON/Designee will audit progress notes at least 3x/week to monitor and ensure timely notification and obtaining treatment orders timely. DON/designee and Social Services is responsible for oversight of audits. Physicians will be contacted and staff will be addressed and re-educated if concerns are noted. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months.	

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