

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2013
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NAME OF PROVIDER OR SUPPLIER  GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 29, 30, 31 and August 1, 2 and 5, 2013</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Survey team: Sharon Lasher, RN, T/C Barbara Gray, RN Leslie Parrett, RN Angel Tomlinson, RN (July 29, 30, 31, and August 1 and 2, 2013)</p> <p>Census bed type: SNF/NF: 48 Residential: 32 Total: 80</p> <p>Census payor type: Medicare: 21 Medicaid: 19 Other: 40 Total: 80</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>Preparation or execution of this plan of corrections does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on August 5, 2012. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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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	<p>IAC 16.2.</p> <p>Quality review completed on August 13, 2013, by Janelyn Kulik, RN.</p>			

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F000279 SS=D	<p>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.</p> <p>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.</p> <p>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).</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 of 2 residents reviewed for toileting decline of the 16 residents whose care plans were reviewed. (Resident #103)</p> <p>Findings include:</p> <p>The record of Resident #103 was reviewed on 7/30/13 at 1:19 p.m.</p> <p>Resident #103's MDS (Minimum Data Set) assessment, dated 6/24/13,</p>	F000279	F279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #103-careplan was developed related to the resident's bladder incontinence Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents for toileting decline and ensure a comprehensive care plan has been developed. Measures put in place and systemic changes made to ensure the	09/04/2013	

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	<p>indicated Resident #6 BIMS, (Brief Interview for Mental Status), was a 1, with a score of 0-7, indicating severe cognitive impairment and urinary continence, frequently incontinent.</p> <p>Resident #103's MDS assessment, dated 5/3/13, indicated urinary continence, always continent.</p> <p>Resident #103's record lacked a care plan for urinary incontinence.</p> <p>Resident #103's "Continence Detail Report" dated 3/23/13 to 7/31/13, indicated Resident #103 was continent from 3/23/13 to her first incontinence episode on 5/13/13., with 3 episodes of incontinence in May, 18 episodes of incontinence in June and 13 episodes of incontinence during the month of July.</p> <p>During an interview on 7/31/13 at 9:58 a.m., LPN #1 indicated "she does not have a care plan for incontinence and she is not on a toileting program because she has not been incontinent."</p> <p>3.1-35(a)</p>		<p>alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: review residents with a change in continence status to ensure a comprehensive care plan has been developed The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</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 ensure physician's orders were followed to hold blood pressure medications before administering them, when blood pressures and heart rates were not documented, for 2 of 16 residents reviewed for physician orders. (Resident #14 and #75).</p> <p>Findings include:</p> <p>1.) Resident #14's record was reviewed on 7/30/13 at 1:09 P.M. Diagnoses included, but were not limited to, coronary artery disease, ischemic cardiomyopathy, cerebral vascular disease, hypertension, post cerebral vascular accident, coronary artery bypass graft, and diabetes mellitus.</p> <p>Resident #14's quarterly MDS (Minimum Data Set) assessment, dated 7/1/13, indicated the resident's BIMS (Brief Interview for Mental Status) score was 3, indicating severe cognitive impairment.</p>	F000282	<p>F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Review of pulse and blood pressure readings for the past 7 days for resident #14 and #75 to ensure MD orders were followed. MD notified of the results for pulse and blood pressure readings for the last 7 days that were within the hold parameters. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with hold parameters for pulse and blood pressure to ensure MD orders were followed. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Physician Orders How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times</p>	09/04/2013

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	<p>Resident #14's care plan, updated 8/2/13, indicated the following: Problem-The resident was diagnosed with hypertension. Goal-The resident's status would remain stable as evidenced by, no pitting edema, circulatory problems, renal complications, or hypotensive/hypertensive crisis. Interventions included but were not limited to, Resident #14 would be observed for signs and symptoms of hypertension. Signs or symptoms of hypertension would be reported to the physician. His blood pressure would be monitored as ordered. His medications would be administered as ordered.</p> <p>Resident #14's physician order, dated 1/7/13, indicated "metoprolol succinate extended release 100 mg (milligrams)-give 1 tablet per peg tube (a tube placed into the stomach through the abdominal wall to provide nutrition and medications)every day for hypertension-hold for systolic blood pressure under 95, diastolic blood pressure under 60, or heart rate under 50."</p> <p>Resident #14's MAR (Medication Administration Record), for July, 2013, indicated metoprolol succinate extended release 100 mg was</p>		<p>4 weeks, then monthly times 5 months to ensure compliance: review all residents with hold parameters for pulse and blood pressure readings to ensure MD orders were followed and MD was notified as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>administered upon rising, every day of the month and lacked documentation of blood pressure or heart rate readings for 27 of 31 days.</p> <p>An interview with LPN #8 on 8/1/13 at 10:49 A.M., indicated a medication requiring a resident's blood pressure and heart rate should be documented on the resident's MAR. LPN #8 indicated Resident #14's blood pressure and heart rate for metoprolol succinate should be documented on his MAR. LPN #8 indicated staff had not been documenting Resident #14's blood pressure or heart rate for most of July, 2013.</p> <p>2.) Resident #75's record was reviewed on 8/2/13 at 10:28 A.M. Diagnoses included, but were not limited to, coronary artery disease, diabetes, and hypertension.</p> <p>Resident #75's quarterly MDS assessment, dated 6/11/13, indicated the resident's BIMS (Brief Interview for Mental Status) score was 13, indicating his cognitive status was intact.</p> <p>Resident #75's care plan, dated 11/26/12, indicated the following: Problem-The resident was at risk for decreased cardiac output related to</p>			

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	<p>coronary artery disease, congestive heart failure, hyperlipidemia, and hypertension. Goal-Resident #75's decreased cardiac output would not interfere with his participation in activities. Interventions included but were not limited to, he would be monitored for angina, fatigue, dizziness, light headedness, syncope, and dyspnea without exertion. His medications would be administered as ordered. He would be assessed for irregular heart sounds and vital signs as needed. His physician would be notified of any problems.</p> <p>Resident #75's physician order, dated 5/31/13, indicated "metoprolol succinate extended release 50 mg-give 1 tablet orally every morning for hypertension-hold for systolic blood pressure under 100, diastolic blood pressure under 70, or heart rate under 60."</p> <p>Resident #75's MAR for July, 2013, indicated metoprolol succinate extended release 50 mg was administered upon rising, every day of the month and lacked documentation of blood pressure or heart rate readings for 29 of 31 days.</p> <p>3.1-35(g)(2)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to assess bladder function, develop a care plan or plan approaches for bladder training for a resident with a decline in bladder function for 1 of 2 residents reviewed who met the criteria for toileting decline. (Resident #103)</p> <p>Findings include:</p> <p>The record of Resident #103 was reviewed on 7/30/13 at 9:58 a.m. Resident #103's diagnoses included, but were not limited to, depression, dementia and diabetes.</p> <p>Resident #103's MDS (Minimum Data Set), assessment, dated 6/24/13, indicated the following: - BIMS (Brief Interview for Mental Status), 5, with a score of 0-7</p>	F000315	F315 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: A bladder/elimination assessment will be completed for resident #103. If the assessment identifies the cause of the decline and it is determined that the resident may benefit from a toileting program, nursing will complete a 72 hour elimination tracking. Interventions and careplan will be updated if needed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All current residents with urinary continence decline have the potential to be affected. All current residents will be assessed for a decline in urinary continence for the past 30 days. Residents identified with a decline in urinary continence status will have a bladder/elimination assessment	09/04/2013			

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	<p>indicating severe cognitive impairment</p> <ul style="list-style-type: none"> <li>- vision, impaired</li> <li>- toilet use, extensive assistance, with one person physical assist</li> <li>- urinary continence, frequently incontinent</li> </ul> <p>Resident #103's MDS, dated 5/3/13, indicated urinary continence, always continent.</p> <p>Resident #103's record lacked a care plan for urinary incontinence.</p> <p>Resident #103's "Continence Detail Report" dated 3/23/13 to 7/31/13, indicated Resident #103 was continent from 3/23/13 to her first incontinence episode on 5/13/13., with 3 episodes of incontinence in May, 18 episodes of incontinence in June and 13 episodes of incontinence during the month of July.</p> <p>During an interview on 7/30/13 at 1:58 p.m., CNA #3 indicated "I have been taking care of (Resident #103) and she is incontinent sometimes but continent some of the time. She will put on her call light when she has to go to the bathroom."</p> <p>During an interview on 7/31/13 at 9:58 a.m., LPN #1, indicated "she</p>		<p>completed. If the assessment identifies the cause of the decline and it is determined that the resident may benefit from a toileting program, nursing will complete a 72 hour elimination tracking. Interventions and care plans will be updated. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing staff on the following campus guidelines: Bowel and Bladder Continence. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS or designee will complete a weekly review of the current residents to identify and decline in urinary incontinence. Those residents noted with a decline will have a bladder/elimination assessment completed. If the nursing assessment identifies the cause of the decline and its determined that the resident may benefit from a toileting program. nursing will complete a 72 hour elimination tracking. Interventions and careplan will be updated. This monitoring will be presented monthly to the QA committee times 6 months for further recommendation.</p>		

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	<p>does not have a care plan for incontinence and she is not on a toileting program because she has not been incontinent."</p> <p>During an interview on 7/31/13 at 10:21 a.m., Resident #103's family member indicated when she was admitted to the facility she was continent but she does have some accidents now.</p> <p>During an interview on 8/1/13 at 1:35 p.m., CNA #5 indicated Resident #103 "does use her call light some of the time when she needs to use the bathroom but this time she was just calling out for help and she does that a lot also."</p> <p>During an observation on 8/1/13 at 1:45 p.m., CNA #5 transferred Resident #103 to the bathroom, with a small amount of assist and the use of her walker. Resident #103's gait was slow and slightly unsteady. Resident #103 voided without difficulty in the toilet. Resident #103 had an adult brief on and it was dry.</p> <p>During an interview on 8/2/13 at 8:57 a.m., LPN #1 indicated Resident #103's incontinent episodes were just missed but her incontinence is care planned now.</p>			

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	<p>During an observation on 8/2/13 at 10:10 a.m., Resident #103 was saying "I need help." Her call light was in front of her, but when asked to use it, she was unable to find it.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=D	<p>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, interview, and record review, the facility failed to implement interventions to prevent falls, for 1 of 3 residents reviewed for falls, of 4 who met the criteria for falls. (Resident #14).</p> <p>Findings include:</p> <p>On 7/30/13 at 12:04 P.M., Resident #14 was observed seated in a high back wheelchair in his bedroom. His call light was attached on his bed rail behind him out of reach. LPN #9 indicated he had been brought to his bedroom by staff so he could get his blood sugar checked. LPN #9 indicated he was not normally in his bedroom. LPN #9 indicated he could not reach his call light at that time.</p> <p>Resident #14's record was reviewed on 7/30/13 at 1:09 P.M. His diagnoses included, but were not limited to, right total knee arthroplasty, hypertension, and post cerebral vascular accident.</p>	F000323	F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #14- bed alarm was immediately placed on resident's bed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Review of preventative measures, for all residents with falls in the past 30 days, to ensure they are in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Team on the following campus guidelines: Fall Management Program How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of fall preventative measures to ensure they are implemented. The results of the	09/04/2013			

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	<p>Resident #14's quarterly Minimum Data Set assessment, dated 7/1/13, indicated his Brief Interview for Mental Status was a score of 3, indicating severe cognitive impairment. He was usually understood and understood others. He required extensive assistance of 2 persons for bed mobility, transfers, and toileting. He did not walk. He had impairment on one side of his upper and lower extremities.</p> <p>A physician's order for Resident #14, dated 5/31/13, indicated he would have a bed alarm. The function and placement of the bed alarm would be checked every shift.</p> <p>A Care Plan for Resident #14, dated 1/7/13, indicated the following: Problem-The resident was at risk for falls. Goal-The resident would have a reduced risk of fall related injury by utilizing fall precautions. Interventions included, but were not limited to, he would have his call light within reach. He would have a bed alarm. He would be taken to the nurses station when staff were not present in the TV room.</p> <p>Fall Circumstance, Assessment, and Intervention documentation for Resident #14, included but was not limited to, the following information:</p>		<p>audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>7/1/13-He had an unwitnessed fall in the TV room at 4:15 P.M. He was found on the floor with no injury. He would be brought to the nurses station when staff were not in the TV room as a prevention update. IDT (Interdisciplinary Team) indicated he was attempting to get out of his chair unassisted. 7/22/13-He had an unwitnessed fall in his bedroom at 9:30 P.M. He received an abrasion to his left elbow. His bed was not in low position and his bedside mats were not on the floor. The IDT indicated staff would be educated to ensure his bed was in low position and his bedside mats were on the floor. He had an unwitnessed fall in his bedroom at 11:15 A.M. He was found on the floor with no injury. The IDT indicated therapy would screen him for wheelchair positioning.</p> <p>On 7/30/13 at 1:58 P.M., Resident #14 was observed lying in bed on his back. A bed alarm was not observed on his bed. An interview at that time with the DoN (Director of Nursing) indicated he did not have an alarm on his bed.</p> <p>On 7/30/13 at 2:01 P.M., the DoN reviewed Resident #14's physician orders and fall care plan. She indicated they both said he would</p>			

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	<p>utilize a bed alarm.</p> <p>Resident #14's record was reviewed again on 7/31/13 at 1:38 P.M.</p> <p>A Fall Circumstance, Assessment and Intervention form for Resident #14, dated 7/30/13, indicated but was not limited to, the following information. Resident #14 had an unwitnessed fall in his bedroom at 2:45 P.M. He was found on the floor with no injury. The IDT indicated he had crawled out of bed.</p> <p>On 8/1/13 at 1:54 P.M., Resident #14 was observed seated in his high back wheelchair in the TV room. He was in the TV room by himself and the TV was turned off.</p> <p>On 8/1/13 at 2:00 P.M., CNA # 10 indicated it was OK for Resident #14 to sit in the TV room alone. She stated, "yeah, he does pretty good."</p> <p>On 8/1/13 at 2:02 P.M., CNA #11 indicated it was OK for Resident #14 to sit in the TV room alone.</p> <p>On 8/1/13 at 2:04 P.M., CNA #12 indicated it was OK for Resident #14 to sit in the TV room alone.. She stated, "if that's what he wanted."</p>			

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	<p>On 8/1/13 at 2:10 P.M., the Activity Director brought the popcorn maker into the TV room. She indicated it was OK for Resident #14 to sit in the TV room alone.</p> <p>A review of Resident #14's CNA Assignment Sheet did not indicate Resident #14 would be taken to the nurses station when staff was not in the TV room.</p> <p>On 8/2/13 at 1:39 P.M., Resident #14 was observed being transferred from his high back wheel chair to his bed, with the assistance of CNA #3 and CNA #13. CNA #3 or CNA #13 did not lock the wheels on his chair prior to transfer. When queried if she would normally lock a resident's wheelchair prior to transfer, CNA #3 indicated she normally locked the wheelchair prior to transfer. She stated "I don't know why I didn't lock it." When queried, CNA #13 stated "I usually do."</p> <p>The most recent Falls Management Program Guidelines provided by the DoN on 8/2/13 at 1:45 P.M., indicated the following: "Procedure: 1.) The fall risk assessment is included as part of the Admission and Monthly Nursing Assessments and Review and Circumstance forms: a.)</p>			

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	<p>Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. b.) Care plan interventions should be implemented that address the resident's risk factors... 6.) Any orders received from the physician should be noted and carried out. 7). The nursing assistant assignment sheet and resident care plan should be updated to reflect any new change in interventions...."</p> <p>3.1-45(a)(2)</p>			
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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview the facility failed to provide interventions to prevent an unplanned weight loss for 1 of 3 residents reviewed for weight loss of 9 residents who met the criteria for nutrition. (Resident # 30).</p> <p>Findings include:</p> <p>Review of Resident # 30's record on 7/31/13 at 9:15 a.m., indicated the Resident's diagnoses included but, were not limited to, dehydration, urinary tract infection, acute renal failure, hypertension and chronic anemia.</p> <p>The Physician's recapitulation orders dated 3/31/13 through 3/31/13 indicated the Resident was ordered a</p>	F000325	F 325 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #30 was a closed record review. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). Will review the current weight status of current residents and add to the Clinically at Risk (CAR) assessment review, if applicable and careplan has been updated. 2). Will review any current significant weight loss/gain to ensure it is documented that the MD was notified and careplan has been updated. 3). Will also review the last RD progress notes in each medical record of current residents to ensure any recommendations listed were implemented and careplan has been updated. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:	09/04/2013			

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	<p>regular diet.</p> <p>Review of a vital signs and weight record indicated Resident # 30's weight:</p> <p>2/02/13 - 123.8 (admission) 2/12/13 - 121.9 (1.9 loss) 2/16/13 - 122.4 (0.4 gain) 2/23/13 - 115.4 (7.0 loss) 3/04/13 - 115.8 (0.4 gain) 3/10/13 - 117.2 (1.4 gain) 3/18/13 - 116.8 (0.4 loss) 3/23/13 - 117.2 (0.4 gain)</p> <p>Review of the Nutrition Assessment and Data Collection form dated 2/13/13 indicated Food/Nutrition History: usual weight 120's. Assessment Nutrition DX (diagnosis):dehydration, UTI (urinary tract infection). Weight steady and appropriate, good po (oral intake)/food and fluid. No pressure areas. Interventions: weekly weights times 4.</p> <p>Dietitian notes dated 2/27/13 indicated weight change 2/23/13 115.4 lb, decreased 7 lbs times 1 week. Assessed per CAR (clinically at risk) 2/27/13. 95% po, 1600 liters fluid with meals. Regular diet. Request re-weight, follow per CAR.</p> <p>On 3/6/13 Dietitian notes indicated</p>		<p>DHS or designee will re-educate the Nursing Leadership Team and the RD on the following guidelines: Clinically at Risk (CAR) Program, High Risk Nutrition, and Weight Tracking. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Per the campus guidelines, the Nursing Leadership Team will review significant weight report in the daily clinical meeting 5 days a week, ongoing. This review is to ensure there are an assessment review (thru the CAR program), MD / RD notification, recommendations implemented and careplan updated. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports (identified as MDSI widget review). The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1, 2, 3). Review 3 resident identified with a significant weight loss/gain to ensure the following: there is an assessment review (thru the CAR program), documentation that the MD has been notified of the loss/gain, the careplan has been updated and the RD progress notes documenting recommendations were transcribed to the recommendation summary form</p>				

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	<p>weight 3/4/13-115.8, 2/23/13-115.4, decreased 8 lbs, times 30 days. Resident followed per CAR for weight change. Regular diet, good po intakes, weight stable times 2 weekly weights. Question weight related to fluids at hospital and related to dehydration diagnosis. Will continue to follow per CAR and monitor weekly weights.</p> <p>Review of Nutrition/Hydration Plan of Care dated 2/27/13 indicated Problem: Resident is at risk for alteration in nutrition and/or hydration status: loss. Co-morbid diagnosis: acute renal failure, dehydration. Other: lactose intolerant. Goal: Adequate meal consumption related to Resident's estimated nutritional needs. Maintenance of weight without an increase or decrease of &gt;5% in 30 days/ &gt;7.5% in 90 days/ &gt;10% in 180 days. Interventions: Diet by MD. Honor preferences/intolerance/allergies, offer alternate/substitute food/beverage items if po is &gt; 50% at meals, monitor nutritionally relevant labs, monitor weight for changes every month/PRN (as needed)</p> <p>Interview on 7/31/13 at 10:25 a.m. with the Registered Dietitian indicated "when someone is dehydrated in the</p>		<p>and followed up on with the MD and careplan updated. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>hospital, there is typical weight loss. I was monitoring weight due to the Resident eating well. I felt it (weight loss) was more fluid related. Since she had IV fluids, I felt the weight loss was due to the IV's."</p> <p>Review of a document provided by the Director of Nursing on 8/2/13 at 1:45 p.m., indicated "Procedure Guidelines High Risk Nutrition" "Program overview: The intent of this program is to assure the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate interventions when there is a nutritional problem. An analysis of weight loss or gain should be examined taking into consideration the resident's usual weight through adult life, the assessment of potential weight loss, current diagnosis and care plan for weight management..." "Purpose: To establish an aggressive nutritional program that will provide interventions for those residents with established criteria defining them as being at high nutritional risk. High Nutritional Risk criteria : (may included but not be limited to:) Significant change in appetite or decrease in oral intake</p>						

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	<p>Significant weight loss: 5% in 30 days, 7.5% in 90 days, or 10% in 180 days Compromised weight status: &lt; 80% of usual or ideal weight..."</p> <p>3.1-46(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</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 interview and record review, the facility failed to attempt a GDR (Gradual Dose Reduction) of Seroquel (antipsychotic) medication for a resident and gave a fast acting insulin without a physician's order at bedtime to a resident for 2 of 10 residents reviewed for unnecessary medication use. (Resident #6 and #75)</p> <p>Findings include:</p>	F000329	F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice The facility will attempt Gradual Dose Reduction (GDR) of medication for resident #6. Physician's orders clarified and MAR updated to show correct orders for blood glucose monitoring TID with meals and insulin sliding scale to accompany for resident #75. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions	09/04/2013			

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	<p>1.) The record of Resident #6 was reviewed on 7/30/13 at 1:19 p.m. Resident #6 diagnoses included, but were not limited to, Alzheimer disease and dementia with psychosis.</p> <p>Resident #6's MDS (Minimum Data Set), assessment, dated 6/24/13, indicated Resident #6 BIMS, (Brief Interview for Mental Status), was a 1, with a score of 0-7, indicating severe cognitive impairment and behaviors marked 0.</p> <p>Resident #6's care plan, dated 4/28/13, indicated "Problem, use of psychotropic drug places resident at risk for drug-related, hypotension, gait disturbance, cognitive impairment, behavioral impairment, activities of daily living decline, decline in appetite and abnormal involuntary movements. Goals, resident will be free from signs and symptoms of drug related, hypotension, gait disturbance, cognitive impairment, behavioral impairment, activities of daily living decline, decline in appetite, abnormal involuntary movements and resident will receive minimal dosage of the prescribed psychotropic drug to ensure maximum functional ability both mentally and physically. Interventions, monitor for any signs or</p>		<p>taken. All residents have the potential to be affected by the same alleged deficient practice. The DHS or designee will review the medical record and MAR of current residents receiving blood glucose monitoring and insulin sliding scale to ensure residents have the correct frequency and dosage as ordered by MD. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Statements of contraindications related to the denial of a gradual dose reductions will be added to each pharmacist recommendations prior to submitting to the physician for review. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit all pharmacy recommendations every month related to gradual dose reductions to ensure the MD has included a statement of contraindication related to the denial of a gradual dose reduction. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>symptoms of drug related (if noted report to nurse), report to physician any negative outcomes associated with use of drug, administer medication as prescribed by the physician, monitor for effectiveness of psychotic drug and work with physician/pharmacy to provide lowest therapeutic dosage.</p> <p>Resident #6's physician's order, dated 4/20/12, indicated "Seroquel 25 mg (milligrams), by mouth, daily at bedtime, for dementia."</p> <p>Resident #6's "Note To Attending Physician/Prescriber" dated 5/12/13, indicated "Current order Seroquel 25 mg, at bedtime, date started, 4/20/12 recommend to change to 12.5 mg at bedtime." Resident #6's physician indicated "Disagree, no change, still significant behaviors and hallucinations."</p> <p>An interview with LPN #1 on 7/31/13 at 2:19 p.m., indicated "when (Resident #6) was on the dementia unit before coming to the health care unit she had behaviors and hallucinations but she was admitted to the health care unit on 1/20/12, and since then she had not had any behaviors or hallucinations."</p>			

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	<p>The "Nursing Spectrum Drug Handbook" 2010 indicated the indications of Seroquel were schizophrenia, acute manic episodes associated with bipolar 1 disorder and depression associated with bipolar disorder. The box warning of Seroquel indicated "elderly patients with dementia-related psychosis are at increased risk for death."</p> <p>A document titled "Gradual Dose Reduction Regulations" dated 2/1/10, provided by the Director of Nursing on 8/2/13 at 2:00 p.m., and indicated by the Director of Nursing to be the most current policy indicated, "When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction of the medication.</p> <p>a.) Antipsychotics. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first</p>						

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	<p>year, unless clinically contraindicated."</p> <p>2.) Resident #75's record was reviewed on 8/2/13 at 10:28 A.M. Diagnoses included, but were not limited to, coronary artery disease, diabetes, and hypertension.</p> <p>Resident #75's quarterly MDS (Minimum Data Set) assessment, dated 6/11/13, indicated the resident's BIMS (Brief Interview for Mental Status) score was 13, indicating his cognitive status was intact.</p> <p>A Care Plan for Resident #75, dated 11/26/12, indicated the following: Problem-Resident #75 had uncontrolled/unstable glucose levels as evidenced by diabetes. Goal-He would remain free of signs and symptoms of hypo/hyperglycemia. Interventions included but were not limited to, he would be monitored for signs and symptoms of hypoglycemia (drowsiness, headache, slurred speech, sweating, tremors, increased pulse, etc...). He would be monitored for signs and symptoms of hyperglycemia (polyuria, polyphagia, polydipsia, abdominal pain, nausea or vomiting, increased respirations, etc...).</p>			

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	<p>A physician's order for Resident #75 indicated the following: 5/31/13-Humalog insulin 100 units/ml (milliliter) solution per blood glucose reading subcutaneous 3 times a day with or after meals for elevated blood glucose. Extended instructions: sliding scale: blood sugar of 121-150 = 2 units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, 401-440 = 16 units, anything over 441 = call the doctor.</p> <p>A physician's order for Resident #75, initiated 5/31/13, on the July, 2013 rewrite order indicated the following: Novolog insulin 100 unit/ml. Accuchecks: sliding scale: 121-150 = 2 units, 151-200 = 4 units, 201-250 =6 units, 251-300 = 8 units, 301-350 =10 units, 351-400 = 12 units, 401-440 = 16 units, above 441 = call the doctor.</p> <p>Documentation for Resident #75's July, 2013, MAR (Medication Administration Record) indicated the following: At bedtime on 7/21/13, he received 2 units of Novolog insulin coverage for a blood sugar reading of 133, with no physician's order for coverage.</p> <p>On 8/2/13 at 11:00 A.M., the DoN</p>						

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	<p>(Director of Nursing) indicated Resident #75's most recent insulin coverage was ordered in May, 2013, when he returned from a local hospital. She indicated the insulin coverage should be given with meals. She indicated Resident #75's July, 2013 rewrite, did not specify when to give the insulin coverage.</p> <p>On 8/2/13 at 12:56 P.M., the DoN indicated Resident #75 received insulin coverage at bedtime on 7/21/13, without an order for coverage.</p> <p>The most recent Guidelines for Medication Orders received from the Corporate nurse on 8/2/13 at 1:45 P.M., indicated the following: "6.) Medication orders: a.) When recording medication orders specify: 1.)The type, route, dosage, frequency, strength of the medication and reason for order...."</p> <p>3.1-48(a)(4) 3.1-48(b)(2)</p>			

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F000371 SS=E	<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 Based on observation and interview, the facility failed to discard leftovers according to their policy, for 1 kitchen observed for food storage, having the potential to affect 79 residents who were served food from the kitchen.</p> <p>Findings include:</p> <p>An initial tour was conducted in the kitchen on 7/29/13 at 9:13 A.M., with the Dietary Manager. The walk in refrigerator held plastic containers that were dated by staff and included the following dates and items: Bacon bits dated 7/23/13, cooked roast beef dated 7/24/13, corn dated 7/22/13, biscuits dated 7/19/13, pineapple dated 7/18/13, spaghetti sauce dated 7/25/13, cake icing dated 7/25/13, peach pie filling dated 7/22/13.</p> <p>The milk cooler contained 2 and 1/4 gallons of chocolate milk with a "sell by date" of 7/23/13.</p> <p>An interview with the Dietary Manager</p>	F000371	F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice All prepared food leftover for greater than 3 days was discarded on 7/29/2013. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken. All residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Director of Food Services will review the Food Labeling Guidelines with all dietary staff. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Food Service or designee will observe food storage areas 5 times weekly and record/discard of food not stored in a sanitary manner. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for	09/04/2013			

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	<p>at that time indicated "I definitely get rid of meats after 3 days. I would keep icing approximately 7 days. I try and use the milk by the sell by date. I throw it out by the sell by date." She indicated she hadn't had time that morning to go through everything and throw things away that needed thrown out.</p> <p>On 8/1/13 at 2:35 P.M., the Dietary Manager indicated she served 79 residents out of the kitchen.</p> <p>The most current Food Labeling Guideline provided by the Dietary Manager on 7/31/13 at 8:22 A.M., indicated the following: "Prepared Leftover food items must be discarded within 3 day...."</p> <p>3.1-21(i)(3)</p>		a minimum of 6 months then randomly thereafter for further recommendation.				

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to document a coumadin medication as given, for 1 of 16 records reviewed for medication administration. (Resident #75)</p> <p>Findings include:</p> <p>Resident #75's record was reviewed on 8/2/13 at 10:28 A.M. Diagnoses included, but were not limited to, coronary artery disease, diabetes, and hypertension.</p> <p>Resident #75's quarterly MDS (Minimum Data Set) assessment, dated 6/11/13, indicated the resident's BIMS (Brief Interview for Mental Status) score was 13, indicating his cognitive status was intact.</p>	F000514	F 514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice Resident #75- Late entry documented to show that the medication was given. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken. All residents have the potential to be affected by the same alleged deficient practice. DHS or designee will complete a ongoing review during daily clinical meeting (5 times per week) of MAR of all residents taking coumadin for documentation of medications given Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Director of Health Services or	09/04/2013			

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	<p>A Care Plan for Resident #75, dated 5/31/13, indicated the following: Problem-Resident #75 took an anti-coagulant medication (coumadin) due to a history of deep vein thrombosis. Goal-He would be free from signs and symptoms of bleeding. Therapeutic anti-coagulant medication levels would be maintained through his next review. Interventions included but were not limited to, he would be assessed for any signs and symptoms of bleeding. He would receive his coumadin as prescribed by his physician.</p> <p>A physician's order for Resident #75 indicated the following: 7/26/13-Start coumadin 7.5 mg (milligrams) on Monday, Wednesday, and Friday, and 5 mg all other days.</p> <p>Documentation for Resident #75's July, 2013, MAR (Medication Administration Record) indicated the following: He did not receive his 5 mg of Coumadin as ordered by the physician, on Tuesday, 7/30/13.</p> <p>On 8/2/13 at 10:32 A.M., LPN #9 indicated Resident #75's coumadin order of 5 mg was not documented as given on 7/30/13.</p>		<p>designee will review Medication Administration Records and the Daily Coumadin Assessment for those residents on Coumadin for completion and proper documentation. DHS or designee will re-educate the Nursing Team on the following campus guidelines: Med Pass Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: MAR will be reviewed to ensure medications are documented as given The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>On 8/2/13 at 12:45 P.M., the DoN indicated she was unable to determine if the coumadin 5 mg dose was given on 7/30/13, due to the medication cart had old and new coumadin cards with doses missing.</p> <p>On 8/2/13 at 1:10 P.M., QMA #14 indicated she was the staff who gave Resident #75 his coumadin 5 mg on 7/30/13 at 5:00 P.M. She indicated she remembered giving Resident #75 his coumadin and iron on 7/30/13, that was ordered for 5:00 P.M., and she forgot to sign the MAR (Medication Administration Record).</p> <p>3.1-50(a)(2)</p>			

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F009999	<p>3.1-14 Personnel</p> <p>(l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This rule was not met as evidenced by:</p>	F009999	<p><b>F9999 Resident Records Complete/Accurate/Accessible</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>No residents were affected by the alleged deficient practice.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</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 facility will ensure required dementia training is completed in a timely manner. The Business Office Manager or designee will audit training records monthly for both new hires and existing employees.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Business Office Manager will record observations noted during review monthly for 3 months and forward findings to Quality</p>	09/04/2013	

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	<p>Based on record review and interview the facility failed to ensure employees completed dementia training in a timely manner for 3 of 10 employees files reviewed. (CNA #4, CNA #7, dietary staff #6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. CNA #4's employee file was reviewed on 8/2/13 at 11:00 a.m. Her employment start date was indicated to be 10/3/12. Her dementia training completion date was to be April, 2013. The facility had no documentation of dementia training being completed.</li> <li>2. CNA #7's employee file was reviewed on 8/2/13 at 11:00 a.m. Her employment start date was indicated to be 9/12/12. Her dementia training completion date was to be March, 2013. The facility had no documentation of dementia training being completed.</li> <li>3. Dietary staff #6's employee file was reviewed on 8/2/13 at 11:00 a.m. His employment start date was indicated to be 9/4/12. His dementia training completion date was to be March, 2013. The facility had no documentation of dementia training</li> </ol>		<p>Assurance for further review.</p> <p><u>All corrective actions will be completed by September 4, 2013.</u></p>				

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	<p>being completed.</p> <p>Interview with Administrator on 8/2/13 at 11:45 a.m. indicated "the staff have access to the computer and are supposed to complete dementia training on their own. I guess we are going to have to check to make sure they are completing what they need to complete on the computer."</p> <p>3.1-14(l) 3.1-14(u)</p>				