

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 19, 20, 21, 22, 25, 26, 27, 2013</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Linn Mackey, RN (March 19, 20, 21, 22, 26, & 27, 2013) Toni Maley, BSW</p> <p>Census payor type: SNF: 8 SNF/NF: 55 Private: 24 Total: 87</p> <p>Census payor type: Medicaid: 20 Medicaid: 31 Other: 36 Total: 87</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>First page of POC Submission of the plan of correction and credible allegation does not constitute an admission by the certified provider at Community Northview Care Center. The Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and services at this health facility. Community Northview Care Center as licensed and certified provider recognizes it obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. If you have any questions, please contact me. Thank you!</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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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician was notified in accordance with physician's orders or when the resident's condition could</p>	F000157	Quality Assurance Committee will review determine the need for further monitoring of documentation. F157 1. What corrective action will be accomplished for those	04/26/2013			

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	<p>require a change of treatment for 3 of 10 residents reviewed for physician's notification regarding abnormal blood sugars (Residents #26, 22, 10).</p> <p>Findings include:</p> <p>1.) Resident #26's record was reviewed on 3/21/13, 9:27 a.m.</p> <p>Resident #26's current diagnoses included, but were not limited to,diabetes mellitus, Alzheimer's disease, congestive heart failure and depression.</p> <p>Resident #26 had a current 3/2013 physician's order to check the blood sugar before meals and at bedtime and to notify the Physician if the blood sugar was less than 60 or more than 400. This order originated on 2/13/09. The resident was to receive 4 ounces of Coke, orange juice or Resource if the blood sugars were less than 60 and the blood sugar was to be rechecked in 15 to 30 minutes. This order originated on 2/13/09.</p> <p>Resident #26 had a current 3/2013 care plan problem regarding diabetes mellitus. This problem originated 4/1/11. Approaches to this problem included, but were not limited to "Fasting Serum Blood Sugars as</p>		<p>residents found to have been affected by the deficient practice? Residents 26, 22 and 10 medical records have been audited for blood sugar result. Resident 26 did have one blood sugar questionable range and the physician was notified with orders received. A diabetic Assessment Flow Sheet has been placed in the medication record that states symptoms, treatment given, family and physician notification, interventions and follow up blood sugars. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All diabetic medical records will be audited for physician and family notification. A diabetic Assessment Flow Sheet has been placed in the medication record that states symptoms, treatment given, family and physician notification and follow up blood sugars. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A blood sugar assessment form has been re-established as part of the medication administration record. Nursing staff were in-serviced on April 16, 2013 on the policies and procedures of documenting the blood sugars, notification to physicians and families, interventions and follow up when indicated. 4. How the corrective</p>	

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	<p>ordered by doctor, Monitor/document/report to MD [medical doctor] s/sx [signs and symptoms] of hypoglycemia."</p> <p>A review of Resident #26's "Medication Administration Records" for December 2012, January, February and March (1-25) 2013 indicated the following episodes of blood sugars below 60 as follows:</p> <p>12/8/12, 7:00 a.m. - 54 - no documented doctor notification 12/14/12, 7:00 a.m. - 55 - no documented doctor notification 12/15/12, 7: 00 a.m. - 57 - no documented doctor notification 12/20/12, 7:00 a.m. - 54 - no documented doctor notification 12/21/12, 7:00 a.m. - 49 - no documented doctor notification 12/23/12, 7:00 a.m. - 53 - no documented doctor notification 1/16/13, 7:00 a.m. - 48 - no documented doctor notification 1/17/13, 7:00 a.m. - 47- no documented interventions - no documented doctor notification 2/7/13, 7:00 a.m. - 57- no documented interventions 3/7/13, 7:00 a.m. - 55 - no documented interventions -no documented doctor notification.</p>		<p>action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? Nursing management will do audits 5 times a week for 2 weeks to include the blood sugar done, assessment completed, interventions completed and to ensure physician notification if applicable. The audits will continue 3 times a week for 2 weeks; 1 time a week for 4 weeks; then monthly for 4 months. The results will be submitted to the monthly Quality Assurance Meeting for discussion and review. The Quality Assurance Committee will review determine the need for further monitoring of documentation blood sugar symptoms, treatment given, family and physician notification, interventions and follow up.</p>				

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	<p>During a 3/25/13, 1:05 p.m. interview, LPN #25 indicated the physician should be notified of blood sugars outside of the Resident's ordered limits. She additionally indicated when a physician was notified it should be documented in the resident's record.</p> <p>During a 3/25/13, 3:20 p.m. interview, the Director of Nursing indicated nurses should document in the electronic medical record when they have notified a physician. She also indicated low blood sugar interventions should be documented. She indicated the facility did not have any documentation of intervention or notification for any of Resident #26's 10 low blood sugar episodes.</p> <p>2.) Resident #22's clinical record was reviewed on 3/22/13 at 1:11 p.m. The resident's diagnoses included, but were not limited to, dead right foot, right mid-foot amputation, and insulin dependent diabetes mellitus.</p> <p>The resident had 3/1/13, signed physician's orders. The resident had a physician's order for blood sugar checks as needed for signs and symptoms of high or low blood sugars. The order indicated the physician was to be notified of blood sugars less than 60. The order</p>			

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	<p>indicated four ounces of coke, orange juice or Resource was to be given for blood sugars below 60 and the blood sugar was to be rechecked in 15 to 30 minutes after being given the drink. This order originated on 3/27/10.</p> <p>Review of Resident #22's blood sugars indicated the resident had a blood sugar of 53 on 3/20/13 at 7:00 a.m. The resident's clinical record lacked an indication of the physician being notified of the low blood sugar or of the resident receiving any type of treatment related to the low blood sugar. In addition, there was no recheck of the blood sugar in 15 to 30 minutes.</p> <p>During an interview with LPN #4 on 3/27/13 at 9:10 a.m., she indicated there should have been documentation on the Medication Administration Record [MAR] and/or in the Nurse's Progress Notes if Coke, orange juice or Resource was given, when the physician was notified and what the blood sugar was when rechecked.</p> <p>3.) Resident # 10's clinical record was reviewed on 3/26/13 at 3:26 p.m. Resident #10's current diagnoses included, but were not limited to,</p>			

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	<p>diabetes mellitus, coronary artery disease, congestive heart failure, neuropathy, and depressive disorder. Resident #10 had a current, 3/13/13, physician's order for blood sugar checks before and after meals twice daily, call if less than 70 or greater than 300.</p> <p>Review of the medication record indicated the following: 3/2/13 700 a.m. Blood sugar was 317-no documentation of doctor notification. 3/11/13 5:00 p.m. blood sugar was 343- no documentation of doctor notification. 3/13/13 5:00 p.m. blood sugar was 330- no documentation of doctor notification. 3/29/13 5:00 p.m. blood sugar was 333- no documentation of doctor notification.</p> <p>An interview on 3/26/13 at 3:00 p.m., with LPN #1 indicated that documentation of doctor notification of abnormal blood sugars was to be documented on the back of the medication record or in the nurse progress note.</p> <p>An interview on 3/27/13 at 1:26 p.m., with LPN #2 indicated that documentation of doctor notification</p>				

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	<p>of abnormal blood sugars was to be documented either on the back of the medication record and in the nurses progress notes.</p> <p>An interview on 3/27/13 at 1:45 p.m., with LPN #3 indicated that documentation of doctor notification of abnormal blood sugars was to be documented in the nurse's progress notes.</p> <p>3.1-5(a)(3)</p>			

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F000309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure residents with abnormal blood sugars received interventions in accordance with physician's orders for low blood sugars for 3 of 6 residents reviewed for blood sugar monitoring (Resident #'s 26, 22, 9) and a resident, who exhibited pain symptoms, received interventions for pain management for 1 of 10 residents reviewed for pain management (Resident #76).</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #9 was reviewed on 3/21/13 at 2:21 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia, diabetes mellitus, and hypertension.</p> <p>A health care plan problem, initiated on 12/17/12, indicated Resident #9 had diabetes mellitus. One of the approaches for this problem was</p>	F000309	<p>309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 9, 22, and 26 medical records have been audited for blood sugar result. Resident 26 did have one blood sugar questionable range and the physician was notified with orders received. A diabetic Assessment Flow Sheet has been placed in the medication record that states symptoms, treatment given, family and physician notification, interventions and follow up blood sugars. Resident 76 chart has been audited for pain management. An updated pain assessment scale has been added to the medication administration record. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All diabetic medical records will be audited for physician and family notification. A diabetic Assessment Flow Sheet has been placed in the medication record that states</p>	04/26/2013	

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	<p>"Monitor/document/report to MD prn s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait."</p> <p>A nursing note entry, dated 1/3/13 at 5:36 a.m., indicated the resident was transferred to a wheelchair and placed in the lounge in view of the staff due to the resident attempting to exit his bed unassisted. The resident was mumbling with nonsensical speech. His blood pressure was elevated at 176/89. His pulse was elevated at 101 beats per minute. His respirations were 20, his temperature was 97.4, and his oxygen saturation rate was 94% on room air. The physician was called and the resident was sent to the emergency room for evaluation and treatment.</p> <p>The next nursing note entry, dated 1/3/13 at 5:50 a.m., indicated the ambulance staff checked the resident's blood sugar in the ambulance and the result was 31 mg/dl.</p> <p>The clinical record lacked any monitoring of the resident's blood sugar for 1/3/13 by the facility.</p>		<p>symptoms, treatment given, family and physician notification and follow up blood sugars. The pain assessment scale is placed in all medication administration records for all residents to assess pain and interventions attempted. An updated pain assessment scale has been added to the medication administration record.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A blood sugar assessment form has been re-established as part of the medication administration record. Nursing staff was in-serviced on April 16, 2013 on the policies and procedures of documenting the blood sugars, notification to physicians and families, interventions and follow up when indicated. A pain scale assessment with interventions attempted and rating scale has been implemented. The nursing staff was in-service on April 16, 2013 on the form that is in each medication and treatment book.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? Nursing management will do audits 5 times a week for 2 weeks to include the blood sugar done, assessment completed, interventions completed and to ensure physician notification if</p>				

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	<p>During an interview with the Director of Nursing on 3/27/13 at 4:03 p.m., additional information was requested related to the lack of blood sugar monitoring on 1/3/13.</p> <p>The facility failed to provide any additional information as of exit on 3/27/13.</p> <p>2.) Resident #26's record was reviewed on 3/21/13, 9:27 a.m.</p> <p>Resident #26's current diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, congestive heart failure and depression.</p> <p>Resident #26 had a current 3/2013 physician's order to check the blood sugar before meals and at bedtime and to notify the Physician if the blood sugar was less than 60 or more than 400. This order originated on 2/13/09. The resident was to receive 4 ounces of Coke, orange juice or Resource if the blood sugars are less than 60 and the blood sugar was to be rechecked in 15 to 30 minutes. This order originated on 2/13/09.</p> <p>Resident #26 had a current 3/2013 care plan problem regarding diabetes mellitus. This problem originated</p>		<p>applicable. The audits will continue 3 times a week for 2 weeks; 1 time a week for 4 weeks; then monthly for 4 months. The results will be submitted to the monthly Quality Assurance Meeting for discussion and review. Nursing management will do audits for 5 times a week for 2 weeks on pain medication given, pain scale used and other interventions attempted and to ensure physician notification if applicable. The audits will continue 3 times a week for 2 weeks; 1 time a week for 4 weeks; then monthly for 4 months. The Quality Assurance Committee will review determine the need for further monitoring of documentation blood sugar symptoms, treatment given, family and physician notification, interventions and follow up.</p>				

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	<p>4/1/11. Approaches to this problem included, but were not limited to "Fasting Serum Blood Sugars as ordered by doctor, Monitor/document/report to MD [medical doctor] s/sx [signs and symptoms] of hypoglycemia."</p> <p>A review of Resident #26's "Medication Administration Records" for January, February and March (1-25) 2013 indicated the following episodes of blood sugars below 60 as follows:</p> <p>1/17/13, 7:00 a.m. - 47- no documented interventions - no documented doctor notification 2/7/13, 7:00 a.m. - 57- no documented interventions 3/7/13, 7:00 a.m. - 55 - no documented interventions -no documented doctor notification.</p> <p>During a 3/25/13, 3:20 p.m. interview, the Director of Nursing indicated nurses should document in the electronic medical record low blood sugar interventions. She indicated the facility did not have any documentation of intervention or notification for any of Resident #26's 3 low blood sugar episodes.</p> <p>3. Resident #22's clinical record was reviewed on 3/22 at 1:11 p.m. The</p>			

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	<p>resident's diagnoses included, but were not limited to, dead right foot, right mid-foot amputation, and insulin dependent diabetes mellitus.</p> <p>The resident had 3/1/13, signed physician's orders. The resident had a physician's order for blood sugar checks as needed for signs and symptoms of high or low blood sugars. The order indicated the physician was to be notified of blood sugars less than 60. The order indicated four ounces of coke, orange juice or Resource was to be given for blood sugars below 60 and the blood sugar was to be rechecked in 15 to 30 minutes after being given the drink. This order originated on 3/27/10.</p> <p>Review of Resident #22's blood sugars indicated the resident had a blood sugar of 53 on 3/20/13 at 7:00 a.m. The resident's clinical record lacked an indication of the resident receiving any type of treatment related to the low blood sugar or of a recheck of the blood sugar in 15 to 30 minutes.</p> <p>During an interview with LPN #4 on 3/27/13 at 9:10 a.m., she indicated there should been documentation on the Medication Administration Record</p>			

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	<p>[MAR] and/or in the Nurse's Progress Notes if Coke, orange juice or Resource was given, when the physician was notified and what the blood sugar was when rechecked.</p> <p>4.) The undated policy and procedure "For Abnormal Blood Sugars Identified By Doctor's Parameters" was provided by the Director of Nursing on 3/26/13 at 9:10 a.m. The policy indicated blood sugars that are above or below doctor's parameters will be assessed by a nurse and documented on the "Diabetic Assessment Flow Sheet."</p> <p>5.) The clinical record for Resident #76 was reviewed on 3/22/13 at 8:13 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, Alzheimer's disease, arthritis, and congestive heart failure.</p> <p>During an interview with Resident #76 on 3/19/13 at 11:20 a.m., he indicated his head hurt.</p> <p>A health care plan problem, initiated on 12/28/12, indicated Resident #76 had pain related to arthritis. One of the approaches for this problem was "Monitor/record pain characteristics each shift and PRN (as needed):</p>			

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	<p>Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g. continuous, intermittent); Aggravating factors; Relieving factors."</p> <p>During an interview with the Assistant Director of Nursing and LPN #1, on 3/26/13 at 10:26 a.m., they indicated the charting of daily or every shift pain was usually during acute situations or during Medicare daily charting.</p> <p>During an interview with the Assistant Director of Nursing on 3/26/13 at 10:46 a.m., she indicated she could not provide any documentation of every shift pain assessment for Resident #76.</p> <p>3.1-37(a)</p>				

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F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure a resident's functional maintenance program was followed daily and a physical therapy consultation was obtained after a fall for 1 of 3 residents reviewed for rehabilitation. (Resident #76)</p> <p>Findings include:</p> <p>The clinical record for Resident #76 was reviewed on 3/22/13 at 8:13 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, decreased activities of daily living function, Alzheimer's disease, arthritis, congestive heart failure, and history of falls.</p> <p>The resident received physical therapy and occupational therapy including, but not limited to, therapeutic exercise and neuromuscular re-education from 12/28/12 to 2/7/13. Upon discharge from therapies the resident was to continue a functional maintenance</p>	F000311	<p>311 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 76 care plan was reviewed and updated. The resident began restorative services minimum 3 times a week. The care plan listed the physical therapy evaluation in error. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents being discharged from therapy services will be evaluated for restorative services. All new admissions will be evaluated for restorative needs. All care plans have been reviewed by nursing management to ensure accuracy of the care plan and services indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The nursing staff was in-serviced on April 16, 2013 on procedures of restorative services and documentation. The MDS Coordinator and Care Plan Coordinator or designees will meet 5 times a week to review all new orders for restorative needs and</p>	04/26/2013	

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	<p>program to be provided by nursing.</p> <p>The clinical record lacked any documentation of the active range of motion and walking services provided by restorative nursing from 2/17/13 until 3/13/13.</p> <p>During an interview with the Minimal Data Set (MDS) Coordinator on 3/26/13 at 2:48 p.m., additional information was requested related to the lack of documentation for the restorative nursing program.</p> <p>During an interview with the MDS Coordinator on 3/27/13 at 10:21 a.m., she indicated Resident #76 had been discharged from therapies on 2/7/13. Resident #76 was not started on the restorative program until 3/13/13. The MDS Coordinator indicated the resident should have been started on the restorative nursing program as soon as his therapies were completed on 2/7/13.</p> <p>A health care plan problem, initiated on 3/11/13, indicated Resident #76 had a fall with minor injury. One of the approaches for this problem was "PT (physical therapy) consult for strength and mobility."</p> <p>The clinical record lacked a physical</p>		<p>resident incidents with interventions.4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? The MDS Coordinator/designee will do audits 5 times a week for 2 weeks to include the restorative services to ensure residents are receiving restorative services as recommended by therapy. The audits will continue 3 times a week for 2 weeks; 1 time a week for 4 weeks; then monthly for 4 monthly. The results will be submitted to the monthly Quality Assurance Meeting for discussion and review. The Quality Assurance Committee will review determine the need for further monitoring of documentation of restoratives services.</p>	

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	<p>therapy consultation from 3/11/13.</p> <p>During an interview with the Assistant Director of Nursing on 3/26/13 at 10:13 a.m., additional information was requested related to the lack of a physical therapy consultation for Resident #76 from 3/11/13.</p> <p>During an interview with Physical Therapy Assistant #5 on 3/26/13 at 2:05 p.m., she indicated a physical therapy consultation had not been completed for Resident #76. She indicated physical therapy did not receive a request for the consultation from 3/11/13.</p> <p>The facility failed to provide any additional information as of exit on 3/27/13.</p> <p>3.1-38(b)(2)</p>			

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F000314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure treatments to prevent pressure areas were completed as ordered by the physician for 2 of 3 residents reviewed for pressure ulcers. (Resident #'s 16 and 51)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #16 was reviewed on 3/21/13 at 10:33 a.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, hypertension, arthritis, osteoporosis, and debility.</p> <p>A health care plan problem, initiated on 10/24/12 and updated on 11/1/12, indicated Resident #16 had the potential for pressure ulcer development. One of the approaches</p>	F000314	<p>314 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 16 skin was assessed and the area had healed and the medication was discontinued on 3/21/13. The physician orders were audited and updated as indicated for the current health status. Resident 51 skin was assessed and the area was healed and the boot was discontinued 3/21/13. The physician orders were assessed and updated as indicated for the current health status. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with skin issues were assessed by the designated wound nurse on 3/26/13. All skin treatment orders were audited and updated as indicated on 3/26/2013. The designated wound RN will assess all resident with skin issues weekly,</p>	04/26/2013			

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	<p>for this problem was "Stoma powder to coccyx q (every) shift and prn (as needed) soilage."</p> <p>The resident had a physician's order for Stoma powder (a wound healing medication) to be applied topically to the coccyx every shift and as needed for soilage. The original order date was 10/24/12. The March Treatment Record indicated the Stoma powder was applied every shift until 3/21/13.</p> <p>During an interview with Resident #16 on 3/21/13 at 1:03 p.m., the resident indicated the powder was no longer used on her "behind." She indicated the powder had not been used "for a while."</p> <p>During an interview with LPN #2 on 3/21/13 at 1:10 p.m., she indicated she stopped using the stoma powder on Resident #16 "over a week ago."</p> <p>2.) On 3/21/13 at 10:16 a.m., Resident #51 was observed in his room with his shoes on both of his feet.</p> <p>The clinical record for Resident #51 was reviewed on 3/21/13 at 9:27 a.m.</p> <p>Diagnoses for Resident #51 included, but were not limited to, hypertension,</p>		<p>review the current treatments, orders and update the physician as indicated for each resident. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The designated wound RN/designee will review daily all new treatment orders and verify orders based resident needs. Nursing staff were in-serviced on 4/16/2013 on documentation of treatments and use of boots. CNA assignments forms have been reviewed and updated. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? The wound RN/designee will audit the boots 5 times a week for 2 weeks to assure appropriate placement, 3 times a week for 2 weeks, 1 time a week for 4 weeks, and 1 time a month for 4 months. The audits will be reported monthly at the Quality Assurance Committee Meeting. The Quality Assurance Committee will review determine the need for further monitoring of documentation of device placement, treatment and orders.</p>		

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	<p>osteoarthritis, diabetes mellitus, and dementia Alzheimer's disease with depression.</p> <p>A health care plan problem, initiated on 12/12/12 and updated on 1/4/13, indicated Resident #51 had the potential or actual impairment to skin integrity. One of the approaches for this problem was "Prevalon boot (heel protector) to R (right) foot at all times except for adl's (activities of daily living)."</p> <p>The resident had a physician's order for a Prevalon boot on the right foot at all times except for activities of daily living (ADLs). The original order date was 1/3/13. The March Treatment Record indicated the Prevalon boot was applied to the right foot every shift including 3/21/13.</p> <p>During an interview with LPN #2 on 3/21/13 at 10:18 a.m., she indicated Resident #51 was to have the boot on his right foot at all times.</p> <p>3.1-40(a)(2)</p>			

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F000323 SS=E	<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.</p> <p>A.) Based on observation, interview and record review, the facility failed to ensure "Safer Swallow Strategies" were followed for 2 of 2 residents reviewed for safety when dining (Residents #19 and #131).</p> <p>B.) Based on observation, interview and record review the facility failed to ensure side rail openings were of a size to prevent/reduce the risk of possible entrapment for 6 of 23 residents reviewed for side rail use (Resident #'s 128, 60, 55, 31, 133, 136)</p> <p>Findings include:</p> <p>A1.) During a 3/21/13, 11:55 a.m. to 12:30 p.m., Cafe' (assisted dining) lunch meal observation, Resident #19 ate her meal without cueing, prompting or assistance from any employee. No employee gave Resident #19 directions regarding her "Safer Swallow Strategies."</p> <p>Resident #19's record was reviewed</p>	F000323	<p>F 323A 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents 19 and 131 have been reviewed by the speech therapist and the swallowing strategies updated on each person. The documentation is provided in a wall holder in the Café for staff to use as references. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents identified as needing assistance have had Safe Swallow Strategies updated and documentation is available in the Café in a wall holder for staff reference and use. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff have been in-serviced by the speech therapist on 4/26/13 on individual strategies and documentation placed in a red folder in the Café for staff use. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program</p>	04/26/2013			

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	<p>on 3/25/13, 2:45 p.m. Resident #19's current diagnoses included, but were not limited to, hypertension, macular degeneration and vision impairment in both eyes.</p> <p>Resident #19 had a current 3/2013 physician's order for a mechanical soft diet. This order originated 1/30/13.</p> <p>Resident #19 had a current 3/11/13 care plan problem regarding potential nutritional problems. This problem originated 12/21/12. Approaches to this problem included, but were not limited to, monitor intake and record each meal and monitor and report to doctor any signs or symptoms of choking, coughing, holding food in mouth, several attempts to swallow or refusing to eat.</p> <p>Resident #19 had a current 2/13/13 "Safer Swallow Strategies" plan, which indicated the following: "1) Encourage bites/sips and self-feeding frequently throughout the meal to improve intake. 2) Small single bites/sips 3) Double swallows after each bite with verbal cue. 4) Clear food from mouth before drinking 5) Cue small sips and follow-up</p>		<p>will be put into place? The nursing managers will monitor 5 times a week for each meal for 2 weeks, then 3 times a week for 2 weeks, then weekly for 4 weeks, then monthly for 4 months. The audits will be reviewed in the monthly Quality Assurance Committee meeting. The Quality Assurance Committee will review determine the need for further monitoring of documentation swallowing strategies needs.</p> <p>F323 B1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents 128, 60, 55, 31, 133, and 136 beds were replaced on 3/19/2013 at the point of identification of potential entrapment. There had been no incidents of side rail related incidents in the last 6 months prior to the survey. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All side rails and beds were checked for entrapment zones on 3/19/2013. Only beds and side rails with gaps under 4 ¾ inches will be used. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance staff will measure all incoming beds for proper safe zones upon delivery. No beds that have</p>		

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	<p>swallow</p> <p>6) Encourage hard and fast swallows."</p> <p>Review of Resident #19's food consumption records for 3/2/13 to 3/25/13 (24 days and 72 possible meals) indicated:</p> <p>a.) 59 meals with recorded meal consumption. The missing meals did not indicate the resident refused meals or was not in the facility when the meal was served.</p> <p>b.) 37 of the recorded 59 meals indicated Resident #19 ate 50% or less of her meal.</p> <p>A2.) During a 3/19/13, 11:55 a.m. to 12:30 p.m. lunch observation of the Cafe' dining room (assisted dining), Resident #131 ate her lunch without any cueing assistance or prompting from staff. No employee gave Resident #19 directions regarding her "Safer Swallow Strategies."</p> <p>During a 3/21/13, 12:00 p.m. to 12:30 p.m. lunch observation of the Cafe' dining room (assisted dining), Resident #131 ate her lunch without any cueing assistance or prompting from staff. Resident #131 could not reach her frozen dessert. She reached her spoon towards it skimming the top of the dessert. At</p>		<p>more than 4 ¼ inch gap areas of entrapment will be allowed to be put in use. Education on entrapment zones was done on 3/19/2013 with maintenance staff, central supply and nursing management.4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? Maintenance staff will check any rented or new beds and report measurements to the Administrator upon delivery. Administrator will review reports to the monthly Quality Assurance Committee for 6 months. The Quality Assurance Committee will review determine the need for further monitoring of documentation of side rail entrapment zones.</p>				

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	<p>12:30 p.m., a staff member placed the frozen dessert closer to the resident and she was able to eat the dessert. No employee gave Resident #19 directions regarding her "Safer Swallow Strategies."</p> <p>Resident #131's record was reviewed on 3/25/13, 1:30 p.m. Resident #131's current diagnoses included, but were not limited to, a history of stroke, hypertension and congestive heart failure.</p> <p>Resident #131 was admitted to the facility on 3/18/13.</p> <p>Resident #131 had a current, 3/18/13, physician's order for a mechanical soft diet with ground meat and honey thickened liquids.</p> <p>Resident #131 had a current, 3/18/13, care plan problem regarding a risk for aspiration related to dysphasia. Approaches to this problem included, but were not limited to, "sipper cups at meals, small bites/sips, offer small bites and wait for swallow, remind resident to swallow and check for pocketing of food in cheeks, drooling, gurgling, s/sx [signs or symptoms] aspiration and lung sounds as needed."</p>						

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	<p>Resident #131 had a 3/20/13 "Safer Swallowing Strategies" which indicated: " Diet: Mechanical Soft and Honey Thick Liquids by open cup (sic) Recent swallow study indicating increased risk of aspiration. 1) Encourage single bites/sips 2) Double swallows 3) Slower eating and drinking 4) Increased chew time"</p> <p>Review of Resident #131's food consumption record for 3/18/13 (1:00 p.m.) to 3/21/13 (1:00 p.m.) (4 days and 9 meals) indicated the following: a.) consumption was documented for 7 of 9 meals. b.) Resident #131 consumed less than 50% all 7 documented meals.</p> <p>During a 3/21/13, 12:45 p.m. interview, LPN #20 indicated residents who needed feeding assistance and swallow strategies had care plans regarding what assistance they needed to eat. She additionally indicated she had no idea how information got from the care plan to the staff assisting the resident. She also indicated speech therapist developed plans for the residents but she did not know by what means the needs of each resident were communicated to the employees.</p>						

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	<p>During a 3/21/13, 12:50 p.m. interview, CNA #21 indicated she had not been told any instructions about how to feed Resident #131. She just watched and responded to how the residents were eating each day. She stated "I do not know how I am supposed to know resident specific feeding instructions."</p> <p>During a 3/21/13, 12:52 p.m. interview, CNA #22 indicated she knew how to feed or assist residents by past experience. She indicated there were not resident specific instructions available.</p> <p>During a 3/21/13, 12:53 p.m. interview, CNA #23 indicated she did not know of any resident specific feeding instructions.</p> <p>During a 3/21/13, 12:55 p.m. interview, the Director of Nursing indicated she was unsure how staff were informed of resident specific feeding instructions and she would check with Speech Therapy and get back with the information.</p> <p>During a 3/22/13, 9:35 a.m., interview, Speech Therapist #24 indicated the direct care staff had been educated regarding resident</p>						

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	<p>specific "Safer Swallow Strategies" and these strategies were posted in a red book on top of the refrigerator in the Cafe dining room. She indicated the staff members feeding residents lunch on 3/19/13 and 3/21/13 should have been aware of the location of the feeding strategies and followed them.</p> <p>B1. A facility wide observation of side rails was made on 3/19/13 from 2:50 p.m. to 3:10 p.m., with the Administrator and the Director of Nursing. The Director of Nursing measured the side rail openings for Resident #'s 128, 60, 55, 31, 133, and 136. The side rails were designed as a rectangle with two short bars spanning the top and bottom of the rails and dividing it into three sections. The middle section of the side rails measured seven inches by seven and one half inches. The Director of Nursing said "we should have caught that," indicating the opening in the side rail was too large and could cause entrapment of a resident's head.</p> <p>B2.) During a 3/19/13, 2:50 p.m., observation, Resident #128's bed was noted to have 2 half side rails at the head of the bed. The side rails had 3 sections. Two of the 3 sections had</p>			

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	<p>openings which were greater than 4 3/4 inch by 4 3/4 inch resulting in an entrapment risk.</p> <p>Resident #128's record was reviewed on 3/25/13, 3:15 p.m. Resident #128's current diagnoses included, but were not limited to, hypertension, hyperlipidemia and gastrointestinal bleed.</p> <p>B3.) Resident #133's was observed in bed on 3/19/13 at 2:45 p.m. The resident's top half side rails were up and he indicated he used them to position himself in the bed.</p> <p>Resident #133's clinical record was reviewed on 3/21/13 at 10:38 a.m. The resident's diagnoses included, but were not limited to, multiple therapies due to decreased mobility, decreased activities of daily living function, and congestive heart failure.</p> <p>B4.) Resident #136 was observed on 3/19/13 at 2:52 p.m., sitting in his wheel chair. His bed had two top half side rails on his bed in the lowered position.</p> <p>Resident #136's clinical record was reviewed on 3/27/13 at 1:17 p.m. Resident #136's diagnoses included, but were not limited to, right hemiparesis and dysarthria.</p>						

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	<p>The resident had a 3/12/13, Nursing admission assessment indicating the resident required extensive assistance with bed mobility and transfers, had pain and lack of hand dexterity.</p> <p>During an interview on 3/19/13 at 3:15 p.m., the Director of Nursing indicated the facility had received the beds, with the large bedrail openings, sometime within the past six months, but she could not remember exactly when they arrived.</p> <p>During an interview with the Administrator on 3/20/13 at 9:25 a.m., she indicated the facility should have identified the problem with the big side rails prior to 3/19/13.</p> <p>B5.) Resident #31's bed was observed to have openings in the side rails which exceeded safety regulations during an audit on all side rails in the facility on 3/20/13.</p> <p>During an interview with Resident #31 on 3/22/13 at 9:08 a.m., she indicated she did use her side rails to "scoot over" in bed. The two top half side rails were in the up position.</p> <p>The clinical record for Resident #31 was reviewed on 3/22/13 at 9:21 a.m. Diagnoses for the resident included, but were not limited to, hypertension,</p>			

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	<p>obstructive pulmonary disease, and dementia with delusions.</p> <p>B6.) Resident #55's bed was observed to have openings in the side rails which exceeded safety regulations during an audit on all side rails in the facility on 3/20/13.</p> <p>The clinical record for Resident #55 was reviewed on 3/21/13 at 3:17 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease, hypertension, and dementia.</p> <p>On 3/25/13 at 10:40 a.m., Resident #55 was observed using a side rail to reposition herself in bed. The two top half side rails were in the up position.</p> <p>B7.) Resident # 60 was observed on 3/20/13 at 9:00 a.m. Resident #60 was in bed with half side rails to both sides of the head of the bed.</p> <p>Resident # 60 was observed on 3/21/13 at 10:00 a.m. Resident #60 was in bed with half side rails to both sides of the head of the bed.</p> <p>Resident # 60's record was reviewed 3/26/13 at 8:20 a.m. Resident # 60's current diagnoses included, but were not limited to Cerebral Vascular Accident, Right sided hemiparesis (weakness of the right side),and</p>				

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	receptive/expressive aphasia (communication deficit). 3.1-19(c)				

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F000329 SS=E	<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 ensure as needed medications had criteria/parameters for use and residents who received psychoactive medications were monitored for side effects as ordered by the physician for 5 of 10 residents who met the criteria for unnecessary medication (Resident #'s 26, 92, 136, 129, and 8).</p> <p>Findings include:</p>	F000329	F 329 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 26 and 31 medical records and care plans have been reviewed and will have orthostatic blood pressures monitored for documentation monthly. Resident 8 and 92 medical records has been reviewed and updated. A pain scale with intervention options has been implemented for all residents. Resident 129's medical record has been reviewed,	04/26/2013	

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	<p>1.) Resident #26's record was reviewed on 3/21/13, 9:27 a.m.</p> <p>Resident #26's current diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, congestive heart failure and depression.</p> <p>Resident #26 had a current 3/2013 order for Abilify 2 mg (an antipsychotic also used to treat depression) 1 tablet daily at bedtime. This order originated 7/25/12.</p> <p>Resident #26 had a current, 7/25/12, care plan problem regarding psychoactive medication use. An approach to this problem was to monitor for side effects.</p> <p>Resident #26 had an 1/25/13 pharmacy recommendation which indicated:</p> <p>"[Resident #26] is receiving Ability 2 mg QHS [every night]. Please consider a monthly orthostatic BP [blood pressure] to monitor for adverse effects. Laying, sitting, standing is preferred or at least laying to sitting." The physician indicated he agreed with the recommendation on 2/20/13.</p>		<p>clarified and updated to include all diagnosis and needs for medication. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All resident medical records were audited to check orders regarding orthostatic blood pressures related to psychotropic medications. A pain scale with intervention options has been implemented for all residents. All residents' physicians' orders have been reviewed and updated for current diagnosis and reason indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The nursing staff was educated on 4/16/13 on completion of physician orders to include diagnosis or reason to be given. A pain scale tool is in place in medication and treatment administration record. All new orders are reviewed daily for accuracy and completion of diagnosis and/or resident need by nursing management. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? The nursing management will audit the medication records daily for 5 times a week for 2 weeks; 3 times a week for 2 weeks, 1 time a week for 4 weeks and monthly</p>				

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	<p>Resident #26 had a 2/20/13 physician's order for monthly orthostatic blood pressures.</p> <p>Resident #26's record lacked documentation of a monthly orthostatic blood pressure being obtained in February or March 2013.</p> <p>2.) Resident #31's record was reviewed on 3/25/13, 2:00 p.m.</p> <p>Resident #31's current diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension and dementia with delusions.</p> <p>Resident #31 had a current 3/2013 physician's order for the following psychoactive medications: a.) Seroquel 25 mg (an antipsychotic medication) 1 tablet every morning. This order originated 9/12/12. b.) Seroquel 25 mg (an antipsychotic medication) 2 tablets at bedtime. This order originated 9/12/12.</p> <p>Resident #31 had a 1/25/13, pharmacy recommendation which indicated: "Please consider an orthostatic BP (blood pressure) monthly to monitor Seroquel use. (lying, sitting,</p>		thereafter. Results of audit will be reported to the monthly to the Quality Assurance Committee on an ongoing basis for review.	

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	<p>standing)" The physician signed the form as agree on 2/20/13.</p> <p>Resident #31 had a current 3/13, care plan problem regarding the use of the psychotropic medications Seroquel. An approach to this problem was to monitor for side effects.</p> <p>Resident #31's record lacked orthostatic blood pressures for February and March 2013.</p> <p>3.) Resident #92's record was reviewed on 3/21/13, 4:10 p.m.</p> <p>Resident #92's current diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>Resident #92 had a current, 3/2013, physician's order for the following as needed pain medications:</p> <p>a.) Tylenol 325 mg - take 2 tablets every 4 hours as needed for pain or temperature. This order originated 12/6/12.</p> <p>b.) hydrocodone/apap 5-325 mg - take 1 tablet every 4 to 6 hours as needed for pain. This order originated 12/6/12.</p> <p>c.) hydrocodone/apap 5-325 mg - take 2 tablets every 4 to 6 hours as needed for pain. This order originated 12/6/12.</p>						

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	<p>Resident #92's record lacked any criteria for assessing levels of the pain and which medication to use under what condition and a criteria to use to determine if the medication should be given every 4 or 6 hours.</p> <p>4.) Resident #8's record was reviewed on 3/26/13, 8:40 a.m.</p> <p>Resident #8's current diagnoses included, but were not limited to, post cerebral vascular accidents, hypertension and history of a left hip fracture.</p> <p>Resident #8 had a current 3/2013 physician's orders for the following as needed pain medications:</p> <p>a.) Tylenol 325 mg - take 2 tablets (650 mg) every 4 hours as needed for pain or a temperature greater than 99 degrees. This order originated 5/19/09.</p> <p>b.) hydrocodone/apap tab 10-325 mg - Take 1 tablet every 6 hours as needed for pain. This order originated 2/12/13.</p> <p>c.) hydrocodone/apap tab 10-325 mg - Take 2 tablets every 6 hour as needed for severe pain. This order originated 2/12/13.</p> <p>Resident #8's record lacked any</p>			

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	<p>criteria for assessing levels of the pain and which medication to use under what condition.</p> <p>A review of Resident #8's Medication Administration Records for March (3/1/13- 3/24/13) indicated the the resident used as needed medications as follows:</p> <p>hydrocodone/apap 10-325 mg -1 tab every 6 hours as needed for pain: 3/1/13, 3/2/13, 3/5/13, 3/6/13 - 2 times, 3/7/13, 3/8/13 - 2 times, 3/9/13 - 2 times, 3/10/13, 3/11/13, 3/12/13, 3/13/13, 3/14/13, 3/16/13, 3/17/13, 3/19/13 - 2 times, 3/20/13 - 2 times, 3/21/13, 3/22/13 - 2 times, 3/23/13, 3/24/13.</p> <p>Hydrocodone/Apap 10-325 mg - 2 tabs every 6 hours as needed for severe pain: 3/3/13, 3/12/13, 3/18/13</p> <p>Tylenol was not given.</p> <p>Resident #8 had a current, 3/13, care plan problem regarding chronic pain. This problem originated 4/1/11. An approach to this problem was to administer pain medication as ordered.</p> <p>5.) Resident #129's clinical record was reviewed on 3/21/13 at 1:30 p.m.</p>			

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	<p>The resident's diagnoses included, but were not limited to, bipolar disorder, anxiety, abdominal pain, systemic lupus erythematosus, anxiety, osteoporosis, rheumatoid arthritis, diabetes mellitus, and depression.</p> <p>The resident had 3/15/13, signed physician's orders. The resident had an order for Xanax [anti-anxiety] 0.5 mg [milligram] 1 by mouth 3 times a day as needed. The order lacked the specific reason to give the medication.</p> <p>The resident had an order for Lasix 20 mg 1 by mouth everyday as needed. The order lacked the reason to give the medication.</p> <p>During an interview with LPN #4 on 3/27/13 at 9:10 a.m., she indicated the resident had received the Lasix on 3/17/13, at the resident's request for puffy legs and had received it for a 2.4 pound weight gain on 3/20/13.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 9:15 a.m., she indicated the orders for the Lasix were unclear as to when the medication should be given.</p> <p>6.) The 12/2000, "Physician's Order</p>						

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	<p>Form" policy was provided by the Director of Nursing on 3/26/13 at 9:10 a.m. The policy indicated all orders would be transcribed to a Physician's Order Form and all areas were to be filled in. The policy indicated the form should contain the name of the medication, the dosage and form of the medication, route of administration, the schedule or time to be given, and the indication or reason to give the medication.</p> <p>7.) An 11/8/12, "Nursing Reminders" was provided by the Assistant Director of Nursing on 3/26/13 at 2:05 p.m., and indicated Medication and Treatment Administration Records were part of charting and was to be completed on the back of the forms for medications given as needed. It indicated psychotropic's were also to be documented on the psychotropic sheet.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F000428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the Consultant Pharmacist reviewed medication orders to ensure directions were clear to understand for 4 of 10 residents reviewed for unnecessary medications. (Resident #'s 76, 9, 69, 22)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #76 was reviewed on 3/22/13 at 8:13 a.m.</p> <p>Diagnoses for Resident #76 included, but were not limited to, hypertension, seizures, and Alzheimer's disease.</p> <p>Current physician's orders for Resident #76 included, but were not limited to, the following orders:</p> <p>a. Temazepam (sedative) 30 milligrams (mg) 1 capsule by mouth at bedtime as needed. The original</p>	F000428	<p>F428</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Consultant pharmacist has been in consultation on 4/4/13 and 4/11/13 with facility on residents 76, 9, 69, and 22. The medical records have been reviewed and updated with current need and diagnosis.</p> <p>2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Consultant pharmacist will review all residents' medical records for irregularities and make recommendations to facility management monthly.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing in-serviced on 4/16/13 on the need to discuss with consultant pharmacist the current needs of the resident and take action on any recommendations.</p>	04/26/2013

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	<p>order date was 12/27/12.</p> <p>b. Lorazepam (a medication given for seizures) inject 0.25 milliliters (ml) intramuscularly at seizure activity greater than 5 minutes as needed. The original order date was 1/24/13.</p> <p>The clinical record lacked any diagnosis related to why the resident was receiving the temazepam and any information or directions from the physician related to how often these "as needed" medications could be given.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:05 a.m., additional information was requested related to the lack of diagnosis for the use of temazepam and the directions for the lorazepam "as needed" order.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 2/27/13 and 3/21/13 with no recommendations having been made for the temazepam or lorazepam "as needed" orders.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:57 a.m., she indicated the pharmacy consultant did not make any</p>		<p>Consultant pharmacist educated on 4/11/13 on facility needs to maintain consistent clinical evaluation of each residents' drug regimen.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? All medical records will be reviewed monthly by the pharmacists. All new orders are reviewed Monday – Friday for diagnosis and resident need. The recommendations and consultant report will be reviewed at each monthly Quality Assurance Committee on an ongoing basis.</p>		

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	<p>recommendations in January, February, or March 2013 related to the temazepam or lorazepam "as needed" orders. She further indicated the facility would call the physician and verify the indication for use of the temazepam.</p> <p>2.) The clinical record for Resident #9 was reviewed on 3/21/13 at 2:21 p.m.</p> <p>Diagnoses for Resident #9 included, but were not limited to, hypertension, diabetes mellitus, and prostate cancer.</p> <p>Current physician's orders for Resident #9 included, but were not limited to, the following orders:</p> <p>a.) Acetaminophen (a pain medication) 325 milligrams (mg) take 2 tablets by mouth every 4 hours as needed for pain. The original order date was 12/20/12.</p> <p>b.) Hydrocodone bitartrate and acetaminophen (a pain medication) 5 mg hydrocodone and 500 mg acetaminophen take 1 tablet by mouth every 8 hours as needed for pain. The original order date was 12/15/12.</p>			

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	<p>The clinical record lacked any information or directions from the physician related to the pain level each "as needed" pain medication should be given.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 1/25/13, 2/27/13 and 3/21/13 with no recommendations having been made for the pain medications "as needed" orders.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 9:13 a.m., additional information was requested related to the directions for the pain medications "as needed" orders.</p> <p>The facility failed to provide any additional information as of exit on 3/27/13.</p> <p>3.) The clinical record for Resident #69 was reviewed on 3/25/13 at 1:40 p.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to, dementia, diabetes mellitus, and depression.</p> <p>Current physician's orders for Resident #9 included, but were not limited to, the following orders:</p>						

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	<p>a.) Acetaminophen (a pain medication) 500 mg take 2 (1000 mg) tablets by mouth every 6 hours as needed. The original order date was 12/2/11.</p> <p>b.) Benzonate (a cough medication) 100 mg take 1 capsule by mouth 3 times daily as needed. The original order date was 1/3/13.</p> <p>The clinical record lacked any diagnosis related to why the resident was receiving the Benzonate and the acetaminophen "as needed" medications.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:05 a.m., additional information was requested related to the lack of diagnosis for the use of the Benzonate and the acetaminophen "as needed" orders.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 2/27/13 and 3/21/13 with no recommendations having been made for the Benzonate or acetaminophen "as needed" orders.</p> <p>During an interview with the Director of Nursing on 3/26/13 at 4 :40 p.m.,</p>			

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	<p>additional information was requested related to the indications for use for the "as needed" medication orders.</p> <p>During an interview with the Care Plan coordinator on 3/26/13 at 4:44 p.m., she indicated she had a master list from the pharmacy consultant and no recommendations were made for Resident #69 in January, February, or March 2013.</p> <p>4.) Resident #22 clinical record was reviewed on 3/22/13 at 1:11 p.m. The resident's diagnoses included, but were not limited to, right mid-foot amputation, peripheral vascular disease, and dead right foot.</p> <p>The resident had 3/1/13, signed physician's orders. The resident's orders included, but were not limited to, hydrocodone/apap [a pain medication] 10-325 mg tablets [milligrams] take 1 to 2 tablets by mouth every 4 to 6 hours as needed. The order lacked the specific amount to be given, the specific frequency to give the medication and the reason to give the medication.</p> <p>The resident had an order for hydrocodone/apap 5/325 mg tablet take 1 to 2 tabs by mouth every 4 to 6 hours as needed. The order lacked the specific amount to be given, the</p>			

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	<p>specific frequency to give the medication and the reason to give the medication.</p> <p>The resident had an order for Mi-acid [an antacid] suspension 30 milliliters every 4 hours as needed. The order lacked the specific reason to give the medication.</p> <p>Review of the Consultant Pharmacist's log indicated the resident's record was reviewed on 3/13/13 with no recommendations related to her orders for hydrocodone/apap 5/325 mg tablets, hydrocodone/apap 10/325 mg tablets, and her Mi-acid not being specific.</p> <p>5.) Review of the current facility policy, dated January 2007, titled "CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS," provided by the Assistant Director of Nursing on 3/26/13 at 1:45 p.m., included, but was not limited to, the following:</p> <p>"...Procedures...</p> <p>E. The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant</p>			

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	<p>pharmacist help to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical series. This includes, but is not limited to:...</p> <p>...2). Evaluating the process of receiving and interpreting prescribers' orders;acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring response to, and using and/or disposing of all medications, biologicals, and chemicals....</p> <p>...F. Specific activities that the consultant pharmacist performs and/or oversees includes, but is not limited to:</p> <p>1.) Reviewing the medication regimen (medication regimen review of each resident at least monthly...</p> <p>...2.) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders as well as recommendations for changes in medication therapy and monitoring of medication therapy monthly...."</p>			

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F000463 SS=C	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to provide a emergency call system for 2 of 2 sun porches. This deficient practice had the potential to effect 63 of 63 residents living in the facility. Findings include: During an environmental tour on 3/22/13 at 1:00 p.m., with the Maintenance Supervisor, Housekeeping Supervisor, and the Administrator in attendance, there were no emergency call systems in the Rosewood sun porch and the Dogwood sun porch. In an interview on 3/22/13 at 1:20 p.m., the Administrator indicated the residents used the sun porches. During an observation on 3/27/13 at 2:30 p.m., Resident #1 and his family were visiting in the Rosewood Sun Porch. In an interview with resident #1's sister, she indicated they used the sun porch frequently. 3.1-19(u)(3)</p>	F000463	<p>F 463 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An audio door bell alarm has been placed in each lounge for anyone to use for assistance in the sun room. These areas were established several years ago. No issues have been noted with residents or visitors the lounges. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Audio door alarms have been installed in each lounge for the residents and visitors to use at their leisure. The audio alarms can be heard at each respective nurse's station. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An audio alarm was installed in each lounge that can be reached by those in a wheelchair. All other exit doors also have audio alarms to alert staff for any needs. The nursing was staff in-serviced on 4.16.2013 on the addition of the sun lounge alarms.4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e.,</p>	04/26/2013			

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			what quality assurance program will be put into place? The audio alarms will have an ongoing weekly check to assure proper working sound by the maintenance director/designee. The maintenance director will report the weekly checks to the monthly QA Committee for 6 months. The Quality Assurance Committee will review determine the need for further monitoring of documentation of door alarms checks.		

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F000514 SS=C	<p>483.75(l)(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 record review and interview, the facility failed to ensure medication orders were complete and dosage information was clear to ensure medications were given correctly and for accurate indication. did not exceed the maximum daily dose for 4 of 10 residents reviewed for unnecessary medications. (Resident #'s 76, 6, 9, and 22)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #76 was reviewed on 3/22/13 at 8:13 a.m.</p> <p>Diagnoses for Resident #76 included, but were not limited to, hypertension, seizures, and Alzheimer's disease.</p>	F000514	<p>F514</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents 76, 9, 69, and 22 medical records have been reviewed, updated and verified with physician for current needs and diagnosis.</p> <p>2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents' medical records have been reviewed and updated with current needs and diagnosis. Any irregularities were corrected after physician notification.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff were in-serviced on</p>	04/26/2013			

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	<p>Current physician's orders for Resident #76 included, but were not limited to, the following orders:</p> <p>a.) Temazepam (sedative) 30 milligrams (mg) 1 capsule by mouth at bedtime as needed. The original order date was 12/27/12.</p> <p>b.) Lorazepam (a medication given for seizures) inject 0.25 milliliters (ml) intramuscularly at seizure activity greater than 5 minutes as needed. The original order date was 1/24/13.</p> <p>The clinical record lacked any diagnosis related to why the resident was receiving the temazepam and any information or directions from the physician related to how often these "as needed" medications could be given.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:05 a.m., additional information was requested related to the lack of diagnosis for the use of temazepam and the directions for the lorazepam "as needed" order.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:57 a.m., she indicated the facility would call the physician and verify the</p>		<p>4/16/2013 for clarifying with the physician the diagnosis and current clinical need upon receiving new orders.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? All medical records were reviewed for complete diagnosis and current resident need. All new orders are reviewed daily for completion with diagnosis, resident need and action taken as indicated by nursing management. Medical Records reviews the rewrites monthly and notifies pharmacy of any irregularities. The Consultant Pharmacist will review each resident's drug monthly and report trends to the monthly Quality Assurance on a ongoing basis.</p>				

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	<p>indication for use of the temazepam and clarify the directions for the lorazepam "as needed" orders.</p> <p>2.) The clinical record for Resident #9 was reviewed on 3/21/13 at 2:21 p.m.</p> <p>Diagnoses for Resident #9 included, but were not limited to, hypertension, diabetes mellitus, and prostate cancer.</p> <p>Current physician's orders for Resident #9 included, but were not limited to, the following orders:</p> <p>a.) Acetaminophen (a pain medication) 325 milligrams (mg) take 2 tablets by mouth every 4 hours as needed for pain. The original order date was 12/20/12.</p> <p>b.) Hydrocodone bitartrate and acetaminophen (a pain medication) 5 mg hydrocodone and 500 mg acetaminophen take 1 tablet by mouth every 8 hours as needed for pain. The original order date was 12/15/12.</p> <p>The clinical record lacked any information or directions from the physician related to the pain level each "as needed" pain medication</p>			

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	<p>should be given.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 9:13 a.m., additional information was requested related to the directions for the pain medications "as needed" orders.</p> <p>The facility failed to provide any additional information as of exit on 3/27/13.</p> <p>3.) The clinical record for Resident #69 was reviewed on 3/25/13 at 1:40 p.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to, dementia, diabetes mellitus, and depression.</p> <p>Current physician's orders for Resident #9 included, but were not limited to, the following orders:</p> <p>a.) Acetaminophen (a pain medication) 500 mg take 2 (1000 mg) tablets by mouth every 6 hours as needed. The original order date was 12/2/11.</p> <p>b.) Benzonate (a cough medication) 100 mg take 1 capsule by mouth 3 times daily as needed. The original order date was 1/3/13.</p>			

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	<p>The clinical record lacked any diagnosis related to why the resident was receiving the Benzolate and the acetaminophen "as needed" medications.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 8:05 a.m., additional information was requested related to the lack of diagnosis for the use of the Benzolate and the acetaminophen "as needed" orders.</p> <p>During an interview with the Director of Nursing on 3/26/13 at 4 :40 p.m., additional information was requested related to the indications for use for the "as needed" medication orders.</p> <p>During an interview with the Assistant Director of Nursing on 3/27/13 at 9:18 a.m., she indicated the indications for use for the Benzolate and the acetaminophen "as needed" medications had been verified with the provider.</p> <p>4.). Resident #22 clinical record was reviewed on 3/22/13 at 1:11 p.m. The resident's diagnoses included, but were not limited to, right mid-foot amputation, peripheral vascular disease, and dead right foot.</p>						

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	<p>The resident had 3/1/13, signed physician's orders. The resident's orders included, but were not limited to, hydrocodone/apap [a pain medication] 10-325 mg tablets [milligrams] take 1 to 2 tablets by mouth every 4 to 6 hours as needed. The order lacked the specific amount to be given, the specific frequency to give the medication and the reason to give the medication.</p> <p>The resident had an order for hydrocodone/apap 5/325 mg tablet take 1 to 2 tabs by mouth ever 4 to 6 hours as needed. The order lacked the specific amount to be given, the specific frequency to give the medication and the reason to give the medication.</p> <p>The resident had an order for Mi-acid [an antacid] suspension 30 milliliters every 4 hours as needed. The order lacked the specific reason to give the medication.</p> <p>5.) Review of the current facility policy, dated December 2000, titled "Physician's Order Form", provided by the Assistant Director of Nursing on 3/26/13 at 1:45 p.m., included, but was not limited to, the following:</p> <p>"All orders received will be transcribed</p>			

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	<p>to a Physician's Order Form.</p> <p>Areas to be filled in are:...</p> <p>...8. Med or TX ordered, dosage, form (pill, liq, supp, etc.), route of administration, schedule or time, and indication/reason...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility's Quality Assessment and Assurance Committee failed to develop and implement appropriate plans of action to address staff not following swallowing strategies for dependent residents for 2 of 2 residents (Resident #'s 19 and 131) reviewed for safe dining and lack of monitoring for high or low blood sugar levels, interventions for low blood sugar</p>	F000520	<p>F 520 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 19,131, 9, 22, and 26 blood sugar results have been reviewed and updated. An updated Diabetic Assessment Flow Sheet has been added to each diabetic resident's medical record. The flow sheet includes treatment, symptoms, doctor notification, family notification and follow up blood sugar. Resident 19 and 131 were evaluated by</p>	04/26/2013

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	<p>levels, and weight based insulin for 3 of 10 residents (Resident #'s 9, 22, and 26) reviewed for diabetic services identified during the Annual Recertification and State Licensure survey.</p> <p>Findings include:</p> <p>During an interview on 3/27/13 at 10:48 a.m., the Administrator and Director of Nursing indicated the facility quality assurance program had not identified any concerns related to staff not following swallowing strategies for dependent residents (Resident #'s 19 and 31) or any problems related to lack of monitoring for high or low blood sugar levels, interventions for low blood sugar levels being completed or weight based insulin for diabetic residents (Resident #'s 9, 22, and 26) within the last year.</p> <p>3.1-52(b)(2)</p>		<p>speech therapist on 4/16/13 and documentation is in the available in the Café for reference during meal time. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility has implemented a Diabetic Assessment Flow Sheet to each diabetic resident's medical record. The flow sheet includes treatment, symptoms, doctor notification, family notification and follow up blood sugar. Speech therapy screens all new admissions. Therapy staff screen all other residents quarterly and as significant changes occur and makes recommendations for follow up to the physician. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff was in-serviced 4/16/13 on documentation of Blood Sugar Assessment Flow Sheet. Nursing staff was in-serviced on the location of the Swallowing Strategy information and how to use the documentation in feeding residents. Nursing staff was educated on 4/16/13 for reporting any trends or patterns to the Quality Assurance Committee for investigation of reported issues. Committee consists of all department managers and medical director. Anyone</p>		

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			interested is welcome to attend the meeting or be a participant. The information is also posted on Point Click Care. Forms for filling concerns are located in the Employee Break Room for informing the Quality Assurance Committee of any issue. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? The blood sugar audits and swallowing strategy audits are being done 5 times a week for 2 weeks, 3 times a week for 2 weeks, 1 time a week, and 1 time a month for 4 months by nursing management. The results are reviewed in the monthly Quality Assurance Committee. The Quality Assurance Committee has a routine agenda of indicators such as infection surveillance, falls, wounds, preventative maintenance, customer concerns, satisfaction surveys, etc., that reviewed monthly. In addition, the recent annual recertification and licensure survey will be reviewed for at least 6 months or as long the interdisciplinary Quality Assurance Committee deems necessary.	

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R000035	<p>410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on record review and interview, the facility failed to ensure service plans were signed by the</p>	R000035	R035 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All residents will	04/26/2013	

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	<p>resident or their Responsible Party for 5 of 7 resident records reviewed for service plans. [Resident #'s R6, R2, R14, R24, R25]</p> <p>Findings include:</p> <p>1. Resident #R6's clinical record was reviewed on 3/26/13 at 9:13 a.m. The resident's diagnoses included, but were not limited to, dementia, depression, chronic pain, and mood irritability.</p> <p>The resident was admitted on 8/3/12 and had an admission service plan and a second service plan dated 2/19/13. The service plans were signed by the Director of Nursing. The space for the Responsible Party was blank. The service plan indicated the resident required the assistance of one for mobility, transfers, bathing, grooming, dressing, toileting, eating, and the administration of medications.</p> <p>2. Resident #R2's clinical record was reviewed on 3/26/13 at 10:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, falls, and insulin dependent diabetes mellitus.</p> <p>The resident was admitted on 3/9/13</p>		<p>have Service Plans signed by the responsible parties by 4/26/13. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? A medical record audit will be completed and all service plans signed by the family/responsible party. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All new residents admitted will have the service plans as part of the admission paperwork signed when admitted to the Alzheimer's Assisted Living Center. Director of Nursing educated on regulation on 3.26.134. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? All new admissions paperwork and medical record will be audited for completed paperwork. All service plans will be audited quarter for 2 months then every six months per State regulations or as needs indicate. The Director of Nursing will report the quarterly report to the QA in May and August. The Quality Assurance Committee will review determine the need for further monitoring of documentation.</p>		

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	<p>and had an admission service plan for that date signed by the Director of Nursing. The space for the Responsible Party was blank. The service plan indicated the resident required the assistance of one for bathing, grooming, and the administration of medications.</p> <p>3. Resident #R14's clinical record was reviewed on 3/26/13 at 10:34 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and colostomy.</p> <p>The resident was admitted on 10/8/12 and had an admission service plan and a second service plan dated 3/14/13. The service plans were signed by the Director of Nursing. The space for the Responsible Party was blank. The service plan indicated the resident required the assistance of one for bathing, grooming, dressing, toileting, eating, and the administration of medications.</p> <p>4. Resident #R24's closed clinical record was reviewed on 3/26/13 at 12:45 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and depression.</p> <p>The resident was admitted on 4/3/12</p>			

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	<p>and had an admission service plan and a second service plan dated 6/27/12. The service plans were signed by the Director of Nursing. The space for the Responsible Party was blank. The service plan indicated the resident required the assistance of one for mobility, bathing, grooming, dressing, toileting, eating, and the administration of medications and the assistance of two for transferring.</p> <p>5. Resident #R25's closed clinical record was reviewed on 3/26/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>The resident was admitted to the facility on 9/26/12 and had an admission service plan signed by the Director of Nursing on that date. The space for the Responsible Party was blank. The service plan indicated the resident required the assistance of one for bathing, grooming, dressing, toileting, and the administration of medications.</p> <p>During an interview with the Director of Nursing on 3/26/13 at 10:05 a.m., she indicated she does not have the residents' responsible parties sign the service plans. She indicated she did</p>			

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	not know they needed to be signed by the responsible party.			