

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/05/2011
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NAME OF PROVIDER OR SUPPLIER  BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN47304
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: November 29, 30, and December 1, 2, and 5, 2011</p> <p>Facility number: 000565 Provider number: 155546 Aim number: 100267630</p> <p>Survey team: Betty Retherford RN, TC Ginger McNamee RN Karen Lewis RN Delinda Easterly RN</p> <p>Census bed type: SNF/NF: 51 SNF: 10 Total: 61</p> <p>Census payor type: Medicare: 14 Medicaid: 35 Other: 12 Total: 61</p> <p>Stage 2 Sample: 34</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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F0252 SS=E	<p>Quality review completed 12/7/11 Cathy Emswiller RN</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure the environment was free from scuffed bathroom and room doors and/or worn finish on room furniture for 9 of 30 rooms on the Center and West halls. This had the potential to affect 15 residents residing in those rooms. (Rooms 7, 8, 9, 16, 18, 20, 22, 26, and 27)</p> <p>Findings include:</p> <p>During the environmental tour conducted with the Maintenance Director, Corporate Maintenance director, and Housekeeping Supervisor, on 12/2/11 at 1:15 p.m., the following was noted:</p> <p>Room 7 bed 1: The finish on the footboard and dresser drawer edges was worn with areas of bare wood noted.</p> <p>Room 8 bed 2: The finish on the drawer edges was worn with areas of bare wood noted. The lower door frame into the room had multiple</p>	F0252	<p>F252 - Safe/Clean/Comfortable/Homelike Environment The scuffed bathroom door, room doors, and/or worn finish has been touched up for Rooms 7, 8, 9, 16, 18, 20, 22, 26, and 27. An action plan has been created to apply finish on all facility bathroom doors, room doors, and/or worn finish on furniture. Maintenance Director/Designee will apply finish on facility bathroom doors, room doors, and/or worn finish on furniture for two areas weekly, until all areas are complete. Maintenance Director/Designee will monitor monthly all facility bathroom doors/room doors and/or worn finish on furniture for any touch-ups. QA Committee to review Maintenance audits monthly times 12 to ensure appropriate follow through.</p>	01/04/2012	

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	<p><b>gouged and nicked areas in the wood.</b></p> <p>Room 9 bed 1: The finish on the edges of the footboard and dresser drawers was worn with areas of bare wood noted.</p> <p>Room 16 bed 2: The bathroom door was scratched and nicked on the lower interior surface.</p> <p>Room 18 bed 1: The bathroom door was scratched and the wood gouged on the lower portion of the door. The finish was off of the edges of the bedside table with areas of bare wood noted.</p> <p>Room 20 bed 2: The door frame of the bathroom and the lower portion of the inside bathroom door had multiple areas of scratched and gouged wood.</p> <p>Room 22 bed 2: The door frame of the bathroom and the lower portion of the inside bathroom door had multiple areas of scratched and gouged wood.</p> <p>Room 26 bed 2: The lower portion of the inside bathroom door had multiple areas of marred wood with the finish missing.</p> <p>Room 27 bed 2: The lower portion of the interior bathroom door was</p>			

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F0279 SS=D	<p>marred and scraped. The edges of the bedside table had areas where the finish was worn off with bare wood noted.</p> <p>During an interview on 12/2/11 at 12:40 p.m., the Maintenance Director indicated the problems with the bathroom doors had been noted and an action plan was being developed to address the issue.</p> <p>3.1-19(f)(5)</p> <p>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). Based on record review and interview, the facility failed to ensure a comprehensive health care plan was developed related to the use of</p>	F0279	F279 - Develop Comprehensive Care Plans The facility has corrected the care plan for Resident #44 to include the use of anti-anxiety and	01/04/2012	

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	<p>anti-anxiety, antidepressant, and antihypertensive medications for 2 of 10 residents reviewed for unnecessary medication use in a Stage 2 sample of 34. (Resident #'s 44 and 60)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #44 was reviewed on 12/1/11 at 11:00 a.m.</p> <p>Diagnoses for Resident #44 included, but were not limited to, dementia, depressive disorder, agitation, dementia with behavioral disturbances, and anxiety.</p> <p>Physician's orders dated, 10/19/11, indicated the resident had an order for citalopram hydrobromide (antidepressant medication) 40 milligrams (mg) everyday. This order remained current on 12/1/11 at 11:00 a.m.</p> <p>The clinical record lacked any comprehensive health care plan (HCP) having been developed related to Resident's #44 diagnosis of depressive disorder or need for antidepressant medication.</p> <p>Physician's orders, dated 10/19/11,</p>		<p>anti-depressant use. The care plan also addresses the behavior of Dementia with Behavioral Disturbances. Resident #60 has been discharged from the facility. All other residents have the potential to be affected by the alleged deficient practice. Social Service Director or Designee to review all residents' medications to ensure any anti-anxiety and anti-depressant use along with the corresponding diagnoses and behaviors have been addressed on all resident care plans. ADON or Designee to audit all resident care plans to ensure anti-hypertensive medications have been included. Social Service Director or Designee to audit medications of all new admissions to the facility to ensure care plans are addressed to include psychoactive medication use and corresponding diagnoses/behaviors. ADON or Designee to audit orders for anti-hypertensive medications to ensure appropriate care plan follow up. In addition, all physician orders will be reviewed daily during Departmental Morning Meetings to identify any residents requiring the need to update the care plans accordingly. Social Service Director and Director of Nursing to reeducate the nursing staff in regards to the updated care plans. MDS Coordinator to review for appropriate care planning upon completion of the</p>	

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	<p>indicated the resident had an order for lorazepam (anti-anxiety medication)1(mg) every 12 hours. This order remained current on 12/1/11 at 11:00 a.m.</p> <p>The clinical record lacked any comprehensive HCP having been developed related to Resident's #44 diagnosis of dementia with behavioral disturbance and anxiety or need for anti-anxiety medication.</p> <p>During an interview with the Consultant RN on 12/1/11, at 3:40 p.m., additional information was requested related to the lack of any comprehensive HCP having been developed regarding the resident's use of antidepressant and anti-anxiety medications.</p> <p>During an interview with the Medical Records designee on 12/2/11 at 8:41 a.m. she provided comprehensive HCPs for the use of antidepressant and anti-anxiety medications which had been initiated 12/1/11.</p> <p>2.) Resident #60's clinical record was reviewed on 12/2/11 at 12:39 p.m. The resident's diagnoses included, but were not limited to, unspecified essential hypertension and renal failure with dialysis treatments three times a week.</p>		MDS.DON to review all completed audits weekly. QA Committee to review audits times four quarters contacted by Social Service Director and Nursing quarterly to ensure appropriate follow through.		

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	<p>The resident's current physician orders were signed by the physician on 11/12/11, and indicated the resident was to receive hydralazine hcl 10 mg every 6 hours as needed for systolic blood pressure greater than 160. This order was initiated on 9/22/11 and remained current.</p> <p>Resident #60's care plan indicated the last care plan review was completed on 12/1/11, by the facility. The care plan did not have a problem or focus related to the resident's diagnosis of hypertension or the need for the as need hydralazine hcl.</p> <p>During an interview with the Director of Nursing and RN Consultant on 12/5/11 at 11:00 a.m., additional information related to a hypertension care plan problem was requested.</p> <p>During the exit conference on 12/5/11 at 3:45 p.m., the Nurse Consultant indicated there had been no care plan developed related to the hypertension.</p> <p>3.) The 6/05, revised "Care Plans" policy was provided by the Director of Nursing on 12/5/11 at 8:30 a.m. The policy indicated the purpose was to promote individualized resident care</p>				

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F0282 SS=E	<p>plans, with specific plans from nursing and other disciplines and to provide continuity of care.</p> <p>3.1-35(a)</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>A.) Based on record review and interview, the facility failed to ensure physicians orders for medications and/or insulin coverage were followed for 3 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 34. (Resident #60, #29, and 65)</p> <p>B.) Based on record review and interview, the facility failed to ensure a safety alarm was in place at the time of a resident's fall (Resident #14) and failed to ensure a fall risk assessment was completed (Resident #29) to identify a resident at risk for falls for 2 of 7 residents reviewed who met the criteria for falls in a Stage 2 Sample of 34.</p> <p>Findings include:</p> <p>A1.) Resident #60's clinical record was reviewed on 12/2/11 at 12:39 p.m. The resident's diagnoses</p>	F0282	F282 - Services By Qualified Persons/Per Care PlanThe facility is unable to correct the alleged deficient practice for Resident #60. All residents have the potential to be affected by the alleged deficient practice. DON/Designee to audit all resident orders/medication administration records for the last 30 days to identify those that have as needed antihypertensive medication orders. Weekly audits to be conducted reviewing those residents identified with as needed antihypertensive medication orders to ensure blood pressures are being obtained and medications are administered appropriately. Physician orders to be reviewed daily during Departmental Morning Meeting to identify any additional residents receiving orders for as needed hypertensive medications requiring weekly monitoring. The alleged deficient practice of time administration discrepancies regarding Ativan for Resident #29 have been corrected to include	01/04/2012

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	<p>included, but were not limited to, unspecified essential hypertension and renal failure with dialysis treatments three times a week.</p> <p>The resident's current physician orders were signed by the physician on 11/12/11, and indicated the resident was to receive hydralazine hcl 10 mg every 6 hours as needed for systolic blood pressure [b/p] greater than 160. This order was initiated on 9/22/11.</p> <p>Review of the resident's blood pressure monitoring for October and November, 2011, indicated the resident's blood pressure was not obtained on the 8th, 11th, 13th, and 14th. The monitoring also indicated the resident's systolic b/p was greater than 160 on the following days and times: October, 2011 162 on the 7th at 1:32 p.m. 176 on the 9th at 2:23 a.m., and 172 at 11:24 p.m. 179 on the 16 at 11:54 p.m. 162 on the 17 at 7:14 p.m. 162 on the 19th at 11:40 p.m. 184 on the 23rd at 10:58 p.m. 168 on the 25th at 9:58 p.m. 184 on the 30th at 11:27 p.m. 162 on the 31st at 7:23 p.m.</p>		<p>6PM. All residents have the potential to be affected by the alleged deficient practice. Ativan orders for all residents will be reviewed to ensure all administration times are accurate. Medical Records to audit all residents with Ativan orders to ensure the correct medication administration times have been entered in the Electronic Medical Administration Record. Auditing will be completed monthly and upon any new order changes identified during Daily Departmental Morning Meetings. DON/Designee to review all medical record audits weekly to ensure accuracy. Audits and DON reviews to be discussed at QA Committee times 12 months. The facility is unable to correct the previous alleged deficient practice for Resident #65. However, the sliding scale order has been clarified to read: If blood sugar is between 421-460, administer 20 units and call the physician if the blood sugar is &lt;60 or &gt;400. The primary physician has been notified of the discrepancies in blood sugar administration documentation. All other residents have the potential to be affected by the alleged deficient practice. Sliding scale insulin orders for all residents have been reviewed to ensure that insulin coverage parameters are complete and orders for physician notification have been</p>		

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	<p>November, 2011 164 on the 6th at 10:36 p.m.</p> <p>Review of the nurse progress note, e-MAR [Medication Administration Record] note and MAR for October and November, 2011, indicated the resident received the hydralazine hcl 10 mg as needed for systolic blood pressure [b/p] greater than 160 on 10/9/11 at 2:03 a.m. This resulted in the resident not receiving the as needed hydralazine hcl nine times from 10/6/11 to 11/6/11, when the systolic blood pressure was greater than 160.</p> <p>During an interview with the Director of Nursing on 12/5/11 at 11:00 a.m., she indicated the resident should have his blood pressure taken daily and given the as needed medication when needed.</p> <p>During an interview LPN #1 on 12/5/11 at 2:25 p.m., she indicated the second shift nurse does the Medicare charting including taking the the vital signs if the systolic blood pressure is above 160 the nurse would be the one to give the as needed medication.</p>		<p>included in the sliding scale orders. DON/Designee to review completed accu checks daily, for all residents receiving sliding scale insulin to ensure that insulin administered is documented as ordered. Medical Records to review physician orders for all new admissions to ensure sliding scale insulin orders are complete and the order contains call parameters for physician notification. The facility is unable to correct the alleged deficient practice for Resident #14. All residents have the potential to be affected by the alleged deficient practice. DON to reeducate nursing staff regarding staff responsibility to check for placement and functioning of safety alarms each shift. DON/Administrator to conduct daily walking rounds to ensure those residents that require a safety alarm has one in place. DON/Designee to review Medical Record audits weekly. A fall risk assessment has been updated for Resident #29 to reflect the current status. All residents have the potential to be affected by the alleged deficient practice. DON/Designee to audit all fall risk assessments to determine those residents at a high risk for falls. All residents at high risk for falls will be identified on the Certified Nursing Assistant (CNA) computer documentation, "Resident Care Cardex" allowing CNAs to view all those residents</p>		

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	<p>A2.) The clinical record for Resident #29 was reviewed on 12/1/11 at 9:55 a.m.</p> <p>Resident #29's current diagnoses included, but were not limited to, Huntington's chorea, allergic rhinitis and disorder of bone and cartilage.</p> <p>Resident #29 had a healthcare plan, dated 7/21/11, which indicated the resident had a problem listed as, potential for discomfort and side effects related to the use of anti-anxiety medication. Interventions for this problem included, but were not limited to, administer medication per physician's orders and observe for side effects of medication.</p>		<p>requiring increased supervision each shift, each day. Nursing staff to be reeducated on identification of those residents at a high risk for falls requiring increased supervision. Nursing staff to add the risk of the need for increased supervision to the "Kardex" upon admission with any change in status. DON/Designee to audit any new admissions or resident change in status by viewing the daily nursing progress notes. QA Committee to discuss audit results and DON reviews monthly times 12 months for any needed changes.</p>		

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	<p>Resident #29 had current a current physician's order for Ativan (an anti-anxiety medication) 0.5 milligrams per gastrostomy-tube daily every 6 hours. The original date of the order was 10/21/11. The times on the medication administration record indicated the Ativan medication was to be given at 12 midnight, 6 a.m., 12 noon, and 4 p.m.</p> <p>During an interview with the RN consultant on 12/1/11 at 11:10 a.m. additional information was requested related to the Ativan medication times noted above.</p> <p>During an interview with the RN consultant on 12/2/11 at 9:30 am she indicated the Ativan medication should have been administered at 12 midnight, 6 a.m., 12 noon ,and 6 p.m.. She indicated the nursing staff had transcribed the medication times incorrectly to the medication administration record. She further indicated Resident #29 had been receiving the Ativan medication at the incorrect time of 4 p.m. from 10/21/11 when it was ordered by the physician. This resulted in the Ativan medication having been administered at the incorrect time for 38 days.</p>			

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	<p>A3.) The clinical record for resident #65 was reviewed on 12/1/11 at 10:00 a.m.</p> <p>Resident #65's current diagnoses included, but were not limited to, diabetes mellitus, hypertension and hyperlipidemia.</p> <p>Resident #65 had physician's orders for the following,</p> <p>A. Lantus (insulin) inject 45 units subcutaneous at bedtime. The original date of this order was 9/20/11.</p> <p>B. Humalog (insulin) inject 10 units subcutaneous three times a day. The original date of this order was 9/20/11.</p> <p>C. Monitor blood glucose levels before meals and at bedtime: 7:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The original date of this order was 9/20/11.</p> <p>D. Administer Humalog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>141 - 180 = 4 unit 181 - 220 = 6 units</p>			

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	<p>221 - 260 = 8 units 261 - 300 = 10 units 301 - 340 = 12 units 341 - 380 = 14 units 381 - 420 = 18 units (421-459 no information noted) 460 = 20 units greater than (no information noted)</p> <p>A health care plan, dated 2/14/11 indicated Resident #65 had a problem listed as, the resident is at risk for complications related to the diagnosis of diabetes mellitus and uses insulin. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered.</p> <p>Review of the October and November 2011 Medication Administration Record (MAR) for Resident #65 lacked documentation of the amount of insulin given on the following dates and times,</p> <p>October 4, 4:00 p.m. blood sugar result was 178, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 4, 8:00 p.m. blood sugar result was 172, no insulin was</p>				

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	<p>documented as having been given, the resident should have received 4 units.</p> <p>October 5, 11:00 a.m. blood sugar result was 260, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 5, 4:00 p.m. blood sugar result was 293, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 5, 8:00 p.m. blood sugar result was 218, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 6, 11:00 a.m. blood sugar result was 186, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 6, 8:00 p.m. blood sugar result was 208, no insulin was documented as having been given, the resident should have received 6 units.</p>				

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	<p>October 13, 8:00 p.m. blood sugar result was 190, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 14, 8:00 p.m. blood sugar result was 200, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 15, 11:00 a.m. blood sugar result was 294, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 15, 4:00 p.m. blood sugar result was 296, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 15, 8:00 p.m. blood sugar result was 258, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 16, 7:00 a.m. blood sugar result was 146, no insulin was documented as having been given, the resident should have received 4</p>				

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	<p>units.</p> <p>October 16, 11:00 a.m. blood sugar result was 176, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 16, 4:00 p.m. blood sugar result was 340, no insulin was documented as having been given, the resident should have received 12 units.</p> <p>October 16, 8:00 p.m. blood sugar result was 199, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 17, 8:00 p.m. blood sugar result was 208, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 18, 7:00 a.m. blood sugar result was 198, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 18, 11:00 a.m. blood sugar result was 177, no insulin was</p>			

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	<p>documented as having been given, the resident should have received 4 units.</p> <p>October 18, 8:00 p.m. blood sugar result was 189, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 20, 8:00 p.m. blood sugar result was 229, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 21, 8:00 p.m. blood sugar result was 222, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 22, 7:00 a.m. blood sugar result was 145, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 22, 8:00 p.m. blood sugar result was 343, no insulin was documented as having been given, the resident should have received 14 units.</p>			

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	<p>October 24, 8:00 p.m. blood sugar result was 221, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 27, 8:00 p.m. blood sugar result was 192, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 28, 8:00 p.m. blood sugar result was 223, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 29, 8:00 p.m. blood sugar result was 274, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 30, 8:00 p.m. blood sugar result was 282, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>November 1, 7:00 a.m. blood sugar result was 203, no insulin was documented as having been given, the resident should have received 6</p>			

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	<p>units.</p> <p>November 1, 11:00 a.m. blood sugar result was 257, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>November 1, 8:00 p.m. blood sugar result was 211, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 4, 8:00 p.m. blood sugar result was 280, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>November 5, 4:00 p.m. blood sugar result was 199, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 6, 4:00 p.m. blood sugar result was 256, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>November 6, 8:00 p.m. blood sugar result was 166, no insulin was documented as having been given,</p>			

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	<p>the resident should have received 4 units.</p> <p>November 8, 8:00 p.m. blood sugar result was 220, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 9, 8:00 p.m. blood sugar result was 147, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>November 11, 8:00 p.m. blood sugar result was 247, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>November 16, 4:00 p.m. blood sugar result was 351, no insulin was documented as having been given, the resident should have received 14 units.</p> <p>November 18, 8:00 p.m. blood sugar result was 261, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>November 27, 7:00 a.m. blood sugar result was 156, no insulin was</p>				

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	<p>documented as having been given, the resident should have received 4 units.</p> <p>November 27, 4:00 p.m. blood sugar result was 196, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 28, 4:00 p.m. blood sugar result was 180, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>During an interview with the RN Consultant on 12/2/11 at 9:00 a.m. additional information was requested related to the lack of sliding scale coverage having been documented as given on the dates and times noted above.</p> <p>During an interview with the Medical Records designee on 12/2/11 at 12:24 p.m. she indicated no additional documentation could be provided regarding the sliding scale coverage on the dates and times noted above.</p> <p>A4.) Review of the current facility policy, dated 3/2005, titled "GLUCOSE</p>				

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	<p>TESTING-FINGERSTICK," was provided by the Director of Nursing on 12/5/11 at 8:30 a.m., included, but was not limited to, the following:</p> <p>"...18. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding coverage, and/or physician intervention is needed to adjust insulin or oral medications), etc...."</p> <p>B1.) The clinical record for Resident #14 was reviewed on 12/2/11 at 2:00 p.m.</p> <p>Resident #14's current diagnoses included, but were not limited to, dementia and cerebral vascular disease.</p> <p>Resident #14 had a "Fall Risk Assessment", dated 5/28/11, which indicated the resident was at a high risk for falls.</p> <p>The clinical record indicated the resident had a history of falls on 7/4/11, 7/21/11 and 9/3/11.</p> <p>Resident #14 had a healthcare plan, dated 7/6/11, which indicated the resident had a problem listed as,</p>			

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	<p>potential for falls related to psychotropic medication use, confusion and a history of falls. Interventions for this problem included, bed pad alarm, chair pad alarm, and motion sensor alarm.</p> <p>A nursing note entry, dated 9/3/11 at 3:39 p.m., indicated, called to room by housekeeping staff, observed resident sitting on floor bedside her bed, no alarms sounding.</p> <p>During an interview with the Director of Nursing on 12/2/11 at 3:20 p.m. she indicated at the time of Resident #14's fall on 9/3/11 the alarms were not in place and were not sounding. She further indicated she had done a "teachable moment" with the staff related to the alarms not being in place as indicated in the plan of care.</p> <p>B2.) The clinical record for Resident #29 was reviewed on 12/1/11 at 9:55 a.m..</p> <p>Resident #29's current diagnoses included, but were not limited to, Huntington's chorea, allergic rhinitis and disorder of bone and cartilage.</p> <p>Resident #29 had a healthcare plan,</p>			

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	<p>dated 9/6/11, which indicated the resident had a problem listed as, the resident has a potential for falls related to decreased mobility, weakness, psychotropic medication use, incontinence, and narcotic analgesic use. Interventions for this problem included, low bed with mats, personal alarms to bed and chair and hipsters.</p> <p>The clinical record indicated the resident had a "Fall Risk Assessment" completed on 6/11/11. The clinical record lacked any documentation of any "Fall Risk Assessment" having been completed following 6/11/11.</p> <p>The clinical record indicated the resident had a history of falls on, 10/21/11 and 11/22/11.</p> <p>During an interview with the RN consultant on 12/1/11 at 2:45 p.m. she indicated a "Fall Risk Assessment" should be completed at a minimum of "quarterly". She further indicated Resident #29 should have had a "Fall Risk Assessment" completed in the month of September 2011. She indicated the nursing staff had not completed a quarterly "Fall Risk Assessment" as indicated in the facility policy</p>			

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F0309 SS=D	<p><b>3.1-35(g)(2)</b> 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 record review and interview, the facility failed to ensure insulin coverage was given as ordered for 1 of 10 residents reviewed for unnecessary medication use in a Stage 2 Sample of 34. (Resident #65)</p> <p>Findings include:</p> <p>1.) The clinical record for resident #65 was reviewed on 12/1/11 at 10:00 a.m.</p> <p>Resident #65's current diagnoses included, but were not limited to, diabetes mellitus, hypertension and hyperlipidemia.</p> <p>Resident #65 had physician's orders for the following,</p> <p>A. Lantus (insulin) inject 45 units subcutaneous at bedtime. The original date of this order was 9/20/11.</p> <p>B. Humalog (insulin) inject 10 units subcutaneous three times a day. The original date of this order was</p>	F0309	F309 - Provide Care/Services for Highest Well BeingThe facility is unable to correct the previous alleged deficient practice for Resident #65. The order for this resident has been clarified to read: If the blood sugar is between 421-460, administer 20 units and to call the physician if the blood sugar is <60 or >400. The primary physician has been notified of the discrepancies in blood sugar administration documentation. All other residents have the potential to be affected by the alleged deficient practice. Sliding scale insulin orders for all residents have been reviewed to ensure that insulin coverage parameters are complete and orders for physician notification have been included in the sliding scale orders. Medical Records to review physician orders for all new admissions to ensure sliding scale insulin orders are complete and the order contains call parameters for physician notification. DON/Designee to review Medical Record audits weekly. QA Committee to discuss audit results monthly times 12 for any needed changes.	01/04/2012

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	<p>9/20/11.</p> <p>C. Monitor blood glucose levels before meals and at bedtime: 7:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The original date of this order was 9/20/11.</p> <p>D. Administer Humalog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>141 - 180 = 4 unit 181 - 220 = 6 units 221 - 260 = 8 units 261 - 300 = 10 units 301 - 340 = 12 units 341 - 380 = 14 units 381 - 420 = 18 units (421-459 no information noted) 460 = 20 units greater than (no information noted)</p> <p>A health care plan, dated 2/14/11 indicated Resident #65 had a problem listed as, the resident is at risk for complications related to the diagnosis of diabetes mellitus and uses insulin. Interventions for this problem included, monitor blood sugars as ordered and administer medication as ordered.</p>				

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	<p>Review of the October and November 2011 Medication Administration Record (MAR) for Resident #65 lacked documentation of the amount of insulin given on the following dates and times,</p> <p>October 4, 4:00 p.m. blood sugar result was 178, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 4, 8:00 p.m. blood sugar result was 172, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 5, 11:00 a.m. blood sugar result was 260, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 5, 4:00 p.m. blood sugar result was 293, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 5, 8:00 p.m. blood sugar result was 218, no insulin was documented as having been given,</p>				

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	<p>the resident should have received 6 units.</p> <p>October 6, 11:00 a.m. blood sugar result was 186, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 6, 8:00 p.m. blood sugar result was 208, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 13, 8:00 p.m. blood sugar result was 190, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 14, 8:00 p.m. blood sugar result was 200, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 15, 11:00 a.m. blood sugar result was 294, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 15, 4:00 p.m. blood sugar</p>				

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	<p>result was 296, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 15, 8:00 p.m. blood sugar result was 258, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 16, 7:00 a.m. blood sugar result was 146, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 16, 11:00 a.m. blood sugar result was 176, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 16, 4:00 p.m. blood sugar result was 340, no insulin was documented as having been given, the resident should have received 12 units.</p> <p>October 16, 8:00 p.m. blood sugar result was 199, no insulin was documented as having been given, the resident should have received 6 units.</p>			

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	<p>October 17, 8:00 p.m. blood sugar result was 208, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 18, 7:00 a.m. blood sugar result was 198, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 18, 11:00 a.m. blood sugar result was 177, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 18, 8:00 p.m. blood sugar result was 189, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 20, 8:00 p.m. blood sugar result was 229, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 21, 8:00 p.m. blood sugar result was 222, no insulin was documented as having been given,</p>			

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	<p>the resident should have received 8 units.</p> <p>October 22, 7:00 a.m. blood sugar result was 145, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>October 22, 8:00 p.m. blood sugar result was 343, no insulin was documented as having been given, the resident should have received 14 units.</p> <p>October 24, 8:00 p.m. blood sugar result was 221, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 27, 8:00 p.m. blood sugar result was 192, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>October 28, 8:00 p.m. blood sugar result was 223, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>October 29, 8:00 p.m. blood sugar</p>			

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	<p>result was 274, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>October 30, 8:00 p.m. blood sugar result was 282, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>November 1, 7:00 a.m. blood sugar result was 203, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 1, 11:00 a.m. blood sugar result was 257, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>November 1, 8:00 p.m. blood sugar result was 211, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 4, 8:00 p.m. blood sugar result was 280, no insulin was documented as having been given, the resident should have received 10 units.</p>				

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	<p>November 5, 4:00 p.m. blood sugar result was 199, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 6, 4:00 p.m. blood sugar result was 256, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>November 6, 8:00 p.m. blood sugar result was 166, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>November 8, 8:00 p.m. blood sugar result was 220, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 9, 8:00 p.m. blood sugar result was 147, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>November 11, 8:00 p.m. blood sugar result was 247, no insulin was documented as having been given, the resident should have received 8</p>			

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	<p>units.</p> <p>November 16, 4:00 p.m. blood sugar result was 351, no insulin was documented as having been given, the resident should have received 14 units.</p> <p>November 18, 8:00 p.m. blood sugar result was 261, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>November 27, 7:00 a.m. blood sugar result was 156, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>November 27, 4:00 p.m. blood sugar result was 196, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>November 28, 4:00 p.m. blood sugar result was 180, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>During an interview with the RN Consultant on 12/2/11 at 9:00 a.m.</p>			

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F0323 SS=G	<p>additional information was requested related to the lack of sliding scale coverage having been documented as given on the dates and times noted above.</p> <p>During an interview with the Medical Records designee on 12/2/11 at 12:24 p.m. she indicated no additional documentation could be provided regarding the sliding scale coverage on the dates and times noted above.</p> <p>2.) Review of the current facility policy, dated 3/2005, titled "GLUCOSE TESTING-FINGERSTICK," was provided by the Director of Nursing on 12/5/11 at 8:30 a.m., included, but was not limited to, the following:</p> <p>"...18. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding coverage, and/or physician intervention is needed to adjust insulin or oral medications), etc...."</p> <p>3.1-37(a)</p> <p>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>				

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	<p>Based on record review and interview, the facility failed to ensure a resident was not left unattended on the toilet resulting in a fall and fracture (Resident #92), failed to ensure a safety alarm was in place at the time of a resident's fall (Resident #14), and failed to ensure a fall risk assessment was completed (Resident #29) to identify a resident at risk for falls for 3 of 7 residents reviewed who met the criteria for falls and/or fracture in a Stage 2 Sample of 34.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #92 was reviewed on 12/1/11 at 11:15 a.m.</p> <p>Diagnoses for Resident #92 included, but were not limited to, recent significant stroke with right hemiparesis and aphasia, history of chronic obstructive pulmonary disease, hypertension, dilated cardomyopathy, cardiac arrhythmias with pacemaker placement, gastrostomy tube placement, and congestive heart failure.</p> <p>A 6/14/11 "Transfer Assessment" indicated the resident could not bear weight and had a limitation of upper body strength. An admission nursing</p>	F0323	<p>F323 - Free of Accident Hazards/Supervision/DevicesThe facility is unable to correct the alleged deficient practice for Resident #92, as this individual no longer resides in the facility. A fall risk assessment has been updated for Resident #29. All residents have the potential to be affected by the alleged deficient practice. DON/Designee to audit all resident transfer and fall risk assessments to determine those residents at high risk for falls. All residents at high risk for falls will be identified on the Certified Nursing Assistants' (CNAs) computer documentation, "Resident Care Cardex", allowing CNAs to view all those residents requiring increased supervision each shift. Nursing staff to be reeducated regarding safety alarms and identification of those residents at high risk for falls who require increased supervision utilizing the "Resident Care Cardex". Nursing staff to add the risk of the need for increased supervision to the Cardex upon admission and with any change in status. DON/Administrator to conduct daily rounds to ensure those residents requiring a safety alarm has one in place. DON/Designee to audit new admissions/resident change in status daily by viewing the daily nursing progress notes in the computer system. QA Committee to review the results of audits/daily rounds monthly times</p>	01/04/2012	

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	<p>assessment, dated 6/14/11 at 1:20 p.m., indicated the resident had a contracture of the right hand, needed the assistance of 2 for transfers, and needed the assistance of 2 for ambulation and mobility needs. A nursing note, dated 6/14/11 at 2 p.m., indicated the resident had fallen within the last 60 days prior to coming to the nursing home.</p> <p>A nursing note, dated 6/15/11 at 1:23 p.m., indicated the resident needed total assistance for transfers, extensive assistance of ambulation, bed mobility, toileting, dressing and grooming. The note indicated the resident had an unsteady gait and balance problem and weakness to right upper and lower extremities. The only injuries documented at the time of the fall was a 0.5 centimeter (cm) by 2 cm "bump knot" noted to the top of right cranial area.</p> <p>A Falls Investigation Worksheet", dated 6/16/11, indicated the resident had an unwitnessed fall on 6/15/11 at 4 p.m. The worksheet indicated the resident was sitting on the toilet in the bathroom at the time of the fall. The note indicated current interventions in place to help reduce falls were a chair pad alarm and a low bed with mat. The root cause analysis section</p>		12 and make revisions as necessary.		

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	<p>indicated "Resident left alone and sitting balance not good. Corrective action given to CNA...."</p> <p>A nursing note, dated 6/19/11 at 3:59 p.m., indicated "[name of doctor] notified of resident's bruising on right shoulder and increased reports of pain. Order received for x-ray of right shoulder...."</p> <p>An right shoulder X-ray report, dated 6/19/11, indicated the resident had an acute distal clavicle fracture.</p> <p>A nursing note, dated 6/19/11 at 5:25 p.m., indicated the physician was notified of the X-ray report and an order for an arm sling was received. The note indicated the resident was to have a followup orthopedic consult.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 12/1/11 at 4:20 p.m., the DoN indicated Resident #92 should not have been left on the toilet unattended prior to the resident's fall on 6/15/11.</p> <p>2.) The clinical record for Resident #14 was reviewed on 12/2/11 at 2:00 p.m.</p> <p>Resident #14's current diagnoses included, but were not limited to,</p>			

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	<p>dementia and cerebral vascular disease.</p> <p>Resident #14 had a "Fall Risk Assessment", dated 5/28/11, which indicated the resident was at a high risk for falls.</p> <p>The clinical record indicated the resident had a history of falls on 7/4/11, 7/21/11 and 9/3/11.</p> <p>Resident #14 had a healthcare plan, dated 7/6/11, which indicated the resident had a problem listed as, potential for falls related to psychotropic medication use, confusion and a history of falls. Interventions for this problem included, bed pad alarm, chair pad alarm, and motion sensor alarm.</p> <p>A nursing note entry, dated 9/3/11 at 3:39 p.m., indicated, called to room by housekeeping staff, observed resident sitting on floor bedside her bed, no alarms sounding.</p> <p>During an interview with the Director of Nursing on 12/2/11 at 3:20 p.m. she indicated at the time of Resident #14's fall on 9/3/11 the alarms were not in place and were not sounding. She further indicated she had done a "teachable moment" with the staff</p>				

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	<p>related to the alarms not being in place as indicated in the plan of care.</p> <p>3.) The clinical record for Resident #29 was reviewed on 12/1/11 at 9:55 a.m..</p> <p>Resident #29's current diagnoses included, but were not limited to, Huntington's chorea, allergic rhinitis and disorder of bone and cartilage.</p> <p>Resident #29 had a healthcare plan, dated 9/6/11, which indicated the resident had a problem listed as, the resident has a potential for falls related to decreased mobility, weakness, psychotropic medication use, incontinence, and narcotic analgesic use. Interventions for this problem included, low bed with mats, personal alarms to bed and chair and hipsters.</p> <p>The clinical record indicated the resident had a "Fall Risk Assessment" completed on 6/11/11. The clinical record lacked any documentation of any "Fall Risk Assessment" having been completed following 6/11/11.</p> <p>The clinical record indicated the resident had a history of falls on,</p>				

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	<p>10/21/11 and 11/22/11.</p> <p>During an interview with the RN consultant on 12/1/11 at 2:45 p.m. she indicated a "Fall Risk Assessment" should be completed at a minimum of "quarterly". She further indicated Resident #29 should have had a "Fall Risk Assessment" completed in the month of September 2011. She indicated the nursing staff had not completed a quarterly "Fall Risk Assessment" as indicated in the facility policy.</p> <p>4.) Review of the current facility policy, dated 8/2009, titled "FALL RISK AND POST FALL INVESTIGATION," was provided by the Director of Nursing on 12/5/11 at 8:30 a.m., included, but was not limited to, the following:</p> <p>"Purpose: 1. To identify treatable conditions and improve overall quality of life for the resident.</p> <p>2. To conduct appropriate assessments prior to and after falls.</p> <p>3. To intervene when possible to "break" a fall.</p> <p>4. To detect reversible causes of falls and to identify supportive aides to prevent falls.</p> <p>5. To identify high-risk residents and institute interventions to reduce falls and the consequences of</p>			

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	<p>falls.</p> <p>Policy: 1. A Fall Risk and other assessment forms will be completed on each resident:</p> <ul style="list-style-type: none"> <li>a. On Admission</li> <li>b. Quarterly</li> <li>c. When a Significant Change Occurs</li> </ul> <p>2. Any resident scoring a "10" or above on the Fall Risk Assessment form will be placed in the "High Risk for potential falls" category....</p> <p>...Performed By: Nursing staff and all interdisciplinary team members.</p> <p>Procedure</p> <p>1. Conduct Fall Risk Assessment as stated under "Policy" above.</p> <p>Rationale</p> <p>1. Staff should regularly monitor residents for changes which might increase chances for falling....</p> <p>...Possible Interventions...</p> <p>...2. Physical...</p> <p>...Bed 1. Personal Bed Alarm Chair 1. Personal Alarm...</p>				

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F0333 SS=D	<p>...5. Staff will assist resident with ADLs and ambulation if needed....</p> <p>...8. A resident who is at high-risk and incapable of voluntary movement may have the following interventions used: a. Total assistance will be used in all transfers...."</p> <p>3.1-45(a)(2) The facility must ensure that residents are free of any significant medication errors. Based on record review and interview the facility failed to give an as needed medication for high blood when ordered by the physician resulting in a significant medication error for 1 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 34. [Resident #60]</p> <p>Findings include:  Resident #60's clinical record was reviewed on 12/2/11 at 12:39 p.m. The resident's diagnoses included, but were not limited to, unspecified essential hypertension and renal failure with dialysis treatments three times a week.  The resident's current physician orders were signed by the physician on 11/12/11, and indicated the</p>	F0333	<p>F333 - Residents Free of Significant Med Errors The facility is unable to correct the alleged deficient practice for Resident #60. All residents have the potential to be affected by the alleged deficient practice. DON/Designee to audit all resident orders/medication administration records for the last 30 days to identify those that have as needed anti-hypertensive medication orders. DON/Designee to conduct weekly audits of those residents identified with an as needed anti-hypertensive medication order to ensure blood pressures are being obtained and medications administered appropriately. Physician orders to be reviewed daily during Departmental Morning Meetings to identify any additional residents receiving orders for as needed antihypertensive medications</p>	01/04/2012

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	<p>resident was to receive hydralazine hcl 10 mg every 6 hours as needed for systolic blood pressure [b/p] greater than 160. This order was initiated on 9/22/11.</p> <p>Review of the resident's blood pressure monitoring for October and November, 2011, indicated the resident's blood pressure was not obtained on the 8th, 11th, 13th, and 14th. The monitoring also indicated the resident's systolic b/p was greater than 160 on the following days and times:</p> <p>October, 2011 162 on the 7th at 1:32 p.m. 176 on the 9th at 2:23 a.m., and 172 at 11:24 p.m. 179 on the 16 at 11:54 p.m. 162 on the 17 at 7:14 p.m. 162 on the 19th at 11:40 p.m. 184 on the 23rd at 10:58 p.m. 168 on the 25th at 9:58 p.m. 184 on the 30th at 11:27 p.m. 162 on the 31st at 7:23 p.m.</p> <p>November, 2011 164 on the 6th at 10:36 p.m.</p> <p>Review of the nurse progress note, e-MAR [Medication Administration Record] note and MAR for October and November, 2011, indicated the resident received the hydralazine hcl</p>		<p>requiring weekly monitoring. Results of weekly audits to be reviewed monthly times 12 during QA Committee meetings.</p>		

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F0428 SS=D	<p>10 mg as needed for systolic blood pressure[b/p] greater than 160 on 10/9/11 at 2:03 a.m. This resulted in the resident not receiving the as needed hydralazine hcl nine times from 10/6/11 to 11/6/11, when the systolic blood pressure was greater than 160.</p> <p>During an interview with the Director of Nursing on 12/5/11 at 11:00 a.m., she indicated the resident should have his blood pressure taken daily and given the as needed medication when needed.</p> <p>During an interview LPN #1 on 12/5/11 at 2:25 p.m., she indicated the second shift nurse does the Medicare charting including taking the the vital signs if the systolic blood pressure is above 160 the nurse would be the one to give the as needed medication.</p> <p>3.1-48(c)(2) 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 record review and interview, the facility failed to ensure the</p>	F0428	F428 - Drug Regimen Review, Report Irregular, Act OnA STAT	01/04/2012	

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	<p>consultant pharmacist identified irregularities related to incorrect medication administration times (Resident # 29) and missing laboratory testing (Resident #49), and blood pressure medication not being given as ordered (Resident #60) for 3 of 10 residents reviewed for unnecessary medications in a Stage 2 Sample of 34.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #49 was reviewed on 12/1/11 at 1:55 p.m.</p> <p>Diagnoses for Resident #49 included, but were not limited to, schizophrenia, bipolar disorder, diabetes mellitus, hypertension, hypothyroidism, anemia, phlebitis and thrombophlebitis of femoral vein, acute renal failure, and Alzheimer's Disease.</p> <p>Resident #49 had a 9/25/10 order for a monthly Pt/INR (a lab test done to test for the thinning of the blood) and a 10/28/10 order for a monthly CBC (complete blood count). These orders were combined on one line the September 2011 recapitulation of physician's orders and read "PT/INR and CBC monthly".</p>		<p>CBC was obtained for Resident #49 on 12/2/11. Lab was notified of the discrepancy. Orders to be revised to include monthly CBC as well as notification to facility. Labs will be obtained when audits are completed for any needed corrections on any other resident orders. All residents have the potential to be affected by the alleged deficient practice. Lab orders for residents currently residing in the facility were audited to ensure that all lab orders were current and correctly printed on the physician order recapulation and that these orders have been obtained according to current physician orders. DON/Designee to audit all resident physician order recapulations to ensure that orders are current with ordered labs. DON/Designee to conduct weekly reviews of record audits to identify any concerns. Audits and DON reviews will be discussed monthly times 12 during QA Committee to identify any needed changes. The alleged deficient practice of time discrepancy for the administration of Ativan for Resident #29 was corrected to include 6PM. All residents have the potential to be affected by the alleged deficient practice. Ativan orders for all residents will be reviewed to ensure all administration times are accurate. Medical Records to audit all residents with Ativan orders to ensure the correct medication</p>		

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	<p>On 10/19/11 a physician's order was written to discontinue the resident's Warfarin medication (a blood thinner) and to discontinue the resident's monthly PT/INR blood testing. No order was written to discontinue the residents monthly CBC.</p> <p>The December 2011 recapitulation of physician's orders lacked any order for a monthly CBC. The last CBC report in the clinical record was dated 10/3/11.</p> <p>During an interview with the DoN on 12/2/11 at 10:40 a.m., additional information was requested related to the lack of any order for the CBC blood test on the December 2011 recapitulation of physician's orders.</p> <p>On 12/2/11 at 12:20 p.m., the DoN indicated the CBC order had been deleted by the pharmacy when the PT/INR order was discontinued. She indicated the physician had been contacted and an order had been received for a stat (immediate) CBC and then a monthly CBC.</p> <p>The clinical record indicated the pharmacist had visited the facility and reviewed the resident's orders on 10/26/11 and 11/30/11 and did not</p>		<p>administration times have been entered in the Electronic Medical Administration Record monthly and upon any new order changes identified during Daily Departmental Morning Meetings. All residents have the potential to be affected by the alleged deficient practice. DON/Designee to audit all resident orders/medical administration records for the last 30 days to identify those that have as needed antihypertensive medication orders. DON/Designee to conduct weekly audits of those residents identified with as needed antihypertensive medication orders to ensure blood pressures are being obtained and medications administered appropriately. Physician orders to be reviewed daily during Departmental Morning Meetings to identify any additional residents receiving orders for as needed antihypertensive medications requiring weekly monitoring. Results of weekly audits to be reviewed during QA Committee monthly times 12.</p>	

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	<p>identify or make any recommendation regarding the CBC order having been deleted without a physician's order to stop the testing.</p> <p>2.) The clinical record for Resident #29 was reviewed on 12/1/11 at 9:55 a.m..</p> <p>Resident #29's current diagnoses included, but were not limited to, Huntington's chorea, allergic rhinitis and disorder of bone and cartilage.</p> <p>Resident #29 had a healthcare plan, dated 7/21/11, which indicated the resident had a problem listed as, potential for discomfort and side effects related to the use of anti-anxiety medication. Interventions for this problem included, but were not limited to, administer medication per physician's orders and observe for side effects of medication.</p> <p>Resident #29 had current a current physician's order for Ativan (an anti-anxiety medication) 0.5 milligrams per gastrostomy-tube daily every 6 hours. The original date of the order was 10/21/11. The times on the medication administration record indicated the Ativan medication was to be given at 12 midnight, 6 a.m., 12 noon, and 4 p.m.</p>				

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	<p>During an interview with the RN consultant on 12/1/11 at 11:10 a.m. additional information was requested related to the Ativan medication times noted above.</p> <p>During an interview with the RN consultant on 12/2/11 at 9:30 am she indicated the Ativan medication should have been administered at 12 midnight, 6 a.m., 12 noon ,and 6 p.m.. She indicated the nursing staff had transcribed the medication times incorrectly to the medication administration record. She further indicated Resident #29 had been receiving the Ativan medication at the incorrect time of 4 p.m. from 10/21/11 when it was ordered by the physician. This resulted in the Ativan medication having been administered at the incorrect time for 38 days.</p> <p>The clinical record indicated the pharmacy consultant had reviewed Resident #29's physician's orders on 10/26/11 and 11/30/11. The pharmacy consultant did not identify or make any recommendations related to the Ativan medication being given at an incorrect time interval.</p> <p>3.) Resident #60's clinical record was reviewed on 12/2/11 at 12:39 p.m. The resident's diagnoses included,</p>			

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	<p>but were not limited to, unspecified essential hypertension and renal failure with dialysis treatments three times a week.</p> <p>The resident's current physician orders were signed by the physician on 11/12/11, and indicated the resident was to receive hydralazine hcl 10 mg every 6 hours as needed for systolic blood pressure [b/p] greater than 160. This order was initiated on 9/22/11.</p> <p>Review of the resident's blood pressure monitoring for October and November, 2011, indicated the resident's blood pressure was not obtained on the 8th, 11th, 13th, and 14th. The monitoring also indicated the resident's systolic b/p was greater than 160 on the following days and times: October, 2011 162 on the 7th at 1:32 p.m. 176 on the 9th at 2:23 a.m., and 172 at 11:24 p.m. 179 on the 16 at 11:54 p.m. 162 on the 17 at 7:14 p.m. 162 on the 19th at 11:40 p.m. 184 on the 23rd at 10:58 p.m. 168 on the 25th at 9:58 p.m. 184 on the 30th at 11:27 p.m. 162 on the 31st at 7:23 p.m.</p>				

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	<p>November, 2011 164 on the 6th at 10:36 p.m.</p> <p>Review of the nurse progress note, e-MAR [Medication Administration Record] note and MAR for October and November, 2011, indicated the resident received the hydralazine hcl 10 mg as needed for systolic blood pressure[b/p] greater than 160 on 10/9/11 at 2:03 a.m. This resulted in the resident not receiving the as needed hydralazine hcl nine times from 10/6/11 to 11/6/11, when the systolic blood pressure was greater than 160.</p> <p>Further information related to why the medication was not given as ordered was requested from the Director of Nursing and the RN Consultant on 12/5/11 at 11:00 a.m. No further information was provided at the time of exit on 12/5/11 at 3:45 p.m.</p> <p>During an interview with the Medical Records Designee on 12/5/11 at 1:25 p.m., she indicated the pharmacist had reviewed the resident's clinical record on 10/26/11 and on 11/29/11 and had not identified or made any recommendations related to the blood pressure medication not being given as ordered.</p>				

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F0514 SS=D	<p>During an interview LPN #1 on 12/5/11 at 2:25 p.m., she indicated the second shift nurse does the Medicare charting including taking the the vital signs if the systolic blood pressure is above 160 the nurse would be the one to give the as needed medication.</p> <p>3.1-25(e)(1) 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 clinical record review and interview, the facility failed to ensure clinical records were complete and accurate in regards to insulin orders (Resident #65) and documentation of accucheck results (Resident #49) for 2 of 5 diabetic residents reviewed of complete and accurate clinical records in a sample of 34.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #49 was reviewed on 12/1/11 at 1:55 p.m.</p>	F0514	F514 - Res Records - Complete/Accurate/AccessibleThe facility is unable to correct the previous alleged deficient practice for Residents #49 and #65. The physician was notified of the alleged deficient practice for Residents #49 and #65. Resident #65's sliding scale order has been clarified to read: If blood sugar is between 421-460, administer 20 units and call the MD if blood sugar <60 or >400. All other residents have the potential to be affected by the alleged deficient practice. Sliding scale insulin orders for all residents have been reviewed to	01/04/2012

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	<p>Diagnoses for Resident #49 included, but were not limited to, schizophrenia, bipolar disorder and diabetes mellitus.</p> <p>The resident had a 9/20/11 order for a weekly FBS (fasting blood sugar) which remained current. The order lacked any parameters related to when the physician wanted to be notified of the results.</p> <p>The October and November 2011 medication administration record (MAR) indicated the fasting blood sugar was being obtained by accucheck testing completed at 6 a.m. weekly on Mondays.</p> <p>The MARs indicated the accucheck was completed on the following dates, but lacked any documented results of the accucheck tests:</p> <p>October 3, 10, 17, 24, 31, and November 7, 2011</p> <p>During an interview with the RN consultant on 12/5/11 at 9:30 a.m., additional information was requested regarding the missing FBS results for October 3, 10, 17, 24, and 31, and November 7, 2011. Information was also requested related to the accucheck method being used to</p>		<p>ensure that insulin coverage parameters are complete and orders for physician notification have been included in the sliding scale orders. Medical Records to review physician orders for all new admissions to ensure sliding scale insulin orders are complete and the order contains call parameters for physician notification. DON/Designee to review the medical record audits weekly. QA Committee to discuss audit results monthly times 12 for any needed changes.</p>	

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	<p>obtain a FBS and the parameters for when the physician wanted to be contacted related to the accucheck results since no lab report would be generated.</p> <p>During an interview with the Medical Records Designee on 12/5/11 at 10:10 a.m., she indicated the resident's physician had been contacted and a weekly accucheck was desired instead of a laboratory fasting blood sugar. She indicated parameters had been obtained and the physician wanted to be called for fasting accucheck results less than 75 or greater than 200. She indicated she had also located the missing blood sugar results noted above. She indicated the accucheck results were on the 24 hour report sheets which were not part of the resident's clinical record.</p> <p>2.) The clinical record for resident #65 was reviewed on 12/1/11 at 10:00 a.m.</p> <p>Resident #65's current diagnoses included, but were not limited to, diabetes mellitus, hypertension and hyperlipidemia.</p> <p>The clinical record indicated the Humalog (insulin) sliding scale coverage order dated 9/20/11 as</p>			

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	<p>follows: 141 - 180 = 4 unit 181 - 220 = 6 units 221 - 260 = 8 units 261 - 300 = 10 units 301 - 340 = 12 units 341 - 380 = 14 units 381 - 420 = 18 units greater than 460 = 20 units</p> <p>During an interview with the Director of Nursing (DoN) on 12/5/11 at 9:00 a.m. she indicated the insulin sliding scale coverage order lacked complete parameters.</p> <p>3.1-50(a)(1)</p>				